**BOARD OF PHARMACY**
Title 4, Chapter 23, Articles 1, 6, & 8

**Amend:** R4-23-110; R4-23-602; R4-23-607; R4-23-693; R4-23-802

**Repeal:** R4-23-603

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **BOARD OF PHARMACY**
Title 4, Chapter 23, Articles 1, 6, & 8

**Amend:** R4-23-110; R4-23-602; R4-23-607; R4-23-693; R4-23-802

**Repeal:** R4-23-603

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**Summary:**

This regular rulemaking from the Board of Pharmacy (Board) seeks to amend five (5) rules and repeal one (1) rule in Title 4, Chapter 23, Articles 1, 6, and 8 regarding Administration, Permits and Distribution of Drugs, and Drug Classification, respectively. Specifically, under Laws 2019, Chapter 83, the Legislature amended A.R.S. §§ 32-1930 and 32-1931 to deregulate non-prescription retailers. As a result, the Board is repealing language in the rules related to non-prescription retailers including references to a permit. Furthermore, under Laws 2024, Chapter 234, the Legislature added a definition of virtual manufacturer to A.R.S. § 32-1901. As a result, the Board is repealing the Board's definition at R4-23-110. Finally, the Board is also amending R4-23-602 to make it easier for a permit applicant to obtain additional time in which to submit information needed to complete an application.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Board cites both general and specific statutory authority for these rules.

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Board indicates it did not review any study relevant to this rulemaking.

**4. Summary of the agency's economic impact analysis:**

The Board indicates that it engages in this rulemaking as described below:

- Under Laws 2019, Chapter 83, the legislature amended A.R.S. §§ 32-1930 and 32-1931 to deregulate non-prescription retailers. As a result, the Board is repealing language related to non-prescription retailers including references to a permit.
- Under Laws 2024, Chapter 234, the legislature added a definition of virtual manufacturer to A.R.S. § 32-1901. As a result, the Board is repealing the Board's definition at R4-23-110.
- The Board is also amending R4-23-602 to make it easier for a permit applicant to obtain additional time in which to submit information needed to complete an application.

The Board determined the only economic impact is the Board's costs associated with this rulemaking. According to the Board, the rulemaking simply makes the rules consistent with statute and the amendment of R4-23-602 simplifies a regulatory burden for permit applicants.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

According to the Board, the rulemaking is neither intrusive nor costly, so the Board did not consider alternative methods.The Board determined that it has incurred and will incur the costs of implementing and enforcing this rulemaking. It believes these costs will be minimal because this rulemaking primarily makes the rules consistent with statute. It also highlights the benefit of having rules consistent with statute as important for a regulatory agency.

Among the businesses the Board identified as directly affected by this rulemaking (virtual manufacturers, non-pharmacy retailers of non-prescription drugs, and permit applicants), the Board believes that there are no costs associated with virtual manufacturers and non-pharmacy retailers of non-prescription drugs, and that there is a minimal cost associated with permit applicants. According to the Board, virtual manufacturers and non-pharmacy retailers will accrue

the benefits of clarity from this rulemaking, and the Board will accrue the benefit of the change impacting permit applicants.

**6. What are the economic impacts on stakeholders?**

The Board identified itself as the only state agency directly affected by the rulemaking and identified virtual manufacturers, non-pharmacy retailers of nonprescription drugs, and permit applicants as businesses directly affected by the rulemaking.

The Board determined that the 446 virtual manufacturers currently operating in Arizona will incur no costs because of the rule amendment, but will have the benefit of relying on a statutory definition. It also determined that non-pharmacy retailers of nonprescription drugs will also incur no costs, as the rulemaking removes from the rule all references to the previously required permit that has not been required to obtain since 2019. Therefore, the Board believes that this rulemaking provides a benefit to non-pharmacy retailers of nonprescription drugs by eliminating a source of potential confusion. Finally, the Board determined that permit applicants will incur a cost to comply with the rulemaking given that they are now required to submit a notice rather than a request of an extension of time to complete an application. However, the Board believes that the cost of the difference between these processes will be minimal. The Board believes the primary benefit from removing this unnecessary regulatory burden accrues to the Board, which will not have to act on requests for an extension of time. According to the Board, during the last fiscal year, the Board received and acted on five requests for an extension of time from permit applicants.

The Board states that because the rulemaking has a minimal economic impact on small businesses, the Board could not reduce the impact.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Board indicates there were no changes between the Notice of Proposed Rulemaking published in the Administrative Register on February 14, 2025 and the Notice of Final Rulemaking now before the Council for consideration.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Board indicates it received no public comments related to this rulemaking.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

While the Board indicates it issues licenses and permits, none of the rules in this rulemaking requires a permit. As such, the requirements in A.R.S. § 41-1037 are not applicable.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board indicates there is no corresponding federal law.

**11. Conclusion**

This regular rulemaking from the Board seeks to amend five (5) rules and repeal one (1) rule in Title 4, Chapter 23, Articles 1, 6, and 8 regarding Administration, Permits and Distribution of Drugs, and Drug Classification, respectively. Specifically, the Board is repealing language in the rules related to non-prescription retailers including references to a permit. Furthermore, the Board is repealing the Board's definition of virtual manufacturer at R4-23-110 as the definition has been codified in statute. Finally, the Board is also amending R4-23-602 to make it easier for a permit applicant to obtain additional time in which to submit information needed to complete an application.

The Board is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A).

Council staff recommends approval of this rulemaking.

**Arizona State Board of Pharmacy**

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April 28, 2025

Ms. Jessica Klein, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 305
Phoenix, AZ 85007

**Re: A.A.C. Title 4. Professions and Occupations**
**Chapter 23. Board of Pharmacy**

Dear Ms. Klein:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

A. Close of record date: The rulemaking record was closed on March 28, 2025, following a period for public comment and an oral proceeding. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B).

B. Relation of the rulemaking to a five-year-review report: The rulemaking does not relate to a 5YRR.

C. New fee: The rulemaking does not establish a new fee.

D. Fee increase: The rulemaking does not increase an existing fee.

E. Immediate effective date: An immediate effective date is not requested.

F. Certification regarding studies: I certify that the preamble accurately discloses the Board did not review any studies in its evaluation of or justification for the rule in this rulemaking.

G. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that the rule in this rulemaking will not require a state agency to employ a new full-time employee. No notification was provided to JLBC.

H. List of documents enclosed:
1. Cover letter signed by the Executive Director;
2. Notice of Final Rulemaking including the preamble, table of contents, and rule text;
3. Economic, Small Business, and Consumer Impact Statement;

Sincerely,

Kam Gandhi

Kamlesh Gandhi
Executive Director

**NOTICE OF FINAL RULEMAKING**
**TITLE 4. PROFESSIONS AND OCCUPATIONS**
**CHAPTER 23. BOARD OF PHARMACY**

**PREAMBLE**

**1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039(B) by the governor on:**

April 21, 2025

**2.**

| Article, Part, or Section Affected (as applicable) | Rulemaking Action |
|---|---|
| R4-23-110 | Amend |
| R4-23-602 | Amend |
| R4-23-603 | Repeal |
| R4-23-607 | Amend |
| R4-23-693 | Amend |
| R4-23-802 | Amend |

**3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. § 32-1904(A)
Implementing statute: A.R.S. §§ 32-1901, 32-1930, and 32-1931

**4. The effective date of the rule:**

These rules will become effective 60 days after a certified original and preamble are filed in the Office of the Secretary of State under A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

**a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable

**b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable

**5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:**

Notice of Rulemaking Docket Opening: 31 A.A.R. 544, Issue Date: February 14, 2025, Issue Number: 7, File number: (R25-11)
Notice of Proposed Rulemaking: 31 A.A.R. 509, Issue Date: February 14, 2025, Issue Number: 7, File number: (R25-09)

**6. The agency's contact person who can answer questions about the rulemaking:**

Name: Kamlesh Gandhi
Title: Executive Director
Address: 1110 W Washington Street, Ste. 260, Phoenix, AZ 85007
Telephone: (602) 771-2727
Email: kgandhi@azpharmacy.gov
Website: www.azpharmacy.gov

**7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

Under Laws 2019, Chapter 83, the legislature amended A.R.S. §§ 32-1930 and 32-1931 to deregulate non-prescription retailers. As a result, the Board is repealing language related to non-prescription retailers including references to a permit.

Under Laws 2024, Chapter 234, the legislature added a definition of virtual manufacturer to A.R.S. § 32-1901. As a result, the Board is repealing the Board's definition at R4-23-110.

The Board is also amending R4-23-602 to make it easier for a permit applicant to obtain additional time in which to submit information needed to complete an application.

**8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying**

**each study, and any analysis of each study and other supporting material:**

Not applicable

**9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**10. A summary of the economic, small business, and consumer impact:**

The Board determined the only economic impact is the Board's costs associated with this rulemaking. The rulemaking simply makes the rules consistent with statute. The amendment of R4-23-602 simplifies a regulatory burden for permit applicants.

**11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

Not applicable

**12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

Not applicable

**13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

Not applicable

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

The Board issues licenses and permits. However, none of the rules in this rulemaking requires a permit.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

No federal law is directly applicable to this subject of this rulemaking.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

**14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Not applicable

**15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**16. The full text of the rules follows:**

**TITLE 4. PROFESSIONS AND OCCUPATIONS**
**CHAPTER 23. BOARD OF PHARMACY**

**ARTICLE 1. ADMINISTRATIVE**

**Section**



**ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS**

**Section**

## ARTICLE 8. DRUG CLASSIFICATION

**Section**



## ARTICLE 1. ADMINISTRATIVE

### R4-23-110. Definitions

In addition to definitions in A.R.S. § 32-1901, the following definitions apply to this Chapter:

"Active ingredient" means any component that furnishes pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or that affects the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug, that are present in the finished drug product in a modified form, and that furnish the specified activity or effect.

"AHCCCS" means the Arizona Health Care Cost Containment System.

"Annual family income" means the combined yearly gross earned income and unearned income of all adult individuals within a family unit.

"Approved course in pharmacy law" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations.

"Approved Provider" means an individual, institution, organization, association, corporation, or agency that is approved by the Accreditation Council for Pharmacy Education (ACPE) in accordance with ACPE's policy and procedures or by the Board as meeting criteria indicative of the ability to provide quality continuing education.

"Assisted living facility" means a residential care institution as defined in A.R.S. § 36-401.

"Authentication of product history" means identifying the purchasing source, the ultimate fate, and any intermediate handling of any component of a radiopharmaceutical or other drug.

"Automated dispensing system" means a mechanical system in a long-term care facility that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of medications, and which collects, controls, and maintains all transaction information.

"Automated storage and distribution system" means a mechanical system that performs operations or activities other than counting, compounding, or administration, relative to the storage, packaging, or distributing of drugs or devices and that collects, controls, and maintains all transaction information.

"Batch" means a specific quantity of drug that has uniform character and quality, within specified limits, and is produced according to a single manufacturing order during the same cycle of manufacture.

"Beyond-use date" means:

A date determined by a pharmacist and placed on a prescription label at the time of dispensing to indicate a time beyond which the contents of the prescription are not recommended to be used; or

A date determined by a pharmacist and placed on a compounded pharmaceutical product's label at the time of preparation as specified in R4-23-410(B)(3)(d), R4-23-410(I)(6)(e), or R4-23-410(J)(1)(d) to indicate a time beyond which the compounded pharmaceutical product is not recommended to be used.

"Biological safety cabinet" means a containment unit suitable for the preparation of low to moderate risk agents when there is a need for protection of the product, personnel, and environment, consistent with National Sanitation Foundation (NSF) standards, published in the National Sanitation Foundation Standard 49, Class II (Laminar Flow) Biohazard Cabinetry, NSF International P. O. Box 130140, Ann Arbor, MI, revised June 1987 edition, (and no future amendments or editions), incorporated by reference and on file with the Board.

"Care-giver" means a person who cares for someone who is sick or disabled or an adult who cares for an infant or child and includes a patient's husband, wife, son, daughter, mother, father, sister, brother, legal guardian, nurse, or medical practitioner.

"Change of ownership," as used in A.R.S. § 32-1901.01(A), means a change of at least 30 percent in voting stock or vested interest that has direct operational oversight.

"Community pharmacy" means any place under the direct supervision of a pharmacist where the practice of pharmacy occurs or where prescription orders are compounded and dispensed other than a hospital pharmacy or a limited service pharmacy.

“Component” means any ingredient used in compounding or manufacturing drugs in dosage form, including an ingredient that may not appear in the finished product.

“Compounding and dispensing counter” means a pharmacy counter working area defined in this Section where a pharmacist, intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist compounds, mixes, combines, counts, pours, or prepares and packages a prescription medication to dispense an individual prescription order or prepackages a drug for future dispensing.

“Computer system” means an automated data-processing system that uses a programmable electronic device to store, retrieve, and process data.

“Computer system audit” means an accounting method, involving multiple single-drug usage reports and audits, used to determine a computer system’s ability to store, retrieve, and process original and refill prescription dispensing information.

“Contact hour” means 50 minutes of participation in a continuing education activity sponsored by an Approved Provider.

“Container” means:

A receptacle, as described in the official compendium or the federal act, that is used in manufacturing or compounding a drug or in distributing, supplying, or dispensing the finished dosage form of a drug; or

A metal receptacle designed to contain liquefied or vaporized compressed medical gas and used in manufacturing, transfilling, distributing, supplying, or dispensing a compressed medical gas.

“Continuing education” means a structured learning process required of a licensee to maintain licensure that includes study in the general areas of socio-economic and legal aspects of health care; the properties and actions of drugs and dosage forms; etiology, characteristics and therapeutics of disease status; or pharmacy practice.

“Continuing education activity” means continuing education obtained through an institute, seminar, lecture, conference, workshop, mediated instruction, programmed learning course, or postgraduate study in an accredited college or school of pharmacy.

“Continuing education unit” or “CEU” means 10 contact hours of participation in a continuing education activity sponsored by an Approved Provider.

“Continuous quality assurance program” or “CQA program” means a planned process designed by a pharmacy permittee to identify, evaluate, and prevent medication errors.

“Correctional facility” has the same meaning as in A.R.S. §§ 13-2501 and 31-341.

“CRT” means a cathode ray tube or other mechanism used to view information produced or stored by a computer system.

“CSPMP” means the Controlled Substances Prescription Monitoring Program established under A.R.S. Title 36, Chapter 28.

“Current good compounding practices” means the minimum standards for methods used in, and facilities or controls used for, compounding a drug to ensure that the drug has the identity and strength and meets the quality and purity characteristics it is represented to possess.

“Current good manufacturing practice” means the minimum standard for methods used in, and facilities or controls used for manufacturing, processing, packing, or holding a drug to ensure that the drug meets the requirements of the federal act as to safety, and has the identity and strength and meets the quality and purity characteristics it is represented to possess.

“Cytotoxic” means a pharmaceutical that is capable of killing living cells.

“Day” means a calendar day unless otherwise specified.

“DEA” means the Drug Enforcement Administration as defined in A.R.S. § 32-1901.

“Declared disaster areas” means areas designated by the governor or by a county, city, or town under A.R.S. § 32-1910 as those areas that have been adversely affected by a natural disaster or terrorist attack and require extraordinary measures to provide adequate, safe, and effective health care for the affected population.

“Delinquent license” means a pharmacist, intern, or pharmacy technician license the Board suspends for failure to renew or pay all required fees on or before the date the renewal is due.

“Dietary supplement or food supplement,” as used in A.R.S. § 32-1904(B), means a product (other than tobacco) that:

Is intended to supplement the diet that contains one or more of the following dietary ingredients: a vitamin, mineral, herb or other botanical, amino acid, dietary substance for use by humans to supplement the diet by increasing the total daily intake, or concentrate, metabolite, constituent, extract, or combinations of these ingredients;

Is intended for ingestion in pill, capsule, tablet, or liquid form;

Is not represented for use as a conventional food or as the sole item of a meal or diet; and

Is labeled as a “dietary supplement” or “food supplement.”

“Digital signature” has the same meaning as in A.R.S. § 41-132(E).

“Dispensing pharmacist” means a pharmacist who, in the process of dispensing a prescription medication after the complete preparation of the prescription medication and before delivery of the prescription medication to a patient or patient’s agent, verifies, checks, and initials the prescription medication label, as required in R4-23-402(A).

“Drug sample” means a unit of a prescription drug that a manufacturer provides free of charge to promote the sale of the drug.

“Durable medical equipment” or “DME” means technologically sophisticated medical equipment that may be used by a patient or consumer in a home or residence. DME may be prescription-only devices as defined in A.R.S. § 32-1901. DME includes:

Air-fluidized beds,

Apnea monitors,

Blood glucose monitors and diabetic testing strips,

Continuous Positive Airway Pressure (CPAP) machines,

Electronic and computerized wheelchairs and seating systems,

Feeding pumps,

Home phototherapy devices,

Hospital beds,

Infusion pumps,

Medical oxygen and oxygen delivery systems excluding compressed medical gases,

Nebulizers,

Respiratory disease management devices,

Sequential compression devices,

Transcutaneous electrical nerve stimulation (TENS) unit, and

Ventilators.

“Earned income” means monetary payments received by an individual as a result of work performed or rental property owned or leased by the individual, including:

Wages,

Commissions and fees,

Salaries and tips,

Profit from self-employment,

Profit from rent received from a tenant or boarder, and

Any other monetary payments received by an individual for work performed or rental of property.

“Electronic signature” has the same meaning as in A.R.S. § 44-7002.

“Eligible patient” means a patient who a pharmacist determines is eligible to receive an immunization using professional judgment after consulting with the patient regarding the patient’s current health condition, recent health condition, and allergies.

“Emergency drug supply unit” means those drugs that may be required to meet the immediate and emergency therapeutic needs of long-term care facility residents and hospice inpatient facility patients, and which are not available from any other authorized source in sufficient time to prevent risk of harm to residents or patients.

“Extreme emergency” means the occurrence of a fire, water leak, electrical failure, public disaster, or other catastrophe constituting an imminent threat of physical harm to pharmacy personnel or patrons.

“Family unit” means:

A group of individuals residing together who are related by birth, marriage, or adoption; or

An individual who:

Does not reside with another individual; or

Resides only with another individual or group of individuals to whom the individual is unrelated by birth, marriage, or adoption.

“FDA” means the Food and Drug Administration, a federal agency within the United States Department of Health and Human Services, established to set safety and quality standards for foods, drugs, cosmetics, and other consumer products.

“Health care decision maker” has the same meaning as in A.R.S. § 12-2291.

“Health care institution” has the same meaning as in A.R.S. § 36-401.

“Hospice inpatient facility” means a health care institution licensed under A.R.S. § 36-401 and Article 8 that provides hospice services to a patient requiring inpatient services.

“Immediate notice” means a required notice sent by mail, fax, or electronic mail to the Board Office within 24 hours.

“Immunizations training program” means an immunization training program for pharmacists and interns that meets the requirements of R4-23-411(E).

“Inactive ingredient” means any component other than an “active ingredient” present in a drug.

“Internal test assessment” means performing quality assurance or other procedures necessary to ensure the integrity of a test.

“ISO Class 5 environment” means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/IEST/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

“ISO Class 7 environment” means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/IEST/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

“Licensed health care professional” means an individual who is licensed and regulated under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 25, 29, or 35.

“Limited-service correctional pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that:

Holds a current Board permit under A.R.S. § 32-1931;

Is located in a correctional facility; and

Uses pharmacists, interns, and support personnel to compound, produce, dispense, and distribute drugs.

“Limited-service long-term care pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board-issued permit and dispenses prescription medication or prescription-only devices to patients in long-term care facilities.

“Limited-service mail-order pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices by mailing or delivering the prescription medication or prescription-only device to an individual by the United States mail, a common or contract carrier, or a delivery service.

“Limited-service nuclear pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and provides radiopharmaceutical services.

“Limited-service pharmacy permittee” means a person who holds a current limited-service pharmacy permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and A.A.C. R4-23-606.

“Limited-service sterile pharmaceutical products pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices as sterile pharmaceutical products.

“Long-term care consultant pharmacist” means a pharmacist providing consulting services to a long-term care facility.

“Long-term care facility” or “LTCF” means a nursing care institution as defined in A.R.S. § 36-401.

“Lot” means a batch or any portion of a batch of a drug, or if a drug produced by a continuous process, an amount of drug produced in a unit of time or quantity in a manner that assures its uniformity. In either case, a lot is identified by a distinctive

lot number and has uniform character and quality with specified limits.

“Lot number” or “control number” means any distinctive combination of letters or numbers, or both, from which the complete history of the compounding or manufacturing, control, packaging, and distribution of a batch or lot of a drug can be determined.

“Low-income subsidy” means Medicare-provided assistance that may partially or fully cover the costs of drugs and is based on the income of an individual and, if applicable, the individual’s spouse.

“Materials approval unit” means any organizational element having the authority and responsibility to approve or reject components, in-process materials, packaging components, and final products.

“Mechanical counting device for a drug in solid, oral dosage form” means a mechanical device that counts drugs in solid, oral dosage forms for dispensing and includes an electronic balance when used to count drugs.

“Mechanical storage and counting device for a drug in solid, oral dosage form” means a mechanical device that stores and counts and may package or label drugs in solid, oral dosage forms for dispensing.

“Mediated instruction” means information transmitted via intermediate mechanisms such as audio or video tape or telephone transmission.

“Medical practitioner-patient relationship” means that before prescribing, dispensing, or administering a prescription-only drug, prescription-only device, or controlled substance to a person, a medical practitioner, as defined in A.R.S. § 32-1901, shall first conduct a physical examination of that person or have previously conducted a physical examination. This subdivision does not apply to:

A medical practitioner who provides temporary patient supervision on behalf of the patient’s regular treating medical practitioner;

Emergency medical situations as defined in A.R.S. § 41-1831;

Prescriptions written to prepare a patient for a medical examination; or

Prescriptions written, prescription-only drugs, prescription-only devices, or controlled substances issued for use by a county or tribal public health department for immunization programs, emergency treatment, in response to an infectious disease investigation, public health emergency, infectious disease outbreak or act of bioterrorism. For purposes of this subsection, “bioterrorism” has the same meaning as in A.R.S. § 36-781.

“Medicare” means a federal health insurance program established under Title XVIII of the Social Security Act.

“Medication error” means any unintended variation from a prescription or medication order. Medication error does not include any variation that is corrected before the medication is dispensed to the patient or patient’s care-giver, or any variation allowed by law.

“Mobile pharmacy” means a pharmacy that is self-propelled or movable by another vehicle that is self-propelled.

“MPJE” means Multistate Pharmacy Jurisprudence Examination, a Board-approved national pharmacy law examination written and administered in cooperation with NABP.

“NABP” means National Association of Boards of Pharmacy.

“NABPLEX” means National Association of Boards of Pharmacy Licensure Examination.

“NAPLEX” means North American Pharmacist Licensure Examination.

“Order” means either of the following:

A prescription order as defined in A.R.S. § 32-1901; or

A medication order as defined in A.A.C. R4-23-651.

“Other designated personnel” means a non-pharmacist individual who is permitted in the pharmacy area, for a limited time, under the direct supervision of a pharmacist, to perform non-pharmacy related duties, such as trash removal, floor maintenance, and telephone or computer repair.

“Outpatient” means an individual who is not a residential patient in a health care institution.

“Outpatient setting” means a location that provides medical treatment to an outpatient.

“Patient profile” means a readily retrievable, centrally located information record that contains patient demographics, allergies, and medication profile.

“Pharmaceutical patient care services” means the provision of drug selection, drug utilization review, drug administration, drug therapy monitoring, and other drug-related patient care services intended to achieve outcomes related to curing or

preventing a disease, eliminating or reducing a patient's symptoms, or arresting or slowing a disease process, by identifying and resolving or preventing potential and actual drug-related problems.

"Pharmaceutical product" means a medicinal drug.

"Pharmacy counter working area" means a clear and continuous working area that contains no major obstacles such as a desktop computer, computer monitor, computer keyboard, external computer drive device, printer, fax machine, pharmacy balance, typewriter, or pill-counting machine, but may contain individual documents or prescription labels, pens, prescription blanks, refill log, pill-counting tray, spatula, stapler, or other similar items necessary for the prescription-filling process.

"Pharmacy law continuing education" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations, offered by an Approved Provider.

"Pharmacy permittee" means a person who holds a current pharmacy permit that complies with A.R.S. §§ 32-1929, 32-1930, 32-1931, 32-1934, and R4-23-606 and R4-23-652.

"Physician" means a medical practitioner licensed under A.R.S. Title 32, Chapter 13 or 17.

"Physician-in-charge" means a physician who is responsible to the Board for all aspects of a prescription medication donation program required in A.R.S. § 32-1909 and operated in the physician's office or in a health care institution.

"Poverty level" means the annual family income for a family unit of a particular size, as specified in the poverty guidelines updated annually in the *Federal Register* by the U.S. Department of Health and Human Services.

"Precursor chemical" means a precursor chemical I as defined in A.R.S. § 13-3401(26) and a precursor chemical II as defined in A.R.S. § 13-3401(27).

"Prepackaged drug" means a drug that is packaged in a frequently prescribed quantity, labeled in compliance with A.R.S. §§ 32-1967 and 32-1968, stored, and subsequently dispensed by a pharmacist or intern under the supervision of a pharmacist, who verifies at the time of dispensing that the drug container is properly labeled, in compliance with A.R.S. § 32-1968, for the patient.

"Prep area" means a specified area either within an ISO class 7 environment or adjacent to but outside an ISO class 7 environment that:

Allows the assembling of necessary drugs, supplies, and equipment for compounding sterile pharmaceutical products, but does not allow the use of paper products such as boxes or bulk drug storage;

Allows personnel to don personnel protective clothing, such as gown, gloves, head cover, and booties before entering the clean compounding area; and

Is a room or a specified area within a room, such as an area specified by a line on the floor.

"Primary care provider" means the medical practitioner who is treating an individual for a disease or medical condition.

"Proprietor" means the owner of a business permitted by the Board under A.R.S. §§ 32-1929, 32-1930, 32-1931, and 32-1934.

"Provider pharmacy" means a pharmacy that contracts with a long-term care facility to supply prescription medication or other services for residents of a long-term care facility.

"Radiopharmaceutical" means any drug that emits ionizing radiation and includes:

Any nonradioactive reagent kit, nuclide generator, or ancillary drug intended to be used in the preparation of a radiopharmaceutical, but does not include drugs such as carbon-containing compounds or potassium-containing salts, that contain trace quantities of naturally occurring radionuclides; and

Any biological product that is labeled with a radionuclide or intended to be labeled with a radionuclide.

"Radiopharmaceutical quality assurance" means performing and interpreting appropriate chemical, biological, and physical tests on radiopharmaceuticals to determine the suitability of the radiopharmaceutical for use in humans and animals. Radiopharmaceutical quality assurance includes internal test assessment, authentication of product history, and appropriate record retention.

"Radiopharmaceutical services" means procuring, storing, handling, compounding, preparing, labeling, quality assurance testing, dispensing, distributing, transferring, recordkeeping, and disposing of radiochemicals, radiopharmaceuticals, and ancillary drugs. Radiopharmaceutical services include quality assurance procedures, radiological health and safety procedures, consulting activities associated with the use of radiopharmaceuticals, and any other activities required for the provision of pharmaceutical care.

“Red C stamp” means a device used with red ink to imprint an invoice with a red letter C at least one inch high, to make an invoice of a Schedule III through IV controlled substance, as defined in A.R.S. § 36-2501, readily retrievable, as required by state and federal rules.

“Refill” means other than the original dispensing of the prescription order, dispensing a prescription order in the same quantity originally ordered or in multiples of the originally ordered quantity when specifically authorized by the prescriber, if the refill is authorized by the prescriber:

In the original prescription order;

By an electronically transmitted refill order that the pharmacist promptly documents and files; or

By an oral refill order that the pharmacist promptly documents and files.

“Regulated chemical” means the same as in A.R.S. § 13-3401(30).

“Remodel” means to alter structurally the pharmacy area or location.

“Remote drug storage area” means an area that is outside the premises of the pharmacy, used for the storage of drugs, locked to deny access by unauthorized persons, and secured against the use of force.

“Resident” means:

An individual admitted to and living in a long-term care facility or an assisted living facility,

An individual who has a place of habitation in Arizona and lives in Arizona as other than a tourist, or

A person that owns or operates a place of business in Arizona.

“Responsible person” means the owner, manager, or other employee who is responsible to the Board for a permitted establishment’s compliance with the laws and administrative rules of this state and of the federal government pertaining to distribution of drugs, devices, precursor chemicals, and regulated chemicals. Nothing in this definition relieves other individuals from the responsibility to comply with state and federal laws and administrative rules.

“Score transfer” means the process that enables an applicant to take the NAPLEX in a jurisdiction and be eligible for licensure by examination in other jurisdictions.

“Security features” means attributes incorporated into the paper of a prescription order, referenced in A.R.S. § 32-1968(A)(4), that are approved by the Board or its staff and include one or more of the following designed to prevent duplication or aid the authentication of a paper document: laid lines, enhanced laid lines, thermochromic ink, artificial watermark, fluorescent ink, chemical void, persistent void, penetrating numbers, high-resolution border, high-resolution latent images, micro-printing, prismatic printing, embossed images, abrasion ink, holograms, and foil stamping.

“Shared order filling” means the following:

Preparing, packaging, compounding, or labeling an order, or any combination of these functions, that are performed by:

A person with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy; or

A person, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

Returning the filled order to the requesting pharmacy for delivery to the patient or patient’s care-giver or, at the request of this pharmacy, directly delivering the filled order to the patient.

“Shared order processing” means the following:

Interpreting the order, performing order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, and when necessary, therapeutic intervention, or any combination of these order processing functions, that are performed by:

A pharmacist or intern, under pharmacist supervision, with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy: or

A pharmacist or intern, under pharmacist supervision, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

After order processing is completed, returning the processed order to the requesting pharmacy for order filling and delivery to the patient or patient’s care-giver or, at the request of this pharmacy, returning the processed order to another pharmacy for order filling and delivery to the patient or patient’s care-giver.

“Shared services” means shared order filling or shared order processing, or both.

“Sight-readable” means that an authorized individual is able to examine a record and read its information from a CRT, microfiche, microfilm, printout, or other method acceptable to the Board or its designee.

“Single-drug audit” means an accounting method that determines the numerical and percentage difference between a drug’s beginning inventory plus purchases and ending inventory plus sales.

“Single-drug usage report” means a computer system printout of original and refill prescription order usage information for a single drug.

“Standard-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded from sterile commercial drugs using sterile commercial devices or a sterile pharmaceutical optic or ophthalmic product compounded from non-sterile ingredients.

“State of emergency” means a governmental declaration issued under A.R.S. § 32-1910 as a result of a natural disaster or terrorist attack that results in individuals being unable to refill existing prescriptions.

“Sterile pharmaceutical product” means a medicinal drug free from living biological organisms.

“Strength” means:

The concentration of the drug substance (for example, weight/weight, weight/volume, or unit dose/volume basis); or

The potency, that is, the therapeutic activity of a drug substance as indicated by bioavailability tests or by controlled clinical data (expressed, for example, in terms of unity by reference to a standard).

“Substantial-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded as a parenteral or injectable dosage form from non-sterile ingredients.

“Supervision” means a pharmacist is present, assumes legal responsibility, and has direct oversight of activities relating to acquiring, preparing, distributing, administering, and selling prescription medications by interns, pharmacy technicians, or pharmacy technician trainees and when used in connection with the intern training requirements means that, in a pharmacy where intern training occurs, an intern preceptor assumes the primary responsibility of teaching the intern during the entire period of the training.

“Supplying” means selling, transferring, or delivering to a patient or a patient’s agent one or more doses of:

A nonprescription drug in the manufacturer’s original container for subsequent use by the patient, or

A compressed medical gas in the manufacturer’s or compressed medical gas distributor’s original container for subsequent use by the patient.

“Support personnel” means an individual, working under the supervision of a pharmacist, trained to perform clerical duties associated with the practice of pharmacy, including cashiering, bookkeeping, pricing, stocking, delivering, answering non-professional telephone inquiries, and documenting third-party reimbursement. Support personnel shall not perform the tasks of a pharmacist, intern, pharmacy technician, or pharmacy technician trainee.

“Temporary pharmacy facility” means a facility established as a result of a declared state of emergency to temporarily provide pharmacy services within or adjacent to declared disaster areas.

“Tourist” means an individual who is living in Arizona but maintains a place of habitation outside of Arizona and lives outside of Arizona for more than six months during a calendar year.

“Transfill” means a manufacturing process by which one or more compressed medical gases are transferred from a bulk container to a properly labeled container for subsequent distribution or supply.

“Unearned income” means monetary payment received by an individual that is not compensation for work performed or rental of property owned or leased by the individual, including:

Unemployment insurance,

Workers’ compensation,

Disability payments,

Payments from the Social Security Administration,

Payments from public assistance,

Periodic insurance or annuity payments,

Retirement or pension payments,

Strike benefits from union funds,

Training stipends,

Child support payments,

Alimony payments,

Military family allotments,

Regular support payments from a relative or other individual not residing in the household,

Investment income,

Royalty payments,

Periodic payments from estates or trusts, and

Any other monetary payments received by an individual that are not:

As a result of work performed or rental of property owned by the individual,

Gifts,

Lump-sum capital gains payments,

Lump-sum inheritance payments,

Lump-sum insurance payments, or

Payments made to compensate for personal injury.

"Verified signature" or "signature verifying" means in relation to a Board license or permit application or report, form, or agreement, the hand-written or electronic signature of an individual who, by placing a hand-written or electronic signature on a hard-copy or electronic license or permit application or report, form, or agreement agrees with and verifies that the statements and information within or attached to the license or permit application or report, form, or agreement are true in every respect and that inaccurate reporting can result in denial or loss of a license or permit or report, form, or agreement.

"Veteran" means an individual who has served in the United States Armed Forces.

~~"Virtual manufacturer" means an entity that contracts for the manufacture of a drug or device for which the entity:~~

~~Owns the New Drug Application or Abbreviated New Drug Application number, as defined by the FDA, for a drug;~~

~~Owns the Unique Device Identification number, as defined by the FDA, for a prescription device;~~

~~Is not involved in the physical manufacture of the drug or device; and~~

~~Contracts with an Arizona-permitted manufacturing entity for the physical manufacture of the drug or device; or~~

~~If the contracted manufacturing entity is in a location not included in the definition at A.R.S. 32-1901 of other jurisdiction, the virtual manufacturer ensures the facility is inspected every time the virtual manufacturer submits an initial or renewal application and determined to comply with current good manufacturing practices as defined by the federal act and the official compendium.~~

~~Virtual manufacturer includes an entity that may be identified as an own-label distributor, which contracts with a manufacturer to produce a drug or device and with another entity to package and label the drug or device, which is then sold under the distributor's name or another name.~~

"Virtual wholesaler" means an entity that engages in the wholesale distribution of a drug or device in, into, or out of Arizona but does not take physical possession of the drug or device. A virtual wholesaler distributes a drug or device only from a Board-permitted facility to:

A Board-permitted pharmacy, drug manufacturer, full-service drug wholesaler, or non-prescription drug wholesaler; or

A medical practitioner licensed under A.R.S. Title 32; and

Virtual wholesaler includes an entity that may be identified as a broker that buys and sells goods for others or a person that facilitates distribution of a drug, chemical, or device regulated by the Board.

"Wholesale distribution" means distribution of a drug to a person other than a consumer or patient, but does not include:

Selling, purchasing, or trading a drug or offering to sell, purchase, or trade a drug for emergency medical reasons. For purposes of this Section, "emergency medical reasons" includes transferring a prescription drug by a community or hospital pharmacy to another community or hospital pharmacy to alleviate a temporary shortage;

Selling, purchasing, or trading a drug, offering to sell, purchase, or trade a drug, or dispensing a drug as specified in a prescription;

Distributing a drug sample by a manufacturers' or distributors' representative; or

Selling, purchasing, or trading blood or blood components intended for transfusion.

"Wholesale distributor" means any person engaged in wholesale distribution of drugs, including: manufacturers; repackers; own-label distributors; private-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and retail pharmacies that conduct wholesale distributions in the amount of at least 5% of gross sales.

## ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

### R4-23-602. Permit Application Process and Time ~~frames~~ Frames

**A.** A person applying for a permit shall:

1. Submit a completed application for the desired permit electronically or manually on a form furnished by the Board, and
2. Submit with the application form:
   a. The documents specified in the application form, and
   b. The permit fee specified in R4-23-205.

**B.** The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.

**C.** Time frames for permits.

1. The Board office shall finish an administrative completeness review within 60 days from the date the application form is received.
   a. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application form.
   b. If the application form is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 60-day time frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
   c. If the Board office does not provide the applicant with written notice regarding administrative completeness, the application form shall be deemed complete 60 days after receipt by the Board office.
2. An applicant with an incomplete application form shall submit to the Board office all of the missing information within 90 days of service of the notice of incompleteness.
   ~~a.~~ If an applicant cannot submit all missing information within 90 days of service of the notice of incompleteness, the applicant may send a written ~~request for an~~ notice of a 30-day extension to the Board office postmarked or delivered no later than 90 days from service of the notice of incompleteness~~;~~
   ~~b. The written request for an extension shall document the reasons the applicant is unable to meet the 90-day deadline; and~~
   ~~c. The Board office shall review the request for an extension of the 90-day deadline and grant the request if the Board office determines an extension of the 90-day deadline will enable the applicant to assemble and submit the missing information. An extension shall be for no more than 30 days. The Board office shall notify the applicant in writing of its decision to grant or deny the request for an extension~~.
3. If an applicant fails to submit a complete application form within the time allowed under subsection (C)(2), the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a permit shall submit a new application and fee as specified in subsection (A).
4. For ~~a nonprescription drug permit applicant,~~ a compressed medical gas distributor permit applicant~~,~~ and a durable medical equipment and compressed medical gas supplier permit applicant, the Board office shall issue a permit on the day the Board office determines an administratively complete application form is received.
5. Except as described in subsection (C)(4), from the date on which the administrative completeness review of an application form is finished, the Board office shall complete a substantive review of the applicant's qualifications in no more than 120 days.
   a. If an applicant is found to be ineligible, the Board office shall issue a written notice of denial to the applicant.
   b. If an applicant is found to be eligible, the Board office shall recommend to the Board that the applicant be issued a permit. Upon receipt of the Board office's recommendation, the Board shall either issue a permit to the applicant or if the Board determines the applicant does not meet eligibility requirements, return the matter to the Board office.
   c. If the Board office finds deficiencies during the substantive review of the application form, the Board office shall issue a written request to the applicant for additional documentation.
   d. The 120-day time frame for a substantive review for the issuance or denial of a permit is suspended from the date of the written request for additional documentation until the date all documentation is received. The applicant shall submit the additional documentation according to subsection (C)(2).

e. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time frame may be extended once for no more than 45 days.

6. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time frames for permits:
   a. Administrative completeness review time frame: 60 days.
   b. Substantive review time frame:
      i. ~~Nonprescription drug permit, compressed~~ Compressed medical gas distributor permit~~,~~ and durable medical equipment and compressed medical gas supplier permit: none.
      ii. Except as described in subsection (C)(6)(b)(i): 120 days.
   c. Overall time frame:
      i. ~~Nonprescription drug permit, compressed~~ Compressed medical gas distributor permit~~,~~ and durable medical equipment and compressed medical gas supplier permit: 60 days.
      ii. Except as described in subsection (C)(6)(c)(i): 180 days.

**D.** Permit renewal.
1. To renew a permit, a permittee shall submit a completed application for permit renewal electronically or manually on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1931, the permit is suspended. The permittee shall pay a penalty as provided in A.R.S. § 32-1931 and R4-23-205 to vacate the suspension.
3. Time frames for permit renewals. The Board office shall follow the time frames established in subsection (C).

**E.** Display of permit. A permittee shall conspicuously display the permit in the location to which it applies.

**R4-23-603. ~~Resident Nonprescription Drugs, Retail~~ Repealed**

**~~A.~~** ~~Permit. A person, including the following, shall not sell or distribute a nonprescription drug without a current Board-issued permit:~~
~~1. A grocer;~~
~~2. Other non-pharmacy retail outlet; or~~
~~3. Mobile or non-fixed location retailer, such as a swap meet vendor.~~

**~~B.~~** ~~A medical practitioner licensed under A.R.S. Title 32 is exempt from the requirements of subsection (A).~~

**~~C.~~** ~~Application. To obtain a permit to sell a nonprescription drug, a person shall submit:~~
~~1. A completed application form and fee as specified in R4-23-602; and~~
~~2. Documentation of compliance with local zoning laws, if required by the Board.~~

**~~D.~~** ~~Drug sales. A nonprescription drug permittee:~~
~~1. Shall sell a drug only in the original container packaged and labeled by the manufacturer; and~~
~~2. Shall not package, repackage, label, or relabel any drug.~~

**~~E.~~** ~~Inspection. A nonprescription drug permittee shall consent to inspection during business hours by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.~~

**~~F.~~** ~~Quality control. A nonprescription drug permittee shall:~~
~~1. Ensure that all drugs stocked, sold, or offered for sale are:~~
~~a. Kept clean;~~
~~b. Protected from contamination, excessive heat, cold, sunlight, and other deteriorating factors;~~
~~c. In compliance with federal law; and~~
~~d. Received from a supplier with a current Board-issued permit as specified in R4-23-601(A).~~
~~2. Develop and implement a program to ensure that:~~
~~a. Any expiration-dated drug is reviewed regularly;~~
~~b. Any drug, that exceeds its expiration date, is deteriorated or damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and~~
~~c. Any quarantined drug is destroyed or returned to its source of supply.~~

**~~G.~~** ~~Notification. A nonprescription drug permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, e-mail or mailing address, or business name.~~

**~~H.~~** ~~Change of ownership. A nonprescription drug permittee shall comply with R4-23-601(F).~~

**~~I.~~** ~~Relocation. No less than 30 days before an existing nonprescription drug permittee relocates, the permittee shall submit a completed application for relocation electronically or manually on a form furnished by the Board, and the documentation required in subsection (C).~~

**~~J.~~** ~~Records. A nonprescription drug permittee shall:~~
~~1. Retain records of the receipt and disposal of nonprescription drugs as required in R4-23-601(D), and~~

2. ~~Comply with the requirements of A.R.S. § 32-1977 and federal law for the retail sale of methamphetamine precursors.~~

**K.** ~~Permit renewal. To renew a nonprescription drug permit, the permittee shall comply with R4-23-602(D).~~

**L.** ~~Nonprescription drug vending machine outlet. In addition to the requirements of R4-23-601, R4-23-602, and subsections (A) through (K), a person selling or distributing a nonprescription drug in a vending machine shall comply with the following requirements:~~

1. ~~Each individual vending machine is considered an outlet and shall have a Board-issued nonprescription drug permit;~~
2. ~~Each nonprescription-drug-permitted vending machine shall display in public view an identification seal, furnished by the Board, containing the permit number, vending machine's serial number, owner's name, and telephone contact number;~~
3. ~~Each nonprescription drug permitted vending machine is assigned a specific location that is within a weather tight structure, protected from direct sunlight, and maintained at a temperature not less than 59° F and not greater than 86° F;~~
4. ~~Each nonprescription drug sold in a vending machine is packaged and labeled in the manufacturer's original FDA-approved container;~~
5. ~~A nonprescription drug permitted vending machine is subject to inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901 as follows:~~
   a. ~~The owner, manager, or other staff of the nonprescription drug permittee shall provide access to the contents of the vending machine within 24 hours of a request from a Board compliance officer or other authorized officer of the law; or~~
   b. ~~The Board compliance staff shall have independent access to the vending machine;~~
6. ~~Before relocating or retiring a nonprescription-drug-permitted vending machine, the owner or manager shall notify the Board in writing. The notice shall include:~~
   a. ~~Permit number;~~
   b. ~~Vending machine's serial number;~~
   c. ~~Action planned (relocate or retire); and~~
   d. ~~If retiring a vending machine, the disposition of the nonprescription drug contents of the vending machine;~~
7. ~~The sale or distribution of a precursor chemical or regulated chemical in a vending machine is prohibited; and~~
8. ~~Under no circumstance may expired drugs be sold or distributed.~~

**R4-23-607. Nonresident Permits**

**A.** Permit. A person that is not a resident of Arizona shall not sell or distribute any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona without possessing both:

1. A current Board-issued nonresident pharmacy permit, nonresident manufacturer permit, or nonresident full-service or nonprescription drug wholesale permit~~, or nonresident nonprescription drug permit~~; and
2. A current equivalent license or permit issued by the licensing authority in the jurisdiction where the person resides.

**B.** Application. To obtain a nonresident pharmacy, nonresident manufacturer, or nonresident full-service or nonprescription drug wholesale, ~~or nonprescription drug permit,~~ a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.

**C.** Notification. A permittee shall submit notification of any change required in this subsection using the permittee's online profile or as a written notice by mail, fax, or e-mail to the Board office within 10 days of the change.

1. Nonresident pharmacy. A nonresident pharmacy permittee shall notify the Board of changes involving the type of pharmacy operated, address, telephone number, business name, or pharmacist-in-charge.
2. Nonresident manufacturer. A nonresident manufacturer permittee shall notify the Board of changes involving listed drugs, address, telephone number, business name, or manager, including manager's telephone number.
3. Nonresident drug wholesaler. A nonresident full-service or nonprescription drug wholesale permittee shall notify the Board of changes involving the types of drugs sold or distributed, address, telephone number, business name, or manager or designated representative, including the manager's or designated representative's telephone number. For a change of designated representative, a nonresident full-service drug wholesale permittee shall submit the documentation, fingerprints, and fee required with the application under subsection (B).
4. ~~Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall notify the Board of changes involving permit category, address, telephone number, business name, or manager, including manager's telephone number.~~

**D.** Change of ownership. A nonresident permittee shall comply with R4-23-601(F).

**E.** Drug sales.

1. Nonresident pharmacy. A nonresident pharmacy permittee shall:

a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device to anyone in Arizona except:
   i. A pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board;
   ii. A medical practitioner currently licensed under A.R.S. Title 32; or
   iii. An Arizona resident upon receipt of a valid prescription order for the resident;
b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except:
   i. A pharmacy, drug manufacturer, or full-service or nonprescription drug wholesaler~~, or nonprescription drug retailer~~ currently permitted by the Board;
   ii. A medical practitioner currently licensed under A.R.S. Title 32; or
   iii. An Arizona resident either upon receipt of a valid prescription order for the resident or in the original container packaged and labeled by the manufacturer;
c. Except for a drug sale that results from the receipt and dispensing of a valid prescription order for an Arizona resident, maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
d. Provide permit and license records upon request, if immediately available, or in no fewer than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.

2. Nonresident manufacturer. A nonresident manufacturer permittee shall:
   a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device to anyone in Arizona except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full-service or nonprescription drug wholesaler~~, or nonprescription drug retailer~~ currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   c. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
   d. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
3. Nonresident full-service drug wholesaler. In addition to complying with the ~~distributions~~ distribution restrictions specified in A.R.S. § 32-1983, a nonresident full-service drug wholesale permittee shall:
   a. Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
   b. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
   c. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
   d. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   e. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full-service or nonprescription drug wholesaler~~, or nonprescription drug retailer~~ currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   f. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
   g. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S.

§ 32-1901.

4. Nonresident nonprescription drug wholesaler. A nonresident nonprescription drug wholesale permittee shall:
   a. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
   b. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
   c. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full-service or nonprescription drug wholesaler~~, or nonprescription drug retailer~~ currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   d. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
   e. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.

~~5. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall not:~~
   ~~a. Sell, distribute, give away, or dispose of a nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except in the original container packaged and labeled by the manufacturer;~~
   ~~b. Package, repackage, label, or relabel any drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona; or~~
   ~~c. Sell, distribute, give away, or dispose of any drug, precursor chemical, or regulated chemical to anyone in Arizona that exceeds its expiration date, is contaminated or deteriorated from excessive heat, cold, sunlight, moisture, or other factors, or does not comply with federal law.~~

**F.** When selling or distributing any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona, a nonresident pharmacy, nonresident manufacturer, or nonresident full-service or nonprescription drug ~~wholesale, or nonprescription drug permittee~~ wholesaler shall comply with federal law, the permittee's resident state drug law, and this Section.

**R4-23-693. Durable Medical Equipment (DME) and Compressed Medical Gas (CMG) Supplier-Resident or Nonresident**

**A.** Permit. A person shall not sell, lease, or supply durable medical equipment or a compressed medical gas to a patient or consumer in Arizona for use in a home or residence without a current Board-issued resident or nonresident durable medical equipment and compressed medical gas supplier permit.
   ~~1.~~ The permit requirements of this Section do not apply to the following unless there is a separate business entity engaged in the business of providing durable medical equipment or a compressed medical gas to a patient or consumer for use in a home or residence:
      ~~a.~~1. A medical practitioner licensed under A.R.S. Title 32;
      ~~b.~~2. A hospital, long-term care facility, hospice, or other health-care facility using durable medical equipment or a compressed medical gas in the normal course of treating a patient; and
      ~~c.~~3. A pharmacy.
   ~~2. Nothing in this Section shall be construed to prohibit a person with a current Board-issued nonprescription drug permit from the retail sale of nonprescription drugs or devices.~~

**B.** Application. To obtain a resident or nonresident DME and CMG supplier permit, a person shall submit a completed application form and fee specified in R4-23-205.
   1. A resident DME and CMG supplier permit applicant shall include documentation of compliance with local zoning laws, if required by the Board.
   2. A nonresident DME and CMG supplier permit applicant that resides in a jurisdiction that issues an equivalent license or permit shall include a copy of the equivalent license or permit.

**C.** Notification. A resident or nonresident DME and CMG supplier permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, email or mailing address, or business name.

**D.** Change of ownership. A resident or nonresident DME and CMG supplier permittee shall comply with R4-23-601(F).

**E.** Relocation.
   1. No fewer than 30 days before a resident DME and CMG supplier permittee relocates, the permittee shall submit a completed application for relocation electronically or manually on a form furnished by the Board, and the documentation required in subsection (B). A fee is not required with an application for relocation.

2. A nonresident DME and CMG supplier permittee shall provide written notice by mail, fax, or e-mail to the Board office no fewer than 10 days before relocating.

**F.** Orders. A resident or nonresident DME and CMG supplier shall sell, lease, or provide:

1. Durable medical equipment that is a prescription-only device, as defined in A.R.S. § 32-1901, only under a prescription or medication order from a medical practitioner; and
2. A compressed medical gas only under a compressed medical gas order from a medical practitioner.

**G.** Restriction. A DME and CMG supplier permit authorizes the permittee to procure, possess, and provide a prescription-only device or compressed medical gas to a patient or consumer as specified in subsection (F). A DME and CMG supplier permit does not authorize the permittee to procure, possess, or provide narcotics or other controlled substances, prescription-only drugs other than compressed medical gases, precursor chemicals, or regulated chemicals.

**H.** Facility. A resident or nonresident DME and CMG supplier permittee shall ensure the facility is clean, uncluttered, sanitary, temperature controlled, and secure from unauthorized access. A permittee shall maintain separate and identified storage areas in the facility and in delivery vehicles for clean, dirty, contaminated, or damaged durable medical equipment or compressed medical gases.

**I.** A resident or nonresident DME and CMG supplier permittee shall not manufacture, process, transfill, package, or label a compressed medical gas, except as stated in subsection (K).

**J.** Records. A resident or nonresident DME and CMG supplier permittee shall establish and implement written procedures for maintaining records about acquisition, distribution, returns, recalls, training of personnel, maintenance, cleaning, and complaints.

**K.** A permittee shall:

1. Ensure a prescription order, medication order, or compressed medical gas order is obtained as specified in subsection (F);
2. Ensure each compressed medical gas container supplied by the permittee contains a label bearing the name and address of the permittee;
3. Ensure all appropriate warning labels are present on the durable medical equipment or compressed medical gas;
4. Retain the records required by Section R4-23-601 and this Section for not fewer than three years, or if supplying a compressed medical gas, one year after the expiration date of the compressed medical gas, whichever is longer; and
5. Make the records required by Section R4-23-601 and this Section available for inspection by the Board or its compliance officer, or if stored in a centralized recordkeeping system apart from the inspection location and not electronically retrievable for inspection, provide the records within four working days of a request by the Board or its staff.

**L.** Inspection.

1. A resident DME and CMG supplier permittee shall make the DME and CMG supplier's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.
2. Within 10 days from the date of a request by the Board or its staff, a nonresident DME and CMG supplier permittee shall provide a copy of the most recent inspection report completed by the permittee's resident licensing authority, or a copy of the most recent inspection report completed by a third-party auditor approved by the permittee's resident licensing authority or the Board or its designee. The Board may inspect, or may employ a third-party auditor to inspect, a nonresident permittee as specified in A.R.S. § 32-1904.

**M.** Permit renewal. To renew a resident or nonresident DME and CMG supplier permit, the permittee shall comply with in R4-23-602(D).

**N.** Nothing in this Section shall be construed to prohibit the emergency administration of oxygen by licensed health-care personnel, emergency medical technicians, first responders, fire fighters, law enforcement officers, and other emergency personnel trained in the proper use of emergency oxygen.

## ARTICLE 8. DRUG CLASSIFICATION

### R4-23-802. Veterinary

Veterinary preparation: A veterinary drug manufacturer or supplier may distribute:

1. A prescription-only veterinary drug to:
   a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
   b. A full-service drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
   c. A pharmacy permitted under A.R.S. Title 32, Chapter 18, and
2. A nonprescription veterinary drug to:
   a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
   ~~b. A nonprescription drug retailer permitted under A.R.S. Title 32, Chapter 18,~~
   ~~c.~~b. A full-service or nonprescription drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or

~~d.~~ c. A pharmacy permitted under A.R.S. Title 32, Chapter 18.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**[1]

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 23. BOARD OF PHARMACY**

1. Identification of the rulemaking:

   Under Laws 2019, Chapter 83, the legislature amended A.R.S. §§ 32-1930 and 32-1931 to deregulate non-prescription retailers. As a result, the Board is repealing language related to non-prescription retailers including references to a permit.

   Under Laws 2024, Chapter 234, the legislature added a definition of virtual manufacturer to A.R.S. § 32-1901. As a result, the Board is repealing the Board's definition at R4-23-110.

   The Board is also amending R4-23-602 to make it easier for a permit applicant to obtain additional time in which to submit information needed to complete an application.

   The conduct and its frequency of occurrence that the rule is designed to change:

   Until the rulemaking is completed, the Board's rules will be inconsistent with statute and R4-23-602 will impose an unnecessary regulatory burden on permit applicants that need additional time to submit information required to complete an application.

   a. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

      Rules that are inconsistent with statute cause confusion for those who must comply with the rules. It is not good government for an agency to impose an unnecessary regulatory burden on those who must comply with the rules.

   b. The estimated change in frequency of the targeted conduct expected from the rule change:

      When the rulemaking is completed, the Board's rules will be consistent with statute and an unnecessary regulatory burden will be eliminated.

2. A brief summary of the information included in the economic, small business, and consumer impact statement;

   The Board determined the only economic impact of the rulemaking are the Board's costs to complete the rulemaking. The rulemaking does not impose a requirement on any person. Rather, it simply makes the rules consistent with statute and removes a source of potential

[1] If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms. (A.R.S. § 41-1055(C)).

confusion. The amendment to R4-23-602 simplifies a regulatory burden for permit applicants so there may be minimal savings for the Board, which no longer has to act on a request for an extension of time to submit required information.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

   Name: Kamlesh Gandhi
   Title: Executive Director
   Address: 1110 W Washington Street, Ste. 260, Phoenix, AZ 85007
   Telephone: (602) 771-2727
   Email: kgandhi@azpharmacy.gov
   Website: www.azpharmacy.gov

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

   Virtual manufacturers, non-pharmacy retailers of nonprescription drugs, permit applicants, and the Board will be directly affected by, bear the costs of, and directly benefit from the rulemaking.

5. Cost-benefit analysis:

   A virtual manufacturer will incur no cost because of the rule amendment but will have the benefit of relying on a statutory definition. There are currently 446 virtual manufacturers operating in Arizona.

   Since 2019, resident non-pharmacy retailers of nonprescription drugs have not been required to obtain a permit from the Board. The rulemaking simply removes from rule all references to the previously required permit. This provides a benefit to non-pharmacy retailers of nonprescription drugs by eliminating a source of potential confusion. There is no cost for the non-pharmacy retailers of nonprescription drugs as a result of the rulemaking.

   Permit applicants will be able to submit notice of an extension of time to complete an application rather than requesting an extension of time. The primary benefit from removing this unnecessary regulatory burden accrues to the Board, which will not have to act on requests for an extension of time. During the last fiscal year, the Board received and acted on five requests for an extension of time from permit applicants.

The Board incurred the cost of completing this rulemaking and will incur the cost of implementing and enforcing it. Because the rulemaking primarily makes the rules consistent with statue, these costs are minimal. However, the benefit of having rules consistent with statute is important for a regulatory agency.

a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:

   The Board is the only state agency directly affected by the rulemaking. The Board will not need additional full-time employees to implement and enforce the rulemaking.

b. Costs and benefits to political subdivisions directly affected by the rulemaking:

   No political subdivision is directly affected by the rulemaking.

c. Costs and benefits to businesses directly affected by the rulemaking:

   Virtual manufacturers, resident non-pharmacy retailers of nonprescription drugs, and permit applicants are businesses directly affected by the rulemaking. Their costs and benefits are described above.

6. Impact on private and public employment:

   The Board determined the rulemaking will have no impact on private or public employment.

7. Impact on small businesses[2]:

   a. Identification of the small business subject to the rulemaking:

      Virtual manufacturers, resident non-pharmacy retailers of nonprescription drugs, and permit applicants are small businesses directly affected by the rulemaking.

   b. Administrative and other costs required for compliance with the rulemaking:

      Only permit applicants incur a cost to comply with the rulemaking. A permit applicant is required to submit a notice of extension of time rather than a request for an extension of time to submit a complete application. The difference in cost for this compliance will be minimal.

   c. Description of methods that may be used to reduce the impact on small businesses:

      Because the rulemaking has minimal economic impact on small businesses, the Board could not reduce the impact.

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

   No private persons or consumers are directly affected by the rulemaking.

[2] Small business has the meaning specified in A.R.S. § 41-1001(23).

9. Probable effects on state revenues:

   There will be no effect on state revenue.

10. Less intrusive or less costly alternative methods considered:

    The rulemaking is neither intrusive nor costly so the Board did not consider alternative methods.

Arizona Administrative CODE
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Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION



# TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 23. BOARD OF PHARMACY

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of October 1, 2024 through December 31, 2024



**Questions about these rules? Contact:**

| | |
|---|---|
| Board: | Board of Pharmacy |
| Address: | 1110 W. Washington St., Suite 260<br>Phoenix, AZ 85007 |
| Website: | www.azpharmacy.gov |
| Name: | Kamlesh Gandhi, Executive Director |
| Telephone: | (602) 771-2727 |
| Email: | kgandhi@azpharmacy.gov |


**The release of this Chapter in Supp. 24-4 replaces Supp. 24-1, 1-84 pages.**
Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State's website, www.azsos.gov under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*


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# TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 23. BOARD OF PHARMACY

Authority: A.R.S. § 32-1904 et seq.

**Supp. 24-4**

## CHAPTER TABLE OF CONTENTS

### ARTICLE 1. ADMINISTRATION



### ARTICLE 2. PHARMACIST LICENSURE



### ARTICLE 3. INTERN TRAINING; INTERN PRECEPTORS



### ARTICLE 4. PROFESSIONAL PRACTICES



### ARTICLE 5. CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

*New Article 5, consisting of Sections R4-23-501 through R4-23-505, made effective August 2, 2014 (Supp. 14-2).*

*Article 5, consisting of Sections R4-23-501 through R4-23-505, expired effective August 30, 2013 (Supp. 14-1).*

*Article 5, consisting of Sections R4-23-501 and R4-23-502, recodified to Article 8 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

## ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS



## ARTICLE 7. NON-PHARMACY LICENSED OUTLETS – GENERAL PROVISIONS

## ARTICLE 8. DRUG CLASSIFICATION

*Article 8, consisting of Sections R4-23-801 and R4-23-802, recodified from Article 5 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

*Article 8, consisting of Sections R4-23-801 through R4-23-804, repealed effective November 4, 1998 (Supp. 98-4).*



## ARTICLE 9. PENALTIES AND MISCELLANEOUS



## ARTICLE 10. UNIFORM CONTROLLED SUBSTANCES AND DRUG OFFENSES



## ARTICLE 11. PHARMACY TECHNICIANS; PHARMACY TECHNICIAN TRAINEES

*Article 11, consisting of R4-23-1101 through R4-23-1105, made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).*



## ARTICLE 12. DONATED MEDICINE PROGRAM

*Article 12, consisting of R4-23-1201 through R4-23-1211, made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).*

## ARTICLE 1. ADMINISTRATION

**R4-23-101. General**

**A.** This Chapter applies to all actions and proceedings of the Board and shall be deemed part of the record in any Board action or proceeding without formal introduction of, or reference to the rules. A party to a Board action is deemed to have knowledge of the rules.

**B.** The Board, within its jurisdiction, may, in the interest of justice, excuse the failure of any person to comply with the rules.

**C.** The Board, within its jurisdiction, may grant an extension of time within which to comply with any rule when it deems the extension to be in the interest of justice.

**Historical Note**

Former Rules 1.1000, 1.1200, and 1.1300; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-102. Meetings**

**A.** The Board shall hold not less than four meetings per fiscal year to conduct general business and interview permit and license applicants.

**B.** A special meeting of the Board may be held at any time subject to the call of the President or a majority of the Board members and in compliance with the notification requirements of A.R.S. § 38-431.02.

**Historical Note**

Former Rules 1.2100, 1.2200, 1.2300, and 1.2400. Amended by final rulemaking at 7 A.A.R. 2143, effective May 1, 2001 (Supp. 01-2).

**R4-23-103. Repealed**

**Historical Note**

Former Rules 1.3100, 1.3200, 1.3300, and 1.3400; Amended subsection (C) effective August 9, 1983 (Supp. 83-4). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-104. Repealed**

**Historical Note**

Former Rules 1.4011, 1.4110, 1.4120, 1.4200, 1.4210, 1.4220, 1.4300, 1.4400, 1.5500, 1.5600, 1.5700, and 1.4500; Amended effective August 23, 1978 (Supp. 78-5); Amended by deleting subsection (B) and renumbering subsections (C) through (J) as subsections (B) through (I) effective August 9, 1983 (Supp. 83-4). Amended effective February 8, 1991 (Supp. 91-1). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-105. Repealed**

**Historical Note**

Former Rules 1.5100, 1.5200, 1.5300, and 1.5400; Amended subsection (B) effective August 9, 1983 (Supp. 83-4). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-106. Repealed**

**Historical Note**

Former Rules 1.5800 and 1.5900. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-107. Repealed**

**Historical Note**

Former Rules 1.5910, 1.5920, 1.5921, and 1.5922. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-108. Repealed**

**Historical Note**

Former Rule 1.5930. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-109. Repealed**

**Historical Note**

Former Rules 1.7100, 1.7200, and 1.7300. Amended effective July 14, 1977 (Supp. 77-4). Amended effective February 8, 1991 (Supp. 91-1). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-110. Definitions**

In addition to definitions in A.R.S. § 32-1901, the following definitions apply to this Chapter:

"Active ingredient" means any component that furnishes pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or that affects the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug, that are present in the finished drug product in a modified form, and that furnish the specified activity or effect.

"AHCCCS" means the Arizona Health Care Cost Containment System.

"Annual family income" means the combined yearly gross earned income and unearned income of all adult individuals within a family unit.

"Approved course in pharmacy law" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations.

"Approved Provider" means an individual, institution, organization, association, corporation, or agency that is approved by the Accreditation Council for Pharmacy Education (ACPE) in accordance with ACPE's policy and procedures or by the Board as meeting criteria indicative of the ability to provide quality continuing education.

"Assisted living facility" means a residential care institution as defined in A.R.S. § 36-401.

"Authentication of product history" means identifying the purchasing source, the ultimate fate, and any intermediate handling of any component of a radiopharmaceutical or other drug.

"Automated dispensing system" means a mechanical system in a long-term care facility that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of med-

ications, and which collects, controls, and maintains all transaction information.

"Automated storage and distribution system" means a mechanical system that performs operations or activities other than counting, compounding, or administration, relative to the storage, packaging, or distributing of drugs or devices and that collects, controls, and maintains all transaction information.

"Batch" means a specific quantity of drug that has uniform character and quality, within specified limits, and is produced according to a single manufacturing order during the same cycle of manufacture.

"Beyond-use date" means:

A date determined by a pharmacist and placed on a prescription label at the time of dispensing to indicate a time beyond which the contents of the prescription are not recommended to be used; or

A date determined by a pharmacist and placed on a compounded pharmaceutical product's label at the time of preparation as specified in R4-23-410(B)(3)(d), R4-23-410(I)(6)(e), or R4-23-410(J)(1)(d) to indicate a time beyond which the compounded pharmaceutical product is not recommended to be used.

"Biological safety cabinet" means a containment unit suitable for the preparation of low to moderate risk agents when there is a need for protection of the product, personnel, and environment, consistent with National Sanitation Foundation (NSF) standards, published in the National Sanitation Foundation Standard 49, Class II (Laminar Flow) Biohazard Cabinetry, NSF International P. O. Box 130140, Ann Arbor, MI, revised June 1987 edition, (and no future amendments or editions), incorporated by reference and on file with the Board.

"Care-giver" means a person who cares for someone who is sick or disabled or an adult who cares for an infant or child and includes a patient's husband, wife, son, daughter, mother, father, sister, brother, legal guardian, nurse, or medical practitioner.

"Change of ownership," as used in A.R.S. § 32-1901.01(A), means a change of at least 30 percent in voting stock or vested interest that has direct operational oversight.

"Community pharmacy" means any place under the direct supervision of a pharmacist where the practice of pharmacy occurs or where prescription orders are compounded and dispensed other than a hospital pharmacy or a limited service pharmacy.

"Component" means any ingredient used in compounding or manufacturing drugs in dosage form, including an ingredient that may not appear in the finished product.

"Compounding and dispensing counter" means a pharmacy counter working area defined in this Section where a pharmacist, intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist compounds, mixes, combines, counts, pours, or prepares and packages a prescription medication to dispense an individual prescription order or prepackages a drug for future dispensing.

"Computer system" means an automated data-processing system that uses a programmable electronic device to store, retrieve, and process data.

"Computer system audit" means an accounting method, involving multiple single-drug usage reports and audits, used to determine a computer system's ability to store, retrieve, and process original and refill prescription dispensing information.

"Contact hour" means 50 minutes of participation in a continuing education activity sponsored by an Approved Provider.

"Container" means:

A receptacle, as described in the official compendium or the federal act, that is used in manufacturing or compounding a drug or in distributing, supplying, or dispensing the finished dosage form of a drug; or

A metal receptacle designed to contain liquefied or vaporized compressed medical gas and used in manufacturing, transfilling, distributing, supplying, or dispensing a compressed medical gas.

"Continuing education" means a structured learning process required of a licensee to maintain licensure that includes study in the general areas of socio-economic and legal aspects of health care; the properties and actions of drugs and dosage forms; etiology, characteristics and therapeutics of disease status; or pharmacy practice.

"Continuing education activity" means continuing education obtained through an institute, seminar, lecture, conference, workshop, mediated instruction, programmed learning course, or postgraduate study in an accredited college or school of pharmacy.

"Continuing education unit" or "CEU" means 10 contact hours of participation in a continuing education activity sponsored by an Approved Provider.

"Continuous quality assurance program" or "CQA program" means a planned process designed by a pharmacy permittee to identify, evaluate, and prevent medication errors.

"Correctional facility" has the same meaning as in A.R.S. §§ 13-2501 and 31-341.

"CRT" means a cathode ray tube or other mechanism used to view information produced or stored by a computer system.

"CSPMP" means the Controlled Substances Prescription Monitoring Program established under A.R.S. Title 36, Chapter 28.

"Current good compounding practices" means the minimum standards for methods used in, and facilities or controls used for, compounding a drug to ensure that the drug has the identity and strength and meets the quality and purity characteristics it is represented to possess.

"Current good manufacturing practice" means the minimum standard for methods used in, and facilities or controls used for manufacturing, processing, packing, or holding a drug to ensure that the drug meets the requirements of the federal act as to safety, and has the identity and strength and meets the quality and purity characteristics it is represented to possess.

"Cytotoxic" means a pharmaceutical that is capable of killing living cells.

"Day" means a calendar day unless otherwise specified.

"DEA" means the Drug Enforcement Administration as defined in A.R.S. § 32-1901.

"Declared disaster areas" means areas designated by the governor or by a county, city, or town under A.R.S. § 32-1910 as

those areas that have been adversely affected by a natural disaster or terrorist attack and require extraordinary measures to provide adequate, safe, and effective health care for the affected population.

"Delinquent license" means a pharmacist, intern, or pharmacy technician license the Board suspends for failure to renew or pay all required fees on or before the date the renewal is due.

"Dietary supplement or food supplement," as used in A.R.S. § 32-1904(B), means a product (other than tobacco) that:

Is intended to supplement the diet that contains one or more of the following dietary ingredients: a vitamin, mineral, herb or other botanical, amino acid, dietary substance for use by humans to supplement the diet by increasing the total daily intake, or concentrate, metabolite, constituent, extract, or combinations of these ingredients;

Is intended for ingestion in pill, capsule, tablet, or liquid form;

Is not represented for use as a conventional food or as the sole item of a meal or diet; and

Is labeled as a "dietary supplement" or "food supplement."

"Digital signature" has the same meaning as in A.R.S. § 41-132(E).

"Dispensing pharmacist" means a pharmacist who, in the process of dispensing a prescription medication after the complete preparation of the prescription medication and before delivery of the prescription medication to a patient or patient's agent, verifies, checks, and initials the prescription medication label, as required in R4-23-402(A).

"Drug sample" means a unit of a prescription drug that a manufacturer provides free of charge to promote the sale of the drug.

"Durable medical equipment" or "DME" means technologically sophisticated medical equipment that may be used by a patient or consumer in a home or residence. DME may be prescription-only devices as defined in A.R.S. § 32-1901. DME includes:

Air-fluidized beds,

Apnea monitors,

Blood glucose monitors and diabetic testing strips,

Continuous Positive Airway Pressure (CPAP) machines,

Electronic and computerized wheelchairs and seating systems,

Feeding pumps,

Home phototherapy devices,

Hospital beds,

Infusion pumps,

Medical oxygen and oxygen delivery systems excluding compressed medical gases,

Nebulizers,

Respiratory disease management devices,

Sequential compression devices,

Transcutaneous electrical nerve stimulation (TENS) unit, and

Ventilators.

"Earned income" means monetary payments received by an individual as a result of work performed or rental property owned or leased by the individual, including:

Wages,

Commissions and fees,

Salaries and tips,

Profit from self-employment,

Profit from rent received from a tenant or boarder, and

Any other monetary payments received by an individual for work performed or rental of property.

"Electronic signature" has the same meaning as in A.R.S. § 44-7002.

"Eligible patient" means a patient who a pharmacist determines is eligible to receive an immunization using professional judgment after consulting with the patient regarding the patient's current health condition, recent health condition, and allergies.

"Emergency drug supply unit" means those drugs that may be required to meet the immediate and emergency therapeutic needs of long-term care facility residents and hospice inpatient facility patients, and which are not available from any other authorized source in sufficient time to prevent risk of harm to residents or patients.

"Extreme emergency" means the occurrence of a fire, water leak, electrical failure, public disaster, or other catastrophe constituting an imminent threat of physical harm to pharmacy personnel or patrons.

"Family unit" means:

A group of individuals residing together who are related by birth, marriage, or adoption; or

An individual who:

Does not reside with another individual; or

Resides only with another individual or group of individuals to whom the individual is unrelated by birth, marriage, or adoption.

"FDA" means the Food and Drug Administration, a federal agency within the United States Department of Health and Human Services, established to set safety and quality standards for foods, drugs, cosmetics, and other consumer products.

"Health care decision maker" has the same meaning as in A.R.S. § 12-2291.

"Health care institution" has the same meaning as in A.R.S. § 36-401.

"Hospice inpatient facility" means a health care institution licensed under A.R.S. § 36-401 and Article 8 that provides hospice services to a patient requiring inpatient services.

"Immediate notice" means a required notice sent by mail, fax, or electronic mail to the Board Office within 24 hours.

"Immunizations training program" means an immunization training program for pharmacists and interns that meets the requirements of R4-23-411(E).

"Inactive ingredient" means any component other than an "active ingredient" present in a drug.

"Internal test assessment" means performing quality assurance or other procedures necessary to ensure the integrity of a test.

"ISO Class 5 environment" means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/IEST/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

"ISO Class 7 environment" means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/IEST/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

"Licensed health care professional" means an individual who is licensed and regulated under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 25, 29, or 35.

"Limited-service correctional pharmacy" means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that:

Holds a current Board permit under A.R.S. § 32-1931;

Is located in a correctional facility; and

Uses pharmacists, interns, and support personnel to compound, produce, dispense, and distribute drugs.

"Limited-service long-term care pharmacy" means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board-issued permit and dispenses prescription medication or prescription-only devices to patients in long-term care facilities.

"Limited-service mail-order pharmacy" means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices by mailing or delivering the prescription medication or prescription-only device to an individual by the United States mail, a common or contract carrier, or a delivery service.

"Limited-service nuclear pharmacy" means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and provides radiopharmaceutical services.

"Limited-service pharmacy permittee" means a person who holds a current limited-service pharmacy permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and A.A.C. R4-23-606.

"Limited-service sterile pharmaceutical products pharmacy" means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices as sterile pharmaceutical products.

"Long-term care consultant pharmacist" means a pharmacist providing consulting services to a long-term care facility.

"Long-term care facility" or "LTCF" means a nursing care institution as defined in A.R.S. § 36-401.

"Lot" means a batch or any portion of a batch of a drug, or if a drug produced by a continuous process, an amount of drug produced in a unit of time or quantity in a manner that assures its uniformity. In either case, a lot is identified by a distinctive lot number and has uniform character and quality with specified limits.

"Lot number" or "control number" means any distinctive combination of letters or numbers, or both, from which the complete history of the compounding or manufacturing, control, packaging, and distribution of a batch or lot of a drug can be determined.

"Low-income subsidy" means Medicare-provided assistance that may partially or fully cover the costs of drugs and is based on the income of an individual and, if applicable, the individual's spouse.

"Materials approval unit" means any organizational element having the authority and responsibility to approve or reject components, in-process materials, packaging components, and final products.

"Mechanical counting device for a drug in solid, oral dosage form" means a mechanical device that counts drugs in solid, oral dosage forms for dispensing and includes an electronic balance when used to count drugs.

"Mechanical storage and counting device for a drug in solid, oral dosage form" means a mechanical device that stores and counts and may package or label drugs in solid, oral dosage forms for dispensing.

"Mediated instruction" means information transmitted via intermediate mechanisms such as audio or video tape or telephone transmission.

"Medical practitioner-patient relationship" means that before prescribing, dispensing, or administering a prescription-only drug, prescription-only device, or controlled substance to a person, a medical practitioner, as defined in A.R.S. § 32-1901, shall first conduct a physical examination of that person or have previously conducted a physical examination. This subdivision does not apply to:

A medical practitioner who provides temporary patient supervision on behalf of the patient's regular treating medical practitioner;

Emergency medical situations as defined in A.R.S. § 41-1831;

Prescriptions written to prepare a patient for a medical examination; or

Prescriptions written, prescription-only drugs, prescription-only devices, or controlled substances issued for use by a county or tribal public health department for immunization programs, emergency treatment, in response to an infectious disease investigation, public health emergency, infectious disease outbreak or act of bioterrorism. For purposes of this subsection, "bioterrorism" has the same meaning as in A.R.S. § 36-781.

"Medicare" means a federal health insurance program established under Title XVIII of the Social Security Act.

"Medication error" means any unintended variation from a prescription or medication order. Medication error does not

include any variation that is corrected before the medication is dispensed to the patient or patient's care-giver, or any variation allowed by law.

"Mobile pharmacy" means a pharmacy that is self-propelled or movable by another vehicle that is self-propelled.

"MPJE" means Multistate Pharmacy Jurisprudence Examination, a Board-approved national pharmacy law examination written and administered in cooperation with NABP.

"NABP" means National Association of Boards of Pharmacy.

"NABPLEX" means National Association of Boards of Pharmacy Licensure Examination.

"NAPLEX" means North American Pharmacist Licensure Examination.

"Order" means either of the following:

A prescription order as defined in A.R.S. § 32-1901; or

A medication order as defined in A.A.C. R4-23-651.

"Other designated personnel" means a non-pharmacist individual who is permitted in the pharmacy area, for a limited time, under the direct supervision of a pharmacist, to perform non-pharmacy related duties, such as trash removal, floor maintenance, and telephone or computer repair.

"Outpatient" means an individual who is not a residential patient in a health care institution.

"Outpatient setting" means a location that provides medical treatment to an outpatient.

"Patient profile" means a readily retrievable, centrally located information record that contains patient demographics, allergies, and medication profile.

"Pharmaceutical patient care services" means the provision of drug selection, drug utilization review, drug administration, drug therapy monitoring, and other drug-related patient care services intended to achieve outcomes related to curing or preventing a disease, eliminating or reducing a patient's symptoms, or arresting or slowing a disease process, by identifying and resolving or preventing potential and actual drug-related problems.

"Pharmaceutical product" means a medicinal drug.

"Pharmacy counter working area" means a clear and continuous working area that contains no major obstacles such as a desktop computer, computer monitor, computer keyboard, external computer drive device, printer, fax machine, pharmacy balance, typewriter, or pill-counting machine, but may contain individual documents or prescription labels, pens, prescription blanks, refill log, pill-counting tray, spatula, stapler, or other similar items necessary for the prescription-filling process.

"Pharmacy law continuing education" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations, offered by an Approved Provider.

"Pharmacy permittee" means a person who holds a current pharmacy permit that complies with A.R.S. §§ 32-1929, 32-1930, 32-1931, 32-1934, and R4-23-606 and R4-23-652.

"Physician" means a medical practitioner licensed under A.R.S. Title 32, Chapter 13 or 17.

"Physician-in-charge" means a physician who is responsible to the Board for all aspects of a prescription medication donation program required in A.R.S. § 32-1909 and operated in the physician's office or in a health care institution.

"Poverty level" means the annual family income for a family unit of a particular size, as specified in the poverty guidelines updated annually in the *Federal Register* by the U.S. Department of Health and Human Services.

"Precursor chemical" means a precursor chemical I as defined in A.R.S. § 13-3401(26) and a precursor chemical II as defined in A.R.S. § 13-3401(27).

"Prepackaged drug" means a drug that is packaged in a frequently prescribed quantity, labeled in compliance with A.R.S. §§ 32-1967 and 32-1968, stored, and subsequently dispensed by a pharmacist or intern under the supervision of a pharmacist, who verifies at the time of dispensing that the drug container is properly labeled, in compliance with A.R.S. § 32-1968, for the patient.

"Prep area" means a specified area either within an ISO class 7 environment or adjacent to but outside an ISO class 7 environment that:

Allows the assembling of necessary drugs, supplies, and equipment for compounding sterile pharmaceutical products, but does not allow the use of paper products such as boxes or bulk drug storage;

Allows personnel to don personnel protective clothing, such as gown, gloves, head cover, and booties before entering the clean compounding area; and

Is a room or a specified area within a room, such as an area specified by a line on the floor.

"Primary care provider" means the medical practitioner who is treating an individual for a disease or medical condition.

"Proprietor" means the owner of a business permitted by the Board under A.R.S. §§ 32-1929, 32-1930, 32-1931, and 32-1934.

"Provider pharmacy" means a pharmacy that contracts with a long-term care facility to supply prescription medication or other services for residents of a long-term care facility.

"Radiopharmaceutical" means any drug that emits ionizing radiation and includes:

Any nonradioactive reagent kit, nuclide generator, or ancillary drug intended to be used in the preparation of a radiopharmaceutical, but does not include drugs such as carbon-containing compounds or potassium-containing salts, that contain trace quantities of naturally occurring radionuclides; and

Any biological product that is labeled with a radionuclide or intended to be labeled with a radionuclide.

"Radiopharmaceutical quality assurance" means performing and interpreting appropriate chemical, biological, and physical tests on radiopharmaceuticals to determine the suitability of the radiopharmaceutical for use in humans and animals. Radiopharmaceutical quality assurance includes internal test assessment, authentication of product history, and appropriate record retention.

"Radiopharmaceutical services" means procuring, storing, handling, compounding, preparing, labeling, quality assurance testing, dispensing, distributing, transferring, recordkeeping,

and disposing of radiochemicals, radiopharmaceuticals, and ancillary drugs. Radiopharmaceutical services include quality assurance procedures, radiological health and safety procedures, consulting activities associated with the use of radiopharmaceuticals, and any other activities required for the provision of pharmaceutical care.

"Red C stamp" means a device used with red ink to imprint an invoice with a red letter C at least one inch high, to make an invoice of a Schedule III through IV controlled substance, as defined in A.R.S. § 36-2501, readily retrievable, as required by state and federal rules.

"Refill" means other than the original dispensing of the prescription order, dispensing a prescription order in the same quantity originally ordered or in multiples of the originally ordered quantity when specifically authorized by the prescriber, if the refill is authorized by the prescriber:

In the original prescription order;

By an electronically transmitted refill order that the pharmacist promptly documents and files; or

By an oral refill order that the pharmacist promptly documents and files.

"Regulated chemical" means the same as in A.R.S. § 13-3401(30).

"Remodel" means to alter structurally the pharmacy area or location.

"Remote drug storage area" means an area that is outside the premises of the pharmacy, used for the storage of drugs, locked to deny access by unauthorized persons, and secured against the use of force.

"Resident" means:

An individual admitted to and living in a long-term care facility or an assisted living facility,

An individual who has a place of habitation in Arizona and lives in Arizona as other than a tourist, or

A person that owns or operates a place of business in Arizona.

"Responsible person" means the owner, manager, or other employee who is responsible to the Board for a permitted establishment's compliance with the laws and administrative rules of this state and of the federal government pertaining to distribution of drugs, devices, precursor chemicals, and regulated chemicals. Nothing in this definition relieves other individuals from the responsibility to comply with state and federal laws and administrative rules.

"Score transfer" means the process that enables an applicant to take the NAPLEX in a jurisdiction and be eligible for licensure by examination in other jurisdictions.

"Security features" means attributes incorporated into the paper of a prescription order, referenced in A.R.S. § 32-1968(A)(4), that are approved by the Board or its staff and include one or more of the following designed to prevent duplication or aid the authentication of a paper document: laid lines, enhanced laid lines, thermochromic ink, artificial watermark, fluorescent ink, chemical void, persistent void, penetrating numbers, high-resolution border, high-resolution latent images, micro-printing, prismatic printing, embossed images, abrasion ink, holograms, and foil stamping.

"Shared order filling" means the following:

Preparing, packaging, compounding, or labeling an order, or any combination of these functions, that are performed by:

A person with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy; or

A person, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

Returning the filled order to the requesting pharmacy for delivery to the patient or patient's care-giver or, at the request of this pharmacy, directly delivering the filled order to the patient.

"Shared order processing" means the following:

Interpreting the order, performing order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, and when necessary, therapeutic intervention, or any combination of these order processing functions, that are performed by:

A pharmacist or intern, under pharmacist supervision, with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy: or

A pharmacist or intern, under pharmacist supervision, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

After order processing is completed, returning the processed order to the requesting pharmacy for order filling and delivery to the patient or patient's caregiver or, at the request of this pharmacy, returning the processed order to another pharmacy for order filling and delivery to the patient or patient's caregiver.

"Shared services" means shared order filling or shared order processing, or both.

"Sight-readable" means that an authorized individual is able to examine a record and read its information from a CRT, microfiche, microfilm, printout, or other method acceptable to the Board or its designee.

"Single-drug audit" means an accounting method that determines the numerical and percentage difference between a drug's beginning inventory plus purchases and ending inventory plus sales.

"Single-drug usage report" means a computer system printout of original and refill prescription order usage information for a single drug.

"Standard-risk sterile pharmaceutical product" means a sterile pharmaceutical product compounded from sterile commercial drugs using sterile commercial devices or a sterile pharmaceutical optic or ophthalmic product compounded from non-sterile ingredients.

"State of emergency" means a governmental declaration issued under A.R.S. § 32-1910 as a result of a natural disaster or terrorist attack that results in individuals being unable to refill existing prescriptions.

"Sterile pharmaceutical product" means a medicinal drug free from living biological organisms.

"Strength" means:

The concentration of the drug substance (for example, weight/weight, weight/volume, or unit dose/volume basis); or

The potency, that is, the therapeutic activity of a drug substance as indicated by bioavailability tests or by controlled clinical data (expressed, for example, in terms of unity by reference to a standard).

"Substantial-risk sterile pharmaceutical product" means a sterile pharmaceutical product compounded as a parenteral or injectable dosage form from non-sterile ingredients.

"Supervision" means a pharmacist is present, assumes legal responsibility, and has direct oversight of activities relating to acquiring, preparing, distributing, administering, and selling prescription medications by interns, pharmacy technicians, or pharmacy technician trainees and when used in connection with the intern training requirements means that, in a pharmacy where intern training occurs, an intern preceptor assumes the primary responsibility of teaching the intern during the entire period of the training.

"Supplying" means selling, transferring, or delivering to a patient or a patient's agent one or more doses of:

A nonprescription drug in the manufacturer's original container for subsequent use by the patient, or

A compressed medical gas in the manufacturer's or compressed medical gas distributor's original container for subsequent use by the patient.

"Support personnel" means an individual, working under the supervision of a pharmacist, trained to perform clerical duties associated with the practice of pharmacy, including cashiering, bookkeeping, pricing, stocking, delivering, answering nonprofessional telephone inquiries, and documenting third-party reimbursement. Support personnel shall not perform the tasks of a pharmacist, intern, pharmacy technician, or pharmacy technician trainee.

"Temporary pharmacy facility" means a facility established as a result of a declared state of emergency to temporarily provide pharmacy services within or adjacent to declared disaster areas.

"Tourist" means an individual who is living in Arizona but maintains a place of habitation outside of Arizona and lives outside of Arizona for more than six months during a calendar year.

"Transfill" means a manufacturing process by which one or more compressed medical gases are transferred from a bulk container to a properly labeled container for subsequent distribution or supply.

"Unearned income" means monetary payment received by an individual that is not compensation for work performed or rental of property owned or leased by the individual, including:

Unemployment insurance,

Workers' compensation,

Disability payments,

Payments from the Social Security Administration,

Payments from public assistance,

Periodic insurance or annuity payments,

Retirement or pension payments,

Strike benefits from union funds,

Training stipends,

Child support payments,

Alimony payments,

Military family allotments,

Regular support payments from a relative or other individual not residing in the household,

Investment income,

Royalty payments,

Periodic payments from estates or trusts, and

Any other monetary payments received by an individual that are not:

As a result of work performed or rental of property owned by the individual,

Gifts,

Lump-sum capital gains payments,

Lump-sum inheritance payments,

Lump-sum insurance payments, or

Payments made to compensate for personal injury.

"Verified signature" or "signature verifying" means in relation to a Board license or permit application or report, form, or agreement, the hand-written or electronic signature of an individual who, by placing a hand-written or electronic signature on a hard-copy or electronic license or permit application or report, form, or agreement agrees with and verifies that the statements and information within or attached to the license or permit application or report, form, or agreement are true in every respect and that inaccurate reporting can result in denial or loss of a license or permit or report, form, or agreement.

"Veteran" means an individual who has served in the United States Armed Forces.

"Virtual manufacturer" means an entity that contracts for the manufacture of a drug or device for which the entity:

Owns the New Drug Application or Abbreviated New Drug Application number, as defined by the FDA, for a drug;

Owns the Unique Device Identification number, as defined by the FDA, for a prescription device;

Is not involved in the physical manufacture of the drug or device; and

Contracts with an Arizona-permitted manufacturing entity for the physical manufacture of the drug or device; or

If the contracted manufacturing entity is in a location not included in the definition at A.R.S. 32-1901 of other jurisdiction, the virtual manufacturer ensures the facility is inspected every time the virtual manufacturer submits an initial or renewal application and determined to comply with current good manufacturing practices as defined by the federal act and the official compendium.

Virtual manufacturer includes an entity that may be identified as an own-label distributor, which contracts with a manufacturer to produce a drug or device and with another entity to package and label the drug or device, which is then sold under the distributor's name or another name.

"Virtual wholesaler" means an entity that engages in the wholesale distribution of a drug or device in, into, or out of Arizona but does not take physical possession of the drug or device. A virtual wholesaler distributes a drug or device only from a Board-permitted facility to:

A Board-permitted pharmacy, drug manufacturer, full-service drug wholesaler, or non-prescription drug wholesaler; or

A medical practitioner licensed under A.R.S. Title 32; and

Virtual wholesaler includes an entity that may be identified as a broker that buys and sells goods for others or a person that facilitates distribution of a drug, chemical, or device regulated by the Board.

"Wholesale distribution" means distribution of a drug to a person other than a consumer or patient, but does not include:

Selling, purchasing, or trading a drug or offering to sell, purchase, or trade a drug for emergency medical reasons. For purposes of this Section, "emergency medical reasons" includes transferring a prescription drug by a community or hospital pharmacy to another community or hospital pharmacy to alleviate a temporary shortage;

Selling, purchasing, or trading a drug, offering to sell, purchase, or trade a drug, or dispensing a drug as specified in a prescription;

Distributing a drug sample by a manufacturers' or distributors' representative; or

Selling, purchasing, or trading blood or blood components intended for transfusion.

"Wholesale distributor" means any person engaged in wholesale distribution of drugs, including: manufacturers; repackers; own-label distributors; private-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and retail pharmacies that conduct wholesale distributions in the amount of at least 5% of gross sales.

**Historical Note**

Adopted effective August 24, 1992 (Supp. 92-2). Amended effective December 18, 1992 (Supp. 92-4). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended effective April 5, 1996 (Supp. 96-2). Amended effective July 8, 1997; amended effective August 5, 1997 (Supp. 97-3). Amended effective January 12, 1998 (Supp. 98-1). Amended effective July 7, 1998 (Supp. 98-3). Amended by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 7 A.A.R. 646, effective January 11, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Amended by final rulemaking at 8 A.A.R. 4898 and 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 3967, effective November 13, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 2258, effective August 6, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 3405, effective October 4, 2008; amended by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009; amended by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 18 A.A.R. 2603, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 2609, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by exempt rulemaking under Laws 2016, Ch. 284, § 3 at 22 A.A.R. 2606, effective August 31, 2016 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-111. Notice of Hearing**

**A.** Except as provided in A.R.S. § 32-1928(B), the Board shall revoke, suspend, place on probation, or fine a licensee or permittee only after:
1. Notice is served under this Section, and
2. A hearing is conducted under R4-23-122.

**B.** The Board shall give notice of hearing to a party at least 30 days before the date set for the hearing in the manner described in R4-23-115(E) and (F). The notice shall include:
1. A statement of the date, time, place, and nature of the hearing;
2. A statement of the legal authority and jurisdiction for the hearing;
3. A reference to the particular section or sections of statute and rule involved; and
4. A statement of the violation or issue asserted by the Board.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-112. Ex Parte Communications**
A party shall not communicate, either directly or indirectly, with a Board member about any substantive issue in a pending matter unless:
1. All parties are present;
2. It is during a scheduled proceeding, where an absent party fails to appear after proper notice; or
3. It is by written motion with copies to all parties.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-113. Motions**
**A.** Purpose. A party requesting a ruling from the Board shall file a motion. Motions may be made for rulings such as:
1. Continuing or expediting a hearing under R4-23-116;
2. Vacating a hearing under R4-23-117;
3. Scheduling a prehearing conference under R4-23-118;
4. Quashing a subpoena under R4-23-119;
5. Requesting telephonic testimony under R4-23-120; and
6. Reconsidering a previous order under R4-23-121.

**B.** Form. Unless made during a prehearing conference or hearing, motions shall be made in writing and shall conform to the requirements of R4-23-115. All motions, whether written or oral, shall state the factual and legal grounds supporting the motion, and the requested action.

**C.** Time limits. Absent good cause, or unless otherwise provided by law or these rules, written motions shall be filed with the Board office at least 15 days before the hearing. A party demonstrates good cause by showing that the grounds for the motion could not have been known in time, using reasonable diligence and:
1. A ruling on the motion will further administrative convenience, expedition or economy; or
2. A ruling on the motion will avoid undue prejudice to any party.

**D.** Response to motion. A party shall file a written response stating any objection to the motion within five days of service, or as directed by the Board.

**E.** Oral argument. A party may request oral argument when filing a motion or response. If necessary to develop a complete record, the Board shall grant oral argument.

**F.** Rulings. Rulings on motions, other than those made during a prehearing conference or the hearing, shall be in writing and served on all parties.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-114. Computing Time**
In computing any time period, the Board shall exclude the day from which the designated time period begins to run. The Board shall include the last day of the period unless it falls on a Saturday, Sunday, or legal holiday. When the time period is 10 days or less, the Board shall exclude Saturdays, Sundays, and legal holidays.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-115. Filing Documents**
**A.** Docket. The Board shall open a docket for each hearing. All documents filed in a matter with the Board shall be date stamped on the day received by the Board office and entered in the docket.

**B.** Definition. "Documents" include papers such as complaints, answers, motions, responses, notices, and briefs.

**C.** Form. A party shall state on the document the name and address of each party served and how service was made under subsection (E). A document shall contain the Board caption and the Board's docket number.

**D.** Signature. A document filed with the Board shall be signed by the party or the party's attorney. A signature constitutes a certification that the signer has read the document, has a good faith basis for submission of the document, and that it is not filed for the purpose of delay or harassment.

**E.** Filing and service. A copy of a document filed with the Board shall be served on all parties. Filing with the Board office and service shall be completed by personal delivery; first-class, certified, or express mail; or facsimile.

**F.** Date of filing and service. A document is filed with the Board on the date it is received by the Board office, as established by the Board office's date stamp on the face of the document. A copy of a document is served on a party as follows:
1. On the date it is personally served,
2. Five days after it is mailed by first-class or express mail,
3. On the date of the return receipt if it is mailed by certified mail, or
4. On the date indicated on the facsimile transmission.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-116. Continuing or Expediting a Hearing; Reconvening a Hearing**
**A.** Continuing or expediting a hearing. When ruling on a motion to continue or expedite, the Board shall consider such factors as:
1. The time remaining between the filing of the motion and the hearing date;
2. The position of other parties;
3. The reasons for expediting the hearing or for the unavailability of the party, representative, or counsel on the date of the scheduled hearing;
4. Whether testimony of an unavailable witness can be taken telephonically or by deposition; and
5. The status of settlement negotiations.

**B.** Reconvening a hearing. The Board may recess a hearing and reconvene at a future date by a verbal ruling.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-117. Vacating a Hearing**
The Board shall vacate a calendared hearing and return the matter to the Board office for further action, if:
1. The parties agree to vacate the hearing;
2. The Board dismisses the matter;
3. The non-Board party withdraws the appeal; or
4. Facts demonstrate to the Board that it is appropriate to vacate the hearing for the purpose of informal disposition, or if the action will further administrative convenience, expedition, and economy and does not conflict with law or cause undue prejudice to any party.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-118. Prehearing Conference**

**A.** Procedure. The Board may hold a prehearing conference. The conference may be held telephonically. The Board may issue a prehearing order outlining the issues to be discussed.

**B.** Record. The Board may record any agreements reached during a prehearing conference by electronic or mechanical means, or memorialize them in an order.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-119. Subpoenas**

**A.** Form. A party wanting the Board to issue a subpoena shall submit a written request to the Board and include:
1. The caption and docket number of the matter;
2. A list or description of any documents sought;
3. The full name and home or business address of the custodian of the documents sought or all persons to be subpoenaed;
4. The date, time, and place to appear or to produce documents according to the subpoena; and
5. The name, address, and telephone number of the party, or the party's attorney, requesting the subpoena.

**B.** The Board may require a brief statement of the relevance of testimony or documents requested.

**C.** Service of subpoena. The Board shall serve a subpoena in a manner allowed by law.

**D.** Objection to subpoena. If a party or the person served with a subpoena objects to the subpoena or any portion of the subpoena, the party or person may file an objection with the Board within five days after service of the subpoena or at the start of the hearing if the subpoena is served fewer than five days before the hearing.

**E.** Quashing or modifying subpoenas. The Board shall quash or modify a subpoena if:
1. It is unreasonable or oppressive, or
2. The desired testimony or evidence may be obtained by an alternative method.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-120. Telephonic Testimony**

The Board may grant a motion for telephonic testimony if:
1. Personal attendance by a party or witness at the hearing will present an undue hardship for the party or witness;
2. Telephonic testimony will not cause undue prejudice to any party; and
3. The proponent of the telephonic testimony pays for any cost of obtaining the testimony telephonically.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-121. Rights and Responsibilities of Parties**

**A.** Generally. A party may present testimony and documentary evidence and argument with respect to the contested issue and may examine and cross-examine witnesses.

**B.** Preparation. A party shall have all witnesses, documents, and exhibits available on the date of the hearing.

**C.** Exhibits. A party shall provide a copy of each exhibit to all other parties at the time the exhibit is offered to the Board, unless the exhibit was previously provided to all other parties.

**D.** Responding to orders. A party shall comply with an order issued by the Board concerning the conduct of a hearing. Unless an objection is made orally during a pre-hearing conference or hearing, a party shall file a motion requesting the Board to reconsider the order.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-122. Conduct of Hearing**

**A.** Public access. Unless otherwise provided by law, all hearings are open to the public and may be conducted in an informal manner as prescribed in A.R.S. § 41-1092 et seq.

**B.** Opening. The Board shall begin the hearing by reading the caption, stating the nature and scope of the hearing, and identifying the parties, counsel, and witnesses for the record.

**C.** Stipulations. The Board shall enter into the record any stipulation, settlement agreement, or consent order entered into by any of the parties before or during the hearing.

**D.** Opening statements. The party with the burden of proof may make an opening statement at the beginning of a hearing. All other parties may make statements in a sequence determined by the Board.

**E.** Order of presentation. After opening statements, the party with the burden of proof shall begin the presentation of evidence, unless the parties agree otherwise or the Board determines that requiring another party to proceed first would be more expeditious or appropriate, and would not prejudice any other party. Copies of documentary evidence may be received in the discretion of the Board. Upon request, parties shall be given an opportunity to compare the copy with the original.

**F.** Examination. A party shall conduct direct and cross examination of witnesses in the order and manner determined by the Board to expedite and ensure a fair hearing. The Board shall make rulings necessary to prevent argumentative, repetitive, or irrelevant questioning and to expedite the examination to the extent consistent with the disclosure of all relevant testimony and information. The Board may take notice of judicially cognizable facts. In addition, the Board may take notice of generally recognized technical or scientific facts within the Board's or its staff's specialized knowledge. A party shall be notified either before or during the hearing or by reference in preliminary reports of the material the Board notices. The Board may use the Board's or its staff's experience, technical competence, and specialized knowledge in the evaluation of the evidence.

**G.** Closing argument. When all evidence has been received, parties shall have the opportunity to present closing oral argument, in a sequence determined by the Board. The Board may permit or require closing oral argument to be supplemented by written memoranda. The Board may permit or require written memoranda to be submitted simultaneously or sequentially, within time periods the Board may prescribe.

**H.** Conclusion of hearing. Unless otherwise provided by the Board, the hearing is concluded upon the submission of all evidence, the making of final argument, and the issuing of a final decision or order of the Board.

**I.** Decisions and orders. Unless otherwise provided by law, any final decisions or order adverse to a party in a hearing shall be in writing or stated in the record. Any final decision shall

include findings of fact and conclusions of law, separately stated. Findings of fact shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Unless otherwise provided by law, each party shall be notified either personally or by mail to the party's last known address of record of any decision or order. Upon request, a copy of the decision or order shall be delivered or mailed to each party and to each party's attorney of record.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-123. Failure of Party to Appear for Hearing**
If a party fails to appear at a hearing, the Board may proceed with the presentation of the evidence of the appearing party, or vacate the hearing and return the matter to the Board office for any further action.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-124. Witnesses; Exclusion from Hearing**
All witnesses at the hearing shall testify under oath or affirmation. At the request of a party, or at the discretion of the Board, the Board may exclude witnesses who are not parties from the hearing room so that they cannot hear the testimony of other witnesses.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-125. Proof**
**A.** Standard of proof. Unless otherwise provided by law, the standard of proof is a preponderance of the evidence.
**B.** Burden of proof. Unless otherwise provided by law:
1. The party asserting a claim, right, or entitlement has the burden of proof;
2. A party asserting an affirmative defense has the burden of establishing the affirmative defense; and
3. The proponent of a motion shall establish the grounds to support the motion.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-126. Disruptions**
A person shall not interfere with access to or from the hearing room, or interfere, or threaten interference with the hearing. If a person interferes, threatens interference, or disrupts the hearing, the Board may order the disruptive person to leave or be removed.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-127. Hearing Record**
**A.** Maintenance. The Board shall maintain the official administrative record of a matter.
**B.** Transfer of record. Any party requesting a copy of the administrative record or any portion of the administrative record shall make a request to the Board office and shall pay the reasonable costs of duplication.
**C.** Release of exhibits. Exhibits shall be released:
1. Upon the order of a court of competent jurisdiction; or
2. Upon motion of the party who submitted the exhibits if the time for judicial appeal has expired and no appeal is pending.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-128. Rehearing or Review and Appeal of Decision**
**A.** The Board shall provide for a rehearing and review of it decisions under A.R.S. Title 41, Chapter 6, Article 10, and this Section. For purposes of these rules, the terms "contested case" and "party" are defined in A.R.S. § 41-1001.
**B.** A party to a contested case shall exhaust the party's administrative remedies by filing a motion for rehearing or review within 30 days after the service of the Board decision that is subject to rehearing or review in order to be eligible for judicial review under A.R.S. Title 12, Chapter 7, Article 6. The Board shall notify a party in its decision, that is subject to rehearing or review, that the party may file a motion for rehearing or review, and that failure to file a motion for rehearing or review within 30 days after service of the decision has the effect of prohibiting the party from seeking judicial review of the Board's decision.
**C.** A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
**D.** The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
1. Irregularity in the proceedings of the Board, or any order or abuse of discretion, that deprived the moving party of a fair hearing;
2. Misconduct of the Board, its staff, its hearing officer, or the prevailing party;
3. Accident or surprise that could not have been prevented by ordinary prudence;
4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
5. Excessive or insufficient penalty;
6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings;
7. That the Board's decision is a result of passion or prejudice; or
8. That the findings of fact or decision is not justified by the evidence or is contrary to law.
**E.** The Board may affirm or modify a decision or grant a rehearing to all or any of the parties on all or part of the issues for any of the reasons in subsection (D). An order modifying a decision or granting a rehearing shall specify with particularity the grounds for the order.
**F.** If a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board may extend this period for a maximum of 20 days, for good cause as described in subsection (I).
**G.** Not later than 10 days after the date of a decision, after giving parties notice and an opportunity to be heard, the Board may grant a rehearing or review on its own initiative for any reason for which it might have granted relief on the motion of a party. The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion.
**H.** If a rehearing is granted, the Board shall hold the rehearing within 60 days after the order granting the rehearing is issued.

**I.** The Board may extend all time limits listed in this Section upon a showing of good cause. A party demonstrates good cause by showing that the grounds for the party's motion or other action could not have been known in time, using reasonable diligence, and a ruling on the motion will:
1. Further administrative convenience, expedition, or economy; or
2. Avoid undue prejudice to any party.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-129. Notice of Judicial Appeal; Transmitting the Transcript**

**A.** Notification to the Board office. Within 10 days of filing a complaint for judicial review of a final administrative decision of the Board, the party shall file a copy of the complaint with the Board office. The Board office shall then transmit the administrative record to the Superior Court.

**B.** Transcript. A party requesting a transcript shall arrange for transcription at the party's expense. The Board office shall make a copy of the audio taped record available to the transcriber. The party arranging for transcription shall deliver the transcript, certified by the transcriber under oath to be a true and accurate transcription of the audio taped record, to the Board office, together with one unbound copy.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

## ARTICLE 2. PHARMACIST LICENSURE

**R4-23-201. General**

**A.** License required. Before practicing as a pharmacist in Arizona, a person shall possess a valid pharmacist license issued by the Board.

**B.** Methods of licensure. Licensure as a pharmacist shall be by:
1. Examination using a Board-approved testing method; or
2. Reciprocity, as provided under A.R.S. § 32-1922(B).

**C.** The Board may reinstate the license of a pharmacist who is practicing pharmacy in another jurisdiction and has an Arizona license that lapsed at least five years ago if the pharmacist:
1. Passes the MPJE or other Board-approved jurisprudence examination, and
2. Pays all fees and penalties specified under A.R.S. § 32-1925(C).

**D.** The Board may reinstate the license of a pharmacist who has not practiced pharmacy within the last 12 months before seeking reinstatement and whose Arizona license lapsed at least five years ago if the pharmacist:
1. Completes the requirements in subsection (C), and
2. Appears before the Board to furnish satisfactory proof of fitness to be licensed as a pharmacist.

**E.** Verification of license. A pharmacy permittee or pharmacist-in-charge shall not allow a person to practice as a pharmacist until the pharmacy permittee or pharmacist-in-charge verifies the person is currently licensed by the Board as a pharmacist.

**Historical Note**

Former Rules 2.1100, 2.1310, 2.1320, and 2.1400. Amended effective August 23, 1978 (Supp. 78-4). Amended by deleting subsection (E) effective April 20, 1982 (Supp. 82-2). Amended subsections (C) and (D) effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-202. Licensure by Examination**

**A.** Eligibility. To be eligible for licensure as a pharmacist by examination, a person shall:
1. Have a degree in pharmacy from an approved school or college of pharmacy; or
2. Qualify under the requirements of A.R.S. § 32-1922(D).

**B.** Application.
1. An applicant for licensure by examination shall:
   a. Submit a completed application on a form furnished by the Board, and
   b. Submit with the application form:
      i. The documents specified in the application form, and
      ii. The application fee specified in R4-23-205.
2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.
3. An applicant for licensure by examination shall register for the NAPLEX and jurisprudence examination through NABP's registration process. When NABP determines the applicant is eligible to test, NABP will issue an authorization to test.
4. The Board shall deem an application for licensure by examination invalid 12 months after the date the application is received. An applicant whose application form is invalid and who wishes to continue licensure procedures, shall submit a new application form and fee as specified under subsection (B)(1).

**C.** Passing grade; notification; re-examination.
1. To pass the required examinations, an applicant shall receive a passing grade on both the NAPLEX and jurisprudence examination.
2. The Board office shall retrieve an applicant's NAPLEX and jurisprudence examination scores from the NABP database no later than two weeks after the applicant's examination date.
3. An applicant who fails the NAPLEX or jurisprudence examination may register with the NABP to retake the examination within the 12-month period defined in subsection (B)(4). An applicant who fails the NAPLEX or jurisprudence examination three times shall petition the Executive Director as specified in R4-23-401 for approval before retaking the examination. If the applicant fails the NAPLEX or jurisprudence examination four times, the applicant shall petition the Board as specified in R4-23-401 for Board consideration before taking the examination for a last time.
4. For the purpose of licensure by examination, the Board office shall deem a passing score on the NAPLEX or jurisprudence examination invalid 24 months after the applicant's examination date. An applicant who fails to complete the licensure process within the 24-month period, and who wishes to continue licensure procedures, shall retake the examination or examinations.

**D.** NAPLEX score transfer.
1. The Board office shall deem a score transfer received on the date the NABP transmits the applicant's official score transfer report to the Board office.

2. An applicant who receives a passing score on the NAPLEX taken in another jurisdiction shall, within 12 months after the date the Board office receives the applicant's official NABP score transfer report, make application for licensure according to subsection (B). After 12 months, an applicant may reapply for licensure in this state under the provisions of subsection (B) or R4-23-203(B).

**E.** Licensure.
1. The Board office shall issue a certificate of licensure and a wall license to a successful applicant.
2. A licensee shall maintain the certificate of licensure in the practice site for inspection by the Board or its designee or review by the public.

**F.** Time frames for licensure by examination.
1. The Board office shall complete an administrative completeness review within 60 days after the date the application form is received.
   a. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application form.
   b. If the application form is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 60-day time frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
   c. If the Board office does not provide the applicant with written notice regarding administrative completeness, the application form shall be deemed complete 60 days after receipt by the Board office.
2. An applicant with an incomplete application form shall submit all of the missing information within 90 business days after service of the notice of incompleteness. If an applicant cannot submit all missing information within 90 business days after service of the notice of incompleteness, the applicant may send a written notice of a 30-day extension to the Board office postmarked or delivered no later than 90 business days after service of the notice of incompleteness.
3. If an applicant fails to submit a complete application form within the time allowed under subsection (F)(2), the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a license shall apply again according to subsection (B).
4. The Board office shall complete a substantive review of the applicant's qualifications in no more than 120 days after the date on which the administrative completeness review of an application form is complete.
   a. The Board office shall deem the application invalid 12 months after the date the application for licensure by examination is received.
   b. If the Board office finds deficiencies during the substantive review of the applicant's qualifications, the Board office shall issue a written request to the applicant for additional documentation.
   c. The 120-day time frame for a substantive review is suspended from the date of a written request for additional documentation until the date all documentation is received. The applicant shall submit the additional documentation according to subsection (F)(2).
   d. If the applicant and the Board office agree in writing, the 120-day substantive review time frame may be extended once for no more than 45 days.
5. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time frames for licensure by examination.
   a. Administrative completeness review time frame: 60 days.
   b. Substantive review time frame: 120 days.
   c. Overall time frame: 180 days.

**G.** License renewal.
1. To renew a license, a pharmacist shall submit a completed license renewal application on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1925, the pharmacist license is suspended and the licensee shall not practice as a pharmacist. The suspended licensee shall pay a reinstatement penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.
3. A licensee shall maintain the renewal certificate of licensure in the practice site for inspection by the Board or its designee or review by the public.
4. Time frames for license renewals. The Board office shall follow the time frames established in subsection (F) when processing a renewal application.

**Historical Note**

Former Rules 2.2100, 2.2200, 2.2300, 2.2400, 2.2500, 2.2600, 2.2700, 2.2800, 2.2910, 2.2920, 2.2930, 2.3000, 2.3010, 2.3100; Amended effective August 23, 1978 (Supp. 78-5). Amended effective June 10, 1981 (Supp. 81-3). Former Section R4-23-202 repealed, new Section R4-23-202 adopted effective July 24, 1985 (Supp. 85-4). Amended effective March 13, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 12 A.A.R. 4689, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1012 and 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-203. Licensure by Reciprocity**

**A.** Eligibility. A person is eligible for licensure by reciprocity if the person is licensed as a pharmacist in another jurisdiction and qualified under A.R.S. § 32-1922(B).

**B.** Application. An applicant for licensure by reciprocity shall comply with R4-23-202(B).

**C.** Passing grade; notification; re-examination. An applicant for licensure by reciprocity shall comply with R4-23-202(C) regarding the jurisprudence examination.

**D.** Licensure. The provisions of R4-23-202(E) apply for an applicant for licensure by reciprocity.

**E.** Time frames for licensure by reciprocity. The Board office shall follow the time frames established in R4-23-202(F).

**F.** License renewal. The procedure specified in R4-23-202(G) applies.

**Historical Note**

Former Rules 2.4100, 2.4200, 2.4310, 2.4320, 2.4330, 2.4340, 2.4350, 2.4360, 2.4400, 2.4510, 2.4520, 2.4522, 2.4523, 2.4530, 2.4540, 2.4550, 2.4560, 2.4610, 2.4620, and 2.4700; Amended effective August 23, 1978 (Supp. 78-4). Amended subsections (H), (L), (O) through (Q) effective June 10, 1981 (Supp. 81-3). Former Section R4-23-203 repealed, new Section R4-23-203 adopted effective July 24, 1985 (Supp. 85-4). Amended effective March 13, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-204. Continuing Education Requirements**

**A.** Under A.R.S. § 32-1936, continuing professional pharmacy education is mandatory for all licensees.
1. General continuing education requirement. In accordance with A.R.S. § 32-1925(F), the Board shall not renew a license unless the licensee has, during the two years preceding the application for renewal, participated in 30 contact hours (3.0 CEUs) of continuing education activity sponsored by an Approved Provider as defined in R4-23-110.
2. Special continuing education requirement. The Board shall not renew a license unless:
   a. A licensee certified under R4-23-411 to administer immunizations, vaccines, and emergency medications has participated in at least two contact hours of continuing education activity related to administering immunizations, vaccines, and emergency medications;
   b. A licensee authorized to dispense controlled substances has participated in at least three contact hours of opioid-related, substance use disorder-related, or addiction-related continuing education activity; and
   c. A licensee who dispenses self-administered hormonal contraceptives under a standing prescription order has participated in at least three contact hours of continuing education activity related to self-administered hormonal contraceptives.
3. A pharmacist is exempt from the continuing education requirement in subsections (A)(1) and (2) between the time of initial licensure and first renewal.

**B.** Acceptance of continuing education units CEUs. The Board shall:
1. Accept CEUs for continuing education activities sponsored only by an Approved Provider;
2. Accept CEUs accrued only during the two-year period immediately before licensure renewal;
3. Not allow CEUs accrued in a biennial renewal period to be carried forward to the succeeding biennial renewal period;
4. Allow a pharmacist who leads, instructs, or lectures to a group of health professionals on pharmacy-related topics in a continuing education activity sponsored by an Approved Provider to receive CEUs for a presentation by following the same attendance procedures as any other attender of the continuing education activity; and
5. Not accept as CEUs the performance of normal teaching duties within a learning institution by a pharmacist whose primary responsibility is the education of health professionals.

**C.** Continuing education records and reporting CEUs. A pharmacist shall:
1. Maintain continuing education records that:
   a. Verify the continuing education activities the pharmacist participated in during the preceding five years; and
   b. Consist of a statement of credit or a certificate issued by an Approved Provider at the conclusion of a continuing education activity;
2. At the time of licensure renewal, attest to the number of CEUs the pharmacist participated in during the renewal period on the biennial renewal form; and
3. When requested by the Board office, submit proof of continuing education participation within 20 days of the request.

**D.** The Board may revoke, suspend, or place on probation the license of a pharmacist who fails to comply with continuing education participation, recording, or reporting requirements of this Section.

**E.** A pharmacist who is aggrieved by any decision of the Board or its administrative staff concerning continuing education units may request a hearing before the Board.

**Historical Note**

Adopted effective September 1, 1981 (Supp. 81-5). Amended effective March 13, 1991 (Supp. 91-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 29 A.A.R. 1655 (July 28, 2023), with an immediate effective date of July 5, 2023 (Supp. 23-3).

**R4-23-205. Fees and Charges**

**A.** The Board establishes and shall collect the full biennial fee for all initial and renewal license and permit applications listed in subsections (B) and (C).

**B.** Licensure fees:
1. Pharmacist:
   a. Initial licensure: $180.
   b. Licensure renewal: $180.
2. Intern. Initial licensure: $50.
3. Pharmacy technician:
   a. Initial licensure: $72.
   b. Licensure renewal: $72.
4. Temporary license valid for 30 days:
   a. Pharmacist: $120.
   b. Intern: $50.
   c. Pharmacy technician: $50.

**C.** Vendor permit fees (Resident and nonresident):
1. Pharmacy: $480 biennially (Including hospital, and limited service).

2. Drug wholesaler or manufacturer:
   a. Manufacturer: $1000 biennially.
   b. Full-service drug wholesaler: $1000 biennially.
   c. Nonprescription drug wholesaler: $500 biennially.
3. Drug packager or repackager: $1000 biennially.
4. Compressed medical gas distributor: $200 biennially.
5. Durable medical equipment and compressed medical gas supplier: $100 biennially.
6. Third-party logistics provider: $1000 biennially.
7. Automated prescription-dispensing kiosk: $480 biennially.

**D.** Pharmacy technician trainee 36-month, non-renewable, registration: $25.
**E.** Reciprocity fee: $150.
**F.** Application fee: $50.
**G.** Certificate fees:
1. Certificate of free sale: $200 per certificate.
2. Certificate of good manufacturing practice: $200 per certificate.

**H.** Charges for services:
1. Wall license.
   a. Pharmacist: $20.
   b. Intern: $10.
   c. Pharmacy technician: $10.
2. Duplicate of any Board-issued certificate: $10.
3. License, permit, or certificate verification: $15.

**I.** Fees are not refunded under any circumstances except for the Board's failure to comply with its established licensure or permit time frames under R4-23-202 or R4-23-602.
**J.** Penalty. A renewal application submitted after the expiration date is subject to a penalty as provided in A.R.S. §§ 32-1925 and 32-1931.
1. Licensee: A penalty equal to half the licensee's biennial licensure renewal fee under subsection (B) and not to exceed $350.
2. Permittee: A penalty equal to half the permittee's biennial permit fee under subsection (C) and not to exceed $350.

**Historical Note**

Adopted effective July 24, 1985 (Supp. 84-5). Amended subsection (A) paragraph (1) effective May 20, 1988 (Supp. 88-2). Amended effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 15 A.A.R. 173, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by exempt rulemaking under Laws 2016, Ch. 284, § 3 at 22 A.A.R. 2606, effective August 31, 2016 (Supp. 16-3). Amended by final exempt rulemaking at 23 A.A.R. 2058, effective August 9, 2017; amended by final exempt rulemaking with amendments to subsection (D), at 23 A.A.R. 2383 (Supp. 17-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1012, and 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

## ARTICLE 3. INTERN TRAINING; INTERN PRECEPTORS

**R4-23-301. Intern Licensure**

**A.** Licensure as an intern is for the purpose of complementing an individual's academic or experiential education in preparation for licensure as a pharmacist. An applicant may request a waiver of intern licensure requirements by submitting a written request as specified in R4-23-401 and appearing in person at a Board meeting.
**B.** The prerequisite for licensure as an intern is one of the following:
1. Current enrollment, in good standing, in an approved college or school of pharmacy;
2. Graduation from a college or school of pharmacy along with:
   a. Proof the applicant is certified by the Foreign Pharmacy Graduate Examination Committee (FPGEC), if applicable; or
   b. Application for licensure as a pharmacist by examination or reciprocity; or
3. By order of the Board if the Board determines the applicant needs intern training.

**C.** If an intern licensee stops attending pharmacy school classes without graduating, the licensee shall immediately stop practicing as an intern and surrender the intern license to the Board or the Board's designee no later than 30 days after the date of the last attended class, unless the licensee petitions the Board as specified in R4-23-401 and receives Board approval to continue working as an intern. A student re-entering a pharmacy program who wishes to continue internship training shall reapply for intern licensure.
**D.** Experiential training. The preceptor supervising an intern shall ensure the training received by the intern includes the activities and services encompassed by the term "practice of pharmacy" as defined in A.R.S. § 32-1901.
**E.** Out-of-state experiential training. The Board shall credit an intern for experiential training received outside this state if the Board determines the experiential training requirements of the jurisdiction in which the training was received are equal to the minimum requirements for experiential training in this state. An applicant seeking credit for experiential training received outside this state shall furnish a certified copy of the training records from:
1. The Board of Pharmacy or the intern licensing agency of the jurisdiction where the training was received; or
2. In a jurisdiction without an intern licensing agency, the director of the applicant's approved college or school of pharmacy's experiential training program.

**F.** Verification of license. A pharmacy permittee or pharmacist-in-charge shall not allow an individual to practice as an intern until the pharmacy permittee or pharmacist-in-charge verifies the individual is currently licensed by the Board as an intern.
**G.** Intern application.
1. An applicant for licensure as an intern shall:
   a. Submit a completed application on a form furnished by the Board, and
   b. Submit with the application form:

i. The documents specified in the application form, and
ii. The initial licensure fee specified in R4-23-205.

2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.

**H.** Licensure.

1. If an applicant is found to be ineligible for intern licensure under statute and rule, the Board office shall issue a written notice of denial to the applicant.
2. If an applicant is found to be eligible for intern licensure under statute and rule, the Board office shall issue a certificate of licensure and a wall license. An applicant who is assigned a license number and has been granted "open" status on the Board's license verification site may begin practice as an intern before receiving the certificate of licensure.
3. An applicant who is assigned a license number and has a "pending" status on the Board's license verification site shall not practice as an intern until the Board office issues a certificate of licensure as specified in subsection (H)(2).
4. A licensee shall maintain the certificate of licensure in the practice site for inspection by the Board or its designee or review by the public.

**I.** Time frames for intern licensure. The Board office shall follow the time frames established in R4-23-202(F).

**J.** License renewal.

1. An intern whose license expires before the intern completes the education or training required for licensure as a pharmacist but fewer than six years after issuance of the initial intern license may renew the intern license for a period equal to the difference between the expiration date of the initial intern license and six years from the issue date of the initial intern license by paying a prorated renewal fee based on the intern initial license fee specified in R4-23-205.
2. If an intern fails to graduate from an approved college or school of pharmacy within six years from the date the Board issues the initial intern license, the intern is not eligible for relicensure as an intern unless the intern obtains Board approval as specified in A.R.S. § 32-1923(E) and R4-23-401. To remain in good standing, an intern who receives Board approval for relicensure shall pay a prorated renewal fee for the number of months of licensure approved by the Board based on the intern initial license fee specified in R4-23-205 before the license expires.
3. If an intern receives Board approval for relicensure and does not pay the renewal fee specified in subsection (J)(2) before the license expires, the intern license is suspended and the suspended licensee shall not practice as an intern until the suspended licensee pays a penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.

**K.** Notification of training. An intern who is employed as an intern outside the experiential training program of an approved college or school of pharmacy shall notify the Board within 10 days of starting or terminating training or changing training site.

**L.** Change of address. An intern shall notify the Board within 10 days after the intern's employment or mailing address changes.

**Historical Note**

Former Rules 3.1000, 3.1100, 3.1200, 3.2000, 3.2100, and 3.2200; Amended effective August 23, 1978 (Supp. 78-4). Amended effective April 20, 1982 (Supp. 82-2). Amended subsections (A), (F) and (G) effective August 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3565, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-302. Training Site; Intern Preceptors; Training Time**

**A.** To receive credit for intern training hours, an intern shall train in a site that:

1. Holds a valid Arizona pharmacy permit; or
2. Is an alternative training site. For purposes of this Section, the term alternative training site is a non-pharmacy training site established and monitored by an approved college or school of pharmacy or other non-pharmacy site where pharmacy-related activities are performed and where an intern gains experience as specified in R4-23-301(D).

**B.** Intern preceptor. To be an intern preceptor, a pharmacist shall:

1. Hold a current unrestricted pharmacist license;
2. Have at least one year of experience as an actively practicing pharmacist; and
3. If found guilty of violating any federal or state law relating to the practice of pharmacy, drug or device distribution, or recordkeeping or unprofessional conduct, enter into an agreement satisfactory to the Board that places restrictions on the pharmacist's license.

**C.** Preceptor responsibilities. A preceptor is responsible for the actions of an intern during the training period. A preceptor shall give an intern the opportunity for skill development and provide the intern with timely and realistic feedback regarding the intern's progress.

**D.** Training hours. An intern preceptor shall ensure the intern receives hours of experiential training consistent with the requirements of the ACPE.

**Historical Note**

Former Rules 3.3000, 3.3100, 3.3200, 3.3300, 3.3310, 3.3320, 3.3330, 3.3340, 3.3400, 3.4000, 3.4100, 3.4200, 3.4300, and 3.4400; Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-303. Repealed**

**Historical Note**

Former Rules 3.5000 and 3.5200; Amended effective August 23, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8

A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2619, effective December 2, 2012 (Supp. 12-4). Repealed by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-304. Repealed**

**Historical Note**

Former Rules 3.6100, 3.6200, 3.6300, and 3.6400; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 18 A.A.R. 2619, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Repealed by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-305. Repealed**

**Historical Note**

Former Rule 3.7000; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Repealed by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

## ARTICLE 4. PROFESSIONAL PRACTICES

**R4-23-401. Time-frames for Board Approvals and Special Requests**

**A.** To request a Board approval required by this Chapter or a special request to deviate from or waive compliance with a requirement of this Chapter, a person shall send a letter by regular mail, e-mail, or facsimile to the Board office, detailing the nature of the approval or special request, including the applicable Arizona Revised Statute or administrative code citation. This Section does not apply to a request from a person regarding the probation, suspension, or revocation of a license or permit.

**B.** The Board office shall complete an administrative completeness review within 15 days from the date of receipt of a written request and immediately open a request file for the applicant.
1. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the request.
2. If the request is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 15-day time-frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
3. If the Board office does not provide the applicant with notice regarding administrative completeness, the request is deemed complete 15 days after receipt by the Board office.

**C.** An applicant with an incomplete request shall submit all of the missing information within 30 days of service of the notice of incompleteness.
1. If an applicant cannot submit all missing information within 30 days of service of the notice of incompleteness, the applicant may send a written request for an extension to the Board office post-marked or delivered no later than 30 days from service of the notice of incompleteness.
2. The written request for an extension shall document the reasons the applicant cannot meet the 30-day deadline.
3. The Board office shall review the request for an extension of the 30-day deadline and grant the request if the Board office determines that an extension of the deadline will enable the applicant to assemble and submit the missing information. An extension shall be for no more than 30 days. The Board office shall notify the applicant in writing of its decision to grant or deny the request for an extension. An applicant who requires an additional extension shall submit an additional written request according to subsections (C)(1) and (C)(2).

**D.** If an applicant fails to submit a complete request within the time allowed, the Board office shall close the applicant's request file. An applicant whose request file is closed and who later wishes to obtain an approval or special request shall apply again according to subsection (A).

**E.** From the date on which the administrative completeness review of a request is finished, the Board shall complete a substantive review of the applicant's request in no more than 120 days.
1. The Board shall:
   a. Approve the request,
   b. Deny the request, or
   c. If the Board determines deficiencies exist, request that the applicant produce additional documentation.
2. If the Board approves or denies, the Board office shall issue a written approval or denial.
3. If the Board finds deficiencies during the substantive review of a request, the Board office shall issue a written request to the applicant for additional documentation.
4. The 120-day time-frame for a substantive review of a request for approval or special request is suspended from the date of a written request for additional documentation until the date of the next Board meeting after all documentation is received. The applicant shall submit the additional documentation according to subsection (C).
5. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time-frame may be extended once for no more than 30 days.

**F.** If the applicant fails to submit the additional information requested within the time allowed, the Board office shall close the applicant's request file. An applicant whose request file is closed and who later wishes to obtain an approval or special request shall apply again according to subsection (A).

**G.** For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time-frames for a Board approval required by this Chapter or a special request to deviate from or waive compliance with a requirement of this Chapter:
1. Administrative completeness review time-frame: 15 days;
2. Substantive review time-frame: 120 days; and
3. Overall time-frame: 135 days.

**Historical Note**

Former Rule 4.1000; Former Section R4-23-401 repealed, new Section R4-23-401 adopted effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Repealed effective August 24, 1992 (Supp. 92-3). New Section made by final rulemaking at 9 A.A.R. 3184, effective August 30, 2003 (Supp. 03-3).

**R4-23-402. Pharmacist, Graduate Intern, and Pharmacy**

**Intern**

**A.** A pharmacist or a graduate intern or pharmacy intern under the supervision of a pharmacist shall perform the following professional practices in dispensing a prescription medication from a prescription order:
1. Receive, reduce to written form, and manually initial oral prescription orders;
2. Obtain and record the name of the individual who communicates an oral prescription order;
3. Obtain, or assume responsibility to obtain, from the patient, patient's agent, or medical practitioner and record, or assume responsibility to record, in the patient's profile, the following information:
   a. Name, address, telephone number, date of birth (or age), and gender;
   b. Individual history including known diseases and medical conditions, known drug allergies or drug reactions, and if available a comprehensive list of medications currently taken and medical devices currently used;
4. Record, or assume responsibility to record, in the patient's profile, a pharmacist's, graduate intern's, or pharmacy intern's comments relevant to the patient's drug therapy, including other information specific to the patient or drug;
5. Verify the legality and pharmaceutical feasibility of dispensing a drug based upon:
   a. The patient's allergies,
   b. Incompatibilities with medications the patient currently takes,
   c. The patient's use of unusual quantities of dangerous drugs or narcotics,
   d. A medical practitioner's signature, and
   e. The frequency of refills;
6. Verify that a dosage is within proper limits;
7. Interpret the prescription order, which includes exercising professional judgment in determining whether to dispense a particular prescription;
8. Compound, mix, combine, or otherwise prepare and package the prescription medication needed to dispense individual prescription orders;
9. Prepackage or supervise the prepackaging of drugs by a pharmacy technician or pharmacy technician trainee under R4-23-1104. For drugs prepackaged by a pharmacy technician or pharmacy technician trainee, a pharmacist shall:
   a. Verify the drug to be prepackaged;
   b. Verify that the label meets the official compendium's standards;
   c. Check the completed prepackaging procedure and product; and
   d. Manually initial the completed label; or
   e. For automated packaging systems, manually initial the completed label or a written log or initial a computer-stored log;
10. Check prescription order data entry to ensure that the data input:
    a. Is for the correct patient by verifying the patient's name, address, telephone number, gender, and date of birth or age;
    b. Is for the correct drug by verifying the drug name, strength, and dosage form;
    c. Communicates the prescriber's directions precisely by verifying dose, dosage form, route of administration, dosing frequency, and quantity; and
    d. Is for the correct medical practitioner by verifying the medical practitioner's name, address, and telephone number;
11. Except as provided in subsection (A)(12), make a final accuracy check of the completed prescription label including verification of medication, accuracy of patient's name, consistency with prescription order, and drug utilization review and initial in handwriting or by another method approved by the Board or its designee the finished label;
12. If a technology-assisted verification of product program is used, make a final accuracy check of the completed prescription label including accuracy of patient's name, consistency with prescription order, and drug utilization review and initial in handwriting or by another method approved by the Board or its designee the finished label. If a technology-assisted verification of product program is used, verification of product is not required.
13. Record, or assume responsibility to record, a prescription serial number and date dispensed on the original prescription order;
14. Obtain, or assume responsibility to obtain, permission to refill a prescription order and record, or assume responsibility to record on the original prescription order:
    a. Date dispensed,
    b. Quantity dispensed, and
    c. Name of medical practitioner or medical practitioner's agent who communicates permission to refill the prescription order;
15. Reduce to written or printed form, or assume responsibility to reduce to written or printed form, a new prescription order received by:
    a. Fax,
    b. E-mail, or
    c. Other means of communication;
16. Verify, or assume responsibility to verify, that a completed prescription medication is sold only to the correct patient, patient's care-giver, or authorized agent;
17. Record on the original prescription order the name or initials of the pharmacist, graduate intern, or pharmacy intern who originally dispenses the prescription order; and
18. Record on the original prescription order the name or initials of the pharmacist, graduate intern, or pharmacy intern who dispenses each refill.

**B.** Only a pharmacist, graduate intern, or pharmacy intern shall provide oral consultation about a prescription medication to a patient or patient's care-giver in an outpatient setting, including a patient discharged from a hospital. The oral consultation is required whenever the following occurs:
1. The prescription medication has not been previously dispensed to the patient in the same strength or dosage form or with the same directions;
2. The pharmacist, through the exercise of professional judgment, determines that oral consultation is warranted; or
3. The patient or patient's care-giver requests oral consultation.

**C.** Oral consultation shall include:
1. Reviewing the name and strength of a prescription medication or name of a prescription-only device and the

labeled indication of use for the prescription medication or prescription-only device;
2. Reviewing the prescription's directions for use;
3. Reviewing the route of administration; and
4. Providing oral information regarding special instructions and written information regarding side effects, procedure for missed doses, or storage requirements.

**D.** When, in the professional judgment of the pharmacist or graduate intern or pharmacy intern under the supervision of a pharmacist, or when circumstance precludes it, oral consultation may be omitted if the pharmacist, graduate intern, or pharmacy intern:
1. Personally provides written information to the patient or patient's care-giver that summarizes the information that would normally be orally communicated;
2. Documents, or assumes responsibility to document, both the circumstance and reason for not providing oral consultation by a method approved by the Board or its designee; and
3. Offers the patient or patient's care-giver the opportunity to communicate with a pharmacist, graduate intern, or pharmacy intern at a later time and provides a method for the patient or patient's care-giver to contact a pharmacist, graduate intern, or pharmacy intern at the pharmacy.

**E.** The pharmacist or graduate intern or pharmacy intern under the supervision of a pharmacist, through the exercise of professional judgment, may provide oral consultation that includes:
1. Common severe adverse effects, interactions, or therapeutic contraindications, and the action required if they occur;
2. Techniques of self-monitoring drug therapy;
3. The duration of the drug therapy; and
4. Prescription refill information.

**F.** Nothing in subsection (B) requires a pharmacist, graduate intern, or pharmacy intern to provide oral consultation if a patient or patient's care-giver refuses the consultation.

**G.** Using a method approved by the Board or its designee, a pharmacist, graduate intern, or pharmacy intern shall document, or assume responsibility to document, that oral consultation is or is not provided.

**H.** Oral consultation documentation. When oral consultation is required as specified in subsection (B), a pharmacist, graduate intern, or pharmacy intern shall:
1. Document, or assume responsibility to document, that oral consultation is provided; or
2. When a patient refuses oral consultation or a person other than the patient or patient's care-giver picks up a prescription and oral consultation is not provided, document, or assume responsibility to document, that oral consultation is not provided; or
3. When a pharmacist, graduate intern, or pharmacy intern determines to omit oral consultation under subsection (D) and oral consultation is not provided, document, or assume responsibility to document, both the circumstance and reason that oral consultation is not provided; and
4. Document, or assume responsibility to document, the name, initials, or identification code of the pharmacist, graduate intern, or pharmacy intern who did or did not provide oral consultation.

**I.** When a prescription is delivered to the patient or patient's care-giver outside the immediate area of a pharmacy and a pharmacist is not present, the prescription shall be accompanied by written or printed patient medication information that, in addition to the requirements in subsection (C), includes:
1. Approved use for the prescription medication;
2. Possible adverse reactions;
3. Drug-drug, food-drug, or disease-drug interactions;
4. Missed dose information; and
5. Telephone number of the dispensing pharmacy or another method approved by the Board or its designee that allows a patient or patient's care-giver to consult with a pharmacist.

**J.** A prescription medication or prescription-only device, delivered to a patient at a location where a licensed health care professional is responsible for administering the prescription medication to the patient, is exempt from the requirement of subsection (C).

**K.** A pharmacist, graduate intern, or pharmacy intern shall wear a badge indicating name and title while on duty.

**L.** Nothing in this Section prevents a hospital pharmacist from accepting a prescription order according to rules pertaining specifically to hospital pharmacies.

**Historical Note**

Former Rule 4.1100; Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Amended effective July 7, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 4656, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 2258, effective August 6, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 274, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 12 A.A.R. 4691, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 23 A.A.R. 3257, effective January 8, 2018 (Supp. 17-4).

**R4-23-403. Repealed**

**Historical Note**

Former Rule 4.1200; Amended effective August 10, 1978 (Supp. 78-4). Amended effective March 28, 1980 (Supp. 80-2). Amended effective August 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective May 16, 1990 (Supp. 90-2). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Section repealed by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

**R4-23-404. Unethical Practices**

**A.** Rebates prohibited. A pharmacist or pharmacy permittee shall not offer, deliver, receive, or accept any unearned rebate, refund, commission, preference, patronage dividend, discount, or other unearned consideration, whether in the form of money or otherwise, as compensation or inducement to refer a patient, client, or customer to any person, except for a rebate or premium paid completely and directly to a patient. A pharmacist or pharmacy permittee shall not:
1. Make payment to a medical practitioner in money or other consideration for a prescription order prescribed by the medical practitioner; or
2. Make payment to a long-term care or assisted living facility or other health care institution in money, discount,

rental, or other consideration in an amount above the prevailing rate for:

a. Prescription medication or devices dispensed or sold for a patient or resident of the facility or institution; or

b. Drug selection or drug utilization review services, drug therapy management services, or other pharmacy consultation services provided for a patient or resident of the facility or institution.

**B.** Prescription order-blank advertising prohibited. A pharmacist or pharmacy permittee shall not:

1. Directly or indirectly furnish to a medical practitioner a prescription order-blank that refers to a specific pharmacist or pharmacy in any manner; or
2. Actively or passively participate in any arrangement or agreement where a prescription order-blank is prepared, written, or issued in a manner that refers to a specific pharmacist or pharmacy.

**C.** Fraudulent claim for service. A pharmacist or pharmacy permittee shall not claim the performance of a service that the pharmacist or pharmacy permittee knows or should know was not performed, such as, claiming to dispense a prescription medication that is not dispensed.

**D.** Fraudulent claim for a fee. A pharmacist or pharmacy permittee:

1. Shall not claim a fee for a service that is not performed or earned;
2. May divide a prescription order into two or more portions of prescription medication at the request of a patient, or for some other ethical reason, and charge a dispensing fee for the additional service; and
3. Shall not divide a prescription order merely to obtain an additional fee.

**E.** Prohibiting a prescription-only drug or device from being dispensed over the counter. A pharmacist shall ensure that:

1. A prescription-only drug or device is dispensed only after receipt of a valid prescription order from a licensed medical practitioner;
2. The dispensed prescription-only drug or device is properly prepared, packaged, and labeled according to this Chapter; and
3. The prescription order is filed according to this Chapter.

**F.** Drugs dispensed in the course of the conduct of a business of dispensing drugs through diagnosis by mail or the internet.

1. A pharmacist shall not dispense a drug from a prescription order if the pharmacist has knowledge, or reasonably should know under the circumstances, that the prescription order was issued on the basis of an internet-based questionnaire or an internet-based consultation without a medical practitioner-patient relationship as defined in R4-23-110.
2. A pharmacist who dispenses a prescription-only drug, prescription-only device, or controlled substance in violation of this Section is engaging in unethical conduct in violation of A.R.S. § 32-1901.01.

**Historical Note**

Former Rules 4.2110, 4.2120, 4.2130, 4.2210, 4.2230, 4.2400, 4.2500, 4.2600, 4.4100, 4.4200, 4.4310, 4.4320, 4.4400, and 4.4500; Amended effective August 10, 1978 (Supp. 78-4); Amended subsection (I) effective August 9, 1983 (Supp. 83-4). Amended by deleting subsections (H) through (M) effective November 18, 1983 (Supp. 83-6). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 14 A.A.R. 3405, effective October 4, 2008 (Supp. 08-3).

**R4-23-405. Change of Responsibility**

A pharmacist designated as the pharmacist-in-charge for a pharmacy, manufacturer, or other establishment shall give immediate notice, as defined in R4-23-110, when:

1. The pharmacist's responsibility as a pharmacist-in-charge is terminated; or
2. The pharmacist knows of a pending termination of the pharmacist's responsibility as the pharmacist-in-charge.

**Historical Note**

Former Rules 4.5100 and 4.5200; Amended effective August 9, 1983 (Supp. 83-4). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1).

**R4-23-406. Repealed**

**Historical Note**

Adopted as an emergency effective January 10, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Amended as an emergency effective April 2, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days. Adopted effective April 10, 1979 (Supp. 79-1). Former Section R4-23-406 repealed, new Section R4-23-406 adopted effective August 9, 1983 (Supp. 83-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Section repealed by final rulemaking at 10 A.A.R. 230, effective March 6, 2004 (Supp. 04-1).

**R4-23-407. Prescription Requirements**

**A.** Prescription orders. A pharmacist shall ensure that:

1. A prescription order the pharmacist uses to dispense a drug or device includes the following information:
   a. Date of issuance;
   b. Name and address of the patient for whom or the owner of the animal for which the drug or device is dispensed;
   c. Drug name, strength, and dosage form or device name;
   d. Name of the manufacturer or distributor of the drug or device if the prescription order is written generically or a substitution is made;
   e. Prescribing medical practitioner's directions for use;
   f. Date of dispensing;
   g. Quantity prescribed and if different, quantity dispensed;
   h. For a prescription order for a controlled substance, the medical practitioner's address and DEA number;
   i. For a written prescription order, the medical practitioner's signature;
   j. For an electronically transmitted prescription order, the medical practitioner's digital or electronic signature;
   k. For an oral prescription order, the medical practitioner's name and telephone number; and
   l. Name or initials of the dispensing pharmacist;
2. A prescription order is kept by the pharmacist or pharmacy permittee as a record of the dispensing of a drug or device for seven years from the date the drug or device is dispensed;

3. The dispensing of a drug or device complies with the packaging requirements of the official compendium and state and federal law; and
4. If the drug dispensed is a schedule II controlled substance that is an opioid, the drug is placed in a container that has a red cap and a warning label stating "CAUTION: OPIOID, Risk of Overdose and Addiction" or other similarly clear language indicating the possibility of overdose and addiction. Under delegation from the Board, the Executive Director may waive the red-cap requirement if implementing the requirement is not feasible because of the specific dosage form or packaging type.

**B.** Prescription refills. A pharmacist shall ensure that the following information is recorded on the back of a prescription order when it is refilled:
1. Date refilled,
2. Quantity dispensed,
3. Name or approved abbreviation of the manufacturer or distributor if the prescription order is written generically or a substitution is made, and
4. The name or initials of the dispensing pharmacist.

**C.** Prescription order adaptation. Except for a prescription order for a controlled substance, a pharmacist, using professional judgment, may make the following adaptations to a prescription order if the pharmacist documents the adaptation in the patient's record:
1. Change the prescribed quantity if the prescribed quantity is not a package size commercially available from the manufacturer;
2. Change the prescribed dosage form or directions for use if the change achieves the intent of the prescribing medical practitioner;
3. Complete missing information on the prescription order if there is sufficient evidence to support the change; and
4. Extend the quantity of a maintenance drug for the limited quantity necessary to achieve medication refill synchronization for the patient.

**D.** A pharmacist may furnish a copy of a prescription order to the patient for whom it is prescribed or to the authorized representative of the patient if the copy is clearly marked "COPY FOR REFERENCE PURPOSES ONLY" or other similar statement. A copy of a prescription order is not a valid prescription order and a pharmacist shall not dispense a drug or device from the information on a copy.

**E.** Transfer of prescription order information. For a transfer of prescription order information to be valid, a pharmacy permittee or pharmacist-in-charge shall ensure that:
1. Both the original and the transferred prescription order are maintained for seven years after the last dispensing date;
2. The original prescription order information for a Schedule III, IV, or V controlled substance is transferred only as specified in 21 CFR 1306.25;
3. The original prescription order information for a non-controlled substance drug is transferred without limitation only up to the number of originally authorized refills;
4. For a transfer within Arizona:
   a. The transfer of original prescription order information for a non-controlled substance drug meets the following conditions:
      i. The transfer of information is communicated electronically, verbally, or by fax directly between:
         (1) Two licensed pharmacists,
         (2) A licensed pharmacist and a licensed intern, or
         (3) Two licensed interns;
      ii. The following information is recorded by the transferring pharmacist or intern:
         (1) The word "void" is written on the face of the invalidated original prescription unless it is an electronic or oral transfer and the transferred prescription order information is invalidated in the transferring pharmacy's computer system; and
         (2) The name and identification code, number, or address and telephone number of the pharmacy to which the prescription is transferred, the name of the receiving pharmacist or intern, the date of transfer, and the name of the transferring pharmacist or intern is written on the back of the prescription or entered into the transferring pharmacy's computer system; and
      iii. The following information is recorded by the receiving pharmacist or intern on the transferred prescription order:
         (1) The word "transfer;"
         (2) Date of issuance of the original prescription order;
         (3) Original number of refills authorized on the original prescription order;
         (4) Date of original dispensing;
         (5) Number of valid refills remaining and the date of the last refill;
         (6) Name and identification code, number, or address, telephone number, and original prescription number of the pharmacy from which the prescription is transferred;
         (7) Name of the transferring pharmacist or intern; and
         (8) Name of the receiving pharmacist or intern;
   b. The transfer of original prescription order information for a Schedule III, IV, or V controlled substance meets the following conditions:
      i. The transfer of information is communicated directly between two licensed pharmacists or interns electronically or verbally;
      ii. The following information is recorded by the transferring pharmacist or intern:
         (1) The word "void" is written on the face of the invalidated original prescription order unless it is an electronic or oral transfer and the transferred prescription order information is invalidated in the transferring pharmacy's computer system; and
         (2) The name, address, and DEA number of the pharmacy to which the prescription is transferred, the name of the receiving pharmacist, the date of transfer, and the name of the transferring pharmacist is written on the back of the prescription order or entered into the transferring pharmacy's computer system; and
      iii. The following information is recorded by the receiving pharmacist on the transferred prescription order:

(1) The word "transfer;"
(2) Date of issuance of original prescription order;
(3) Original number of refills authorized on the original prescription order;
(4) Date of original dispensing;
(5) Number of valid refills remaining and the date of the last refill;
(6) Name, address, DEA number, and original prescription number of the pharmacy from which the prescription is transferred;
(7) Name of the transferring pharmacist; and
(8) Name of the receiving pharmacist;

5. For a transfer from out-of-state:
   a. The transfer of original prescription order information for a non-controlled substance drug meets the conditions in subsections (E)(4)(a)(i) and (E)(4)(a)(iii); and
   b. The transfer of original prescription order information for a Schedule III, IV, or V controlled substance meets the conditions in subsections (E)(4)(b)(i) and (E)(4)(b)(iii); and
6. For an electronic transfer, the electronic transfer of original prescription order information meets the following conditions:
   a. The electronic transfer is between pharmacies owned by the same company using a common or shared database;
   b. The electronic transfer of original prescription order information for a non-controlled substance drug is performed by a pharmacist or intern, pharmacy technician trainee, or pharmacy technician under the supervision of a pharmacist;
   c. The electronic transfer of original prescription order information for a controlled substance is performed between two licensed pharmacists;
   d. The electronic transfer of original prescription order information for a non-controlled substance drug meets the following conditions:
      i. The transferring pharmacy's computer system:
         (1) Invalidates the transferred original prescription order information;
         (2) Records the identification code, number, or address of the pharmacy to which the prescription order information is transferred;
         (3) Records the name or identification code of the receiving pharmacist, intern, pharmacy technician trainee, or pharmacy technician; and
         (4) Records the date of transfer; and
      ii. The receiving pharmacy's computer system;
         (1) Records that a prescription transfer occurred;
         (2) Records the date of issuance of the original prescription order;
         (3) Records the original number of refills authorized on the original prescription order;
         (4) Records the date of original dispensing;
         (5) Records the number of valid refills remaining and the date of the last refill;
         (6) Records the identification code, number, or address and original prescription number of the pharmacy from which the prescription is transferred;
         (7) Records the name or identification code of the receiving pharmacist or intern, pharmacy technician trainee, or pharmacy technician; and
         (8) Records the date of transfer;
   e. The electronic transfer of original prescription order information for a controlled substance meets the following conditions:
      i. The transferring pharmacy's computer system:
         (1) Invalidates the transferred original prescription order information;
         (2) Records the identification code, number, or address, and DEA number of the pharmacy to which the prescription order information is transferred;
         (3) Records the name or identification code of the receiving pharmacist;
         (4) Records the date of transfer; and
         (5) Records the name or identification code of the transferring pharmacist; and
      ii. The electronic prescription order information received by the computer system of the receiving pharmacy includes the information required in subsection (E)(4)(b)(iii); and
   f. In addition to electronic documentation of a transferred prescription order in the computer system, an original prescription order containing the requirements of this Section is filed in compliance with A.R.S. § 32-1964.

**F.** Transmission of a prescription order from a medical practitioner to a pharmacy by fax.

1. A medical practitioner or medical practitioner's agent may transmit a prescription order for a Schedule III, IV, or V controlled substance, prescription-only drug, or non-prescription drug to a pharmacy by fax under the following conditions:
   a. The prescription order is faxed only to the pharmacy of the patient's choice;
   b. The faxed prescription order:
      i. Contains all the information required for a prescription order in A.R.S. §§ 32-1968 and 36-2525; and
      ii. Is only faxed from the medical practitioner's practice location, except that a nurse in a hospital, long-term care facility, or inpatient hospice may send a fax of a prescription order for a patient of the facility; and
   c. The faxed prescription order shall contain the following additional information:
      i. The date the prescription order is faxed;
      ii. The fax number of the prescribing medical practitioner or the facility from which the prescription order is faxed, and the telephone number of the facility; and
      iii. The name of the person who transmits the fax, if other than the medical practitioner.
2. A medical practitioner or medical practitioner's agent may fax a prescription order for a Schedule II controlled substance for information purposes only, unless the faxed prescription order meets the requirements of A.R.S. § 36-2525(F) and (G).

3. A pharmacy may receive a faxed prescription order for a Schedule II controlled substance for information purposes only, except a faxed prescription order for a Schedule II controlled substance that meets the requirements of A.R.S. § 36-2525(F) and (G) may serve as the original written prescription order.
4. To meet the seven-year record retention requirement of A.R.S. § 32-1964, a pharmacy shall receive a faxed prescription order on plain paper or may make a photocopy of the faxed prescription order.
5. A medical practitioner or the medical practitioner's agent may fax refill authorizations to a pharmacy if the faxed authorization includes the medical practitioner's telephone and fax numbers, the medical practitioner's signature or medical practitioner's agent's name, and date of authorization.

**G.** Electronic transmission of a prescription order from a medical practitioner to a pharmacy.
1. Unless otherwise prohibited by law, a medical practitioner or medical practitioner's agent may transmit a prescription order by electronic means, directly or through an intermediary, including an E-prescribing network, to the dispensing pharmacy as specified in A.R.S. § 32-1968.
2. For electronic transmission of a Schedule II, III, IV, or V controlled substance prescription order, the medical practitioner and pharmacy shall ensure the transmission complies with any security or other requirements of federal law.
3. The medical practitioner and pharmacy shall ensure all electronic transmissions comply with all the security requirements of state or federal law related to the privacy of protected health information.
4. In addition to the information required to be included on a prescription order as specified in A.R.S. § 32-1968, a medical practitioner shall ensure an electronically transmitted prescription order includes:
   a. The date of transmission; and
   b. If the individual transmitting the prescription is not the medical practitioner, the name of the medical practitioner's authorized agent who transmits the prescription order.
5. A pharmacy receiving an electronically transmitted prescription order shall maintain the prescription order as specified in A.R.S. § 32-1964 or R4-23-408(H)(2).
6. A medical practitioner or medical practitioner's agent shall transmit an electronic prescription order only to the pharmacy of the patient's choice.

**H.** Exceptions under A.R.S. § 36-2525 regarding electronic prescribing requirements:
1. Medical practitioner exceptions. A medical practitioner who is authorized to prescribe a controlled substance may furnish a written prescription order is accordance with R4-23-407 rather than an electronically transmitted prescription order if the prescription order is written:
   a. In this state to be filled in a jurisdiction outside this state;
   b. For a medication that requires compounding two or more ingredients;
   c. For a medication that is not in the E-prescribing database;
   d. For an individual who is detained by or in custody of an Arizona or federal law enforcement agency; or
   e. Under A.R.S. § 36-2525(N) or (O); and
2. Pharmacist exceptions. A pharmacist may dispense a controlled substance from a written rather than electronically transmitted prescription order if the prescription order:
   a. Is written by a medical practitioner who is not licensed in this state but rather, is licensed in a jurisdiction outside this state. The pharmacist is not required to verify whether the medical practitioner is licensed;
   b. Is written for a medication that requires compounding two or more ingredients;
   c. Is written for a medication that is not in the E-prescribing database;
   d. Is written for an individual who is detained by or in custody of an Arizona or federal law enforcement agency; or
   e. Is received under A.R.S. § 36-2525(D).

**Historical Note**

Adopted effective November 18, 1983 (Supp. 83-6). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020; and amended by final rulemaking at 26 A.A.R. 544, with an immediate effective date of March 3, 2020 (Supp. 20-1).

**R4-23-407.1. Dispensing an Opioid Antagonist**

**A.** As used in this Section:
1. "Community member" means any person in position to assist an individual at risk of experiencing an opioid-related overdose. This includes emergency first responders, peace officers or other law enforcement personnel, fire department personnel, school district employees, and personnel of a facility or center that provides services to individuals at risk of experiencing an opioid-related overdose.
2. "Opioid antagonist" means any drug approved by the U.S. Food and Drug Administration that binds to opioid receptors, effectively blocking or inhibiting the receptor and preventing the body from responding to the opioid. Naloxone hydrochloride is an opioid antagonist.
3. "Opioid-related overdose" means an acute condition caused by excessive opioids. An opioid-related overdose can be identified by a triad of symptoms: decreased level of consciousness, pinpoint pupils, and respiratory depression. Other symptoms may include seizures, muscle spasms, and coma or death. An opioid-related overdose requires medical assistance.

**B.** When dispensing an opioid antagonist under A.R.S. § 32-1979, a pharmacist or pharmacy intern shall provide the following education to the individual to whom the opioid antagonist is dispensed:
1. How to prevent an opioid-related overdose;
2. How to recognize an opioid-related overdose;
3. How to administer an opioid antagonist safely to an individual experiencing an opioid-related overdose;
4. Precautions regarding:
   a. Potential side effects, and

b. Possible adverse events associated with administration of the opioid antagonist; and

5. Importance of seeking emergency medical assistance for the individual experiencing an opioid-related overdose before or after administering the opioid antagonist.

**C.** Before dispensing an opioid antagonist under A.R.S. § 32-1979(A), a licensed pharmacist shall complete an opioid prevention and treatment training program that includes the following information:

1. How to recognize the symptoms of an opioid-related overdose,
2. How to respond to a suspected opioid-related overdose,
3. How to administer all preparations of an opioid antagonist, and
4. The information needed by an individual to whom an opioid antagonist is dispensed.

**D.** A pharmacist who has completed an opioid prevention and treatment training program described in subsection (C):

1. May administer an opioid antagonist to an individual the pharmacist believes is experiencing an opioid-related overdose, and
2. Is exempt from civil liability under the terms of A.R.S. § 36-2267(B).

**E.** Dispensing an opioid antagonist under A.R.S. § 32-1979 by invoice to a community member is not wholesale distribution as defined at A.R.S. § 32-1981.

**F.** When dispensing an opioid antagonist on a standing order, as defined under A.R.S. § 32-1968, a pharmacist or pharmacy intern shall comply with R4-23-407 except subsection (A)(1)(b), R4-23-408, and R4-23-409.

**Historical Note**

New Section made by emergency rulemaking at 23 A.A.R. 31, effective December 15, 2016 for 180 days (Supp. 16-4). New Section made by final rulemaking before emergency expired at 23 A.A.R. 967, effective June 3, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-407.2. Dispensing a Self-administered Hormonal Contraceptive**

**A.** Standard procedures. The first time a pharmacist dispenses a self-administered hormonal contraceptive under a standing prescription order, as authorized under A.R.S. § 32-1979.01, to a patient, the pharmacist shall:

1. Determine the patient is at least 18 years old;
2. Obtain from the patient a completed self-screening risk assessment based on nationally recognized guidelines;
3. Provide the patient with written information prepared by the manufacturer of the hormonal contraceptive; and
4. Provide the following information orally to the patient:
   a. How hormonal contraception works;
   b. When and how to take the self-administered hormonal contraceptive;
   c. Risks associated with taking a self-administered hormonal contraceptive; and
   d. When to seek medical assistance while taking a self-administered hormonal contraceptive.

**B.** A pharmacist who dispenses a self-administered hormonal contraceptive under a standing prescription order shall have a patient complete the self-screening risk assessment based on nationally recognized guidelines, required under subsection (A)(2), annually.

**C.** A pharmacist who dispenses a self-administered hormonal contraceptive under a standing prescription order shall maintain evidence of the patient's age at the time of initial dispensing and the completed nationally recognized self-screening risk assessment for at least seven years. The pharmacist shall ensure this information is readily retrievable and available to the Board on request.

**D.** When dispensing a self-administered hormonal contraceptive under a standing prescription order, a pharmacist shall comply with R4-23-407 except subsection (A)(1)(b), R4-23-408, and R4-23-409.

**E.** During each biennial renewal period, a pharmacist who dispenses self-administered hormonal contraceptives under a standing prescription order shall complete the three contact hours of continuing education specified under R4-23-204(A)(2)(c).

**Historical Note**

New Section made by final rulemaking 29 A.A.R. 1655 (July 28, 2023) with an immediate effective date of July 5, 2023 (Supp. 23-3).

**R4-23-408. Computer Records**

**A.** Systems manual. A pharmacy permittee or pharmacist-in-charge shall:

1. Develop, implement, and comply with policies and procedures for the following operational aspects of a computer system:
   a. Examples of all output documentation provided by the computer system that contains original or refill prescription order or patient profile information;
   b. Steps a pharmacy employee follows when the computer system is not operational due to scheduled or unscheduled system interruption;
   c. Regular and routine backup file procedure and file maintenance, including secure storage of backup files;
   d. Audit procedures, personnel code assignments, and personnel responsibilities; and
   e. Quality assurance mechanism for data entry validation;
2. Review biennially and, if necessary, revise the policies and procedures required under this Section;
3. Document the review required under subsection (A)(2);
4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee; and
5. Make the policies and procedures available within the pharmacy for reference by pharmacy personnel and inspection by the Board or its designee.

**B.** Computer system data storage and retrieval. A pharmacy permittee or pharmacist-in-charge shall ensure the computer system is capable of:

1. Producing sight-readable information on all original and refill prescription orders and patient profiles;
2. Providing online retrieval (via CRT display or hard-copy printout) of original prescription order information required in A.R.S. § 32-1968(C), R4-23-402(A), and R4-23-407(A);
3. Providing online retrieval (via CRT display or hard-copy printout) of patient profile information required in R4-23-402(A);
4. Providing documentation identifying the pharmacist responsible for dispensing each original or refill prescription order, except a pharmacy permittee with a computer system that is in use before the effective date of this Section that cannot provide documentation identifying the

dispensing pharmacist may continue to use the computer system by providing manual documentation identifying the dispensing pharmacist;

5. Producing a printout of all prescription order information, including a single-drug usage report that contains:
   a. The name of the prescribing medical practitioner;
   b. The name and address of the patient;
   c. The quantity dispensed on each original or refill prescription order;
   d. The date of dispensing for each original or refill prescription order;
   e. The name or identification code of the dispensing pharmacist; and
   f. The serial number of each prescription order; and
6. Providing a printout of requested prescription order information to an individual pharmacy within 72 hours of the request if prescription order information is maintained in a centralized computer record system.

**C.** A pharmacy permittee or pharmacist-in-charge of a pharmacy that uses a pharmacy computer system:

1. Shall notify the D.E.A. and the Board in writing that original and refill prescription order information and patient profiles are stored in a pharmacy computer system;
2. Shall comply with this Section if the pharmacy computer system's refill records are used as an alternative to the manual refill records required in R4-23-407(B);
3. Is exempt from the manual refill recordkeeping requirements of R4-23-407(B), if the pharmacy computer system complies with the requirements of this Section; and
4. Shall ensure that documentation of the accuracy of original and refill prescription order information entered into a computer system is provided by each pharmacist using the computer system and kept on file in the pharmacy for seven years from the date of the last refill. Documentation includes one of the following:
   a. A hard-copy printout of each day's original and refill prescription order data that:
      i. States original and refill data for prescriptions dispensed by each pharmacist is reviewed for accuracy;
      ii. Includes the printed name of each dispensing pharmacist; and
      iii. Is signed and initialed by each dispensing pharmacist; or
   b. A log book or separate file of daily statements that:
      i. States original and refill data for prescriptions dispensed by each pharmacist is reviewed for accuracy;
      ii. Includes the printed name of each dispensing pharmacist; and
      iii. Is signed and initialed by each dispensing pharmacist.

**D.** If a pharmacy computer system does not comply with the requirements of subsections (A), (B), and (F), the pharmacy permittee or pharmacist-in-charge shall bring the computer system into compliance within three months of a notice of noncompliance or violation letter. If the computer system is still noncompliant with subsection (A), (B), or (F) after three months, the pharmacy permittee or pharmacist-in-charge shall immediately comply with the manual recordkeeping requirements of R4-23-402 and R4-23-407.

**E.** If a pharmacy's personnel perform manual recordkeeping under subsection (D), the pharmacy's personnel shall continue manual recordkeeping until the pharmacist-in-charge sends proof, verified by a Board compliance officer, that the computer system complies with subsections (A), (B), and (F).

**F.** Security. To maintain the confidentiality of patient records, a pharmacy permittee or pharmacist-in-charge shall ensure:

1. The computer system has security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription order information and patient profiles; and
2. After a prescription order is dispensed, any alteration of prescription order information is documented, including the identification of the pharmacist responsible for the alteration.

**G.** A computer system that does not comply with all the requirements of subsections (A), (B), and (F) may be used in a pharmacy if:

1. The computer system was in use in the pharmacy before July 11, 2001, and
2. The pharmacy complies with the manual recordkeeping requirements of R4-23-402 and R4-23-407.

**H.** Prescription records and retention.

1. Instead of filing the original hard-copy prescription order as required in A.R.S. § 32-1964, a pharmacy permittee or pharmacist-in-charge may use an electronic imaging recordkeeping system, if:
   a. The system is capable of capturing, storing, and reproducing the exact image of a prescription order, including the reverse side of the prescription order if necessary;
   b. Any notes of clarification of or alterations to a prescription order are directly associated with the electronic image of the prescription order;
   c. A prescription order image and any associated notes of clarification of or alterations to the prescription order are retained for no fewer than seven years from the date the prescription order is last dispensed;
   d. Policies and procedures for the use of an electronic imaging recordkeeping system are developed, implemented, reviewed, and revised in the same manner described in subsection (A) and complied with; and
   e. The prescription is not for a controlled substance.
2. If a pharmacy's computer system fields are automatically populated by an electronically transmitted prescription order, the automated record constitutes the original prescription order and a hard-copy or electronic image is not required if the computer system is capable of maintaining, printing, and providing all the prescription order information required in A.R.S. §§ 32-1968 and 36-2525 and R4-23-407(A) within 72 hours of a request by the Board, the Board's compliance officers, other authorized regulatory board agents, or authorized officers of the law.

**I.** A pharmacy permittee or pharmacist-in-charge shall make all prescription records available within 72 hours after a Board request.

**Historical Note**

Adopted effective November 18, 1983 (Supp. 83-6). Amended by final rulemaking at 7 A.A.R. 646, effective January 11, 2001 (Supp. 01-1). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 4270, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 274, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006

(Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-409. Returning Drugs and Devices**

**A.** After a person for whom a drug is prescribed or the person's agent takes the drug from the premises where sold, distributed, or dispensed, a pharmacist or pharmacy permittee shall not accept the drug for return or exchange for the purpose of resale unless the pharmacist determines that:
1. The drug is in its original, manufacturer's, unopened container; and
2. The drug or its container has not been subjected to contamination or deterioration.

**B.** The provisions of subsection (A) of this Section do not apply to a drug dispensed to:
1. A hospital inpatient as defined in R4-23-651; or
2. A resident of a long-term care facility where a licensed health care professional administers the drug, and the pharmacist ensures and documents that the drug:
   a. Has been stored in compliance with the requirements of the official compendium; and
   b. Is not obviously contaminated or deteriorated.

**C.** After a person for whom a device is prescribed or the person's agent takes the device from the premises where sold, distributed, or dispensed, a pharmacist or pharmacy permittee shall not accept the device for return or exchange for the purpose of resale or reuse unless the pharmacist determines that:
1. The device is inspected and is free of defects;
2. The device is rendered incapable of transferring disease; and
3. The device, if resold or reused, is not claimed to be new or unused.

**Historical Note**

Adopted effective November 18, 1983 (Supp. 83-6). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1).

**R4-23-410. Current Good Compounding Practices**

**A.** This Section establishes the current good compounding practices to be used by a pharmacist licensed by the Board, in a pharmacy permitted by the Board, and in compliance with applicable federal and state law governing the practice of pharmacy.

**B.** A pharmacy permittee shall ensure compliance with the provisions in this subsection.
1. All substances for compounding that are received, stored, or used by the pharmacy permittee:
   a. Meet official compendium requirements;
   b. Are of high quality, such as Chemically Pure (CP), Analytical Reagent (AR), certified American Chemical Society (ACS), or Food Chemical Codex (FCC) grade; or
   c. Are obtained from a source that, in the professional judgment of the pharmacist, is acceptable and reliable.
2. Before compounding a pharmaceutical product in excess of the quantity dispensed in anticipation of receiving valid prescriptions for the pharmaceutical product, a pharmacist, employed by the pharmacy permittee, shall establish a history of compounding valid prescriptions for the pharmaceutical product.
3. Neither the pharmacy permittee nor a pharmacist employed by the pharmacy permittee provides a compounded pharmaceutical product to a pharmacy, medical practitioner, or other person for dispensing or distributing except that a compounded pharmaceutical product may be provided to a medical practitioner to administer to a patient of the medical practitioner if each container is accompanied by the written list required in subsection (I)(5) and has a label that includes the following:
   a. The pharmacy's name, address, and telephone number;
   b. The pharmaceutical product's name and the information required in subsection (I)(4);
   c. A lot or control number;
   d. A beyond-use-date based upon the pharmacist's professional judgment, but not more than the maximum guidelines recommended in the Pharmacy Compounding Practices chapter of the official compendium unless there is published or unpublished stability test data that shows a longer period is appropriate;
   e. The statement "Not For Dispensing;" and
   f. The statement "For Office or Hospital Administration Only."
4. A pharmacy or pharmacist may advertise or otherwise promote the fact that the pharmacy or pharmacist provides prescription compounding services.

**C.** A pharmacy permittee shall ensure compliance with the organization, training, and personnel issues in this subsection.
1. Before dispensing a compounded pharmaceutical product, a pharmacist:
   a. Inspects and approves or rejects, or assumes responsibility for inspecting and approving or rejecting, components, pharmaceutical product containers and closures, in-process materials, and labeling;
   b. Prepares or assumes responsibility for preparing all compounding records;
   c. Reviews all compounding records to ensure that no errors occur in the compounding process;
   d. Ensures the proper use, cleanliness, and maintenance of all compounding equipment; and
   e. Documents by hand-written initials or signature in the compounding record the completion of the requirements of subsections (C)(1)(a), (b), (c), and (d).
2. A pharmacist engaged in compounding:
   a. Complies with the current good compounding practices and applicable state pharmacy laws;
   b. Maintains compounding proficiency through current awareness, training, and continuing education; and
   c. Ensures that personnel engaged in compounding wear:
      i. Clean clothing appropriate to the work performed; and
      ii. Protective apparel, such as coats, aprons, gowns, gloves or masks to protect the personnel from chemical exposure and prevent pharmaceutical product contamination.

**D.** A pharmacy permittee shall ensure the security, safety, and quality of a compounded pharmaceutical product by conforming with the following standards:
1. Implement procedures to exclude from direct contact with components, pharmaceutical product containers and closures, in-process materials, labeling, and pharmaceutical products, any person with an apparent illness or open lesion that may adversely affect the safety or quality of a

compounded pharmaceutical product, until the illness or lesion, as determined by competent medical personnel, does not jeopardize the safety or quality of a compounded pharmaceutical product; and

2. Require all personnel to inform a pharmacist of any health condition that may adversely affect a compounded pharmaceutical product.

**E.** A pharmacy permittee shall provide compounding facilities that conform with the standards in this subsection.

1. In addition to the minimum area requirements of R4-23-609, R4-23-655, or R4-23-673, the compounding area:
   a. Complies with the requirements in R4-23-611; and
   b. Has sufficient space to permit efficient pharmacy practice, free movement of personnel, and visual surveillance by a pharmacist.
2. If sterile pharmaceutical product or radiopharmaceutical product compounding is performed, the compounding area complies with the requirements of R4-23-670, R4-23-681, and R4-23-682.
3. A clean, dry, and temperature-controlled area and, if required, a refrigerated area, in which to store properly labeled containers of bulk drugs, chemicals, and materials used in compounding, that complies with state statutes and rules.

**F.** To protect pharmaceutical product safety, identity, strength, quality, and purity, a pharmacy permittee shall ensure that equipment and utensils used in pharmaceutical product compounding are:

1. Of appropriate design, adequate size, and suitably located for proper operation, cleaning, and maintenance;
2. Made of material that is not reactive, additive, or absorptive when exposed to components, in-process materials, or pharmaceutical products;
3. Cleaned and protected from contamination before use;
4. Inspected and determined suitable for use before initiation of compounding operations; and
5. Routinely inspected, calibrated, or checked to make proper performance certain.

**G.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with procedures to prevent cross-contamination when pharmaceutical products that require special precautions to prevent cross-contamination, such as penicillin, are used in a compounding procedure. The procedures shall include either the dedication of equipment or the meticulous cleaning of contaminated equipment before its use in compounding other pharmaceutical products.

**H.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with control procedures for components and pharmaceutical product containers and closures, either written or electronically stored with printable documentation, that conform with the standards in this subsection.

1. Components and pharmaceutical product containers and closures are:
   a. Stored off the floor,
   b. Handled and stored to prevent contamination, and
   c. Rotated so the oldest approved stock is used first.
2. Container closure systems comply with official compendium standards.
3. Pharmaceutical product containers and closures are clean and made of material that is not reactive, additive, or absorptive.

**I.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with pharmaceutical product compounding controls that conform with the standards in this subsection.

1. Pharmaceutical product compounding procedures are available in either written form or electronically stored with printable documentation:
   a. To ensure that a finished pharmaceutical product has the identity, strength, quality, and purity it is purported or represented to possess, the procedures include, for each pharmaceutical product compounded, a description of:
      i. The components, their manufacturer, lot number, expiration date, and amounts, the order of component addition, if applicable, and the compounding process;
      ii. The equipment and utensils used; and
      iii. The pharmaceutical product container and closure system proper for the sterility and stability of the pharmaceutical product as it is intended to be used.
   b. To test the pharmaceutical product being compounded, the procedures monitor the output and validate the performance of compounding processes that may cause variability in the final pharmaceutical product, including assessing:
      i. Dosage form weight variation;
      ii. Adequacy of mixing to ensure uniformity and homogeneity; and
      iii. Clarity, completeness, and pH of solutions, if applicable.
2. Components for pharmaceutical product compounding are accurately weighed, measured, or subdivided. To ensure that each weight, measure, or subdivision is correct as stated in the compounding procedures, a pharmacist:
   a. Checks and rechecks, or assumes responsibility for checking and re-checking, the operations at each stage of the compounding process; and
   b. Documents by hand-written initials or signature the completion and accuracy of the compounding process.
3. Compounding equipment and utensils are properly cleaned and maintained.
4. In addition to the labeling requirements of A.R.S. § 32-1968(D), the label contains:
   a. A statement, symbol, designation, or abbreviation that the pharmaceutical product is a compounded pharmaceutical product, and
   b. A beyond-use-date as specified in subsection (B)(3)(d).
5. A written list of the compounded pharmaceutical product's active ingredients is given to the patient at the time of dispensing.
6. When a component is removed from its original container and transferred to another container, the new container label contains, in full text or an abbreviated code system, the following:
   a. The component name,
   b. The manufacturer's or supplier's name,
   c. The lot or control number,
   d. The weight or measure,
   e. The beyond-use-date as specified in subsection (B)(3)(d), and
   f. The transfer date.

**J.** A pharmacy permittee shall ensure that the pharmacist-in-charge stores any quantity of compounded pharmaceutical product produced in excess of the quantity dispensed in accordance with subsection (B):
1. In an appropriate container with a label that contains:
   a. A complete list of components or the pharmaceutical product's name;
   b. The preparation date;
   c. The assigned lot or control number; and
   d. A beyond-use-date as specified in subsection (B)(3)(d); and
2. Under conditions, dictated by the pharmaceutical product's composition and stability characteristics, that ensure its strength, quality, and purity.

**K.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with record-keeping procedures that comply with this subsection:
1. Pharmaceutical product compounding procedures and other records required by this Section are maintained by the pharmacy for not less than seven years, and
2. Pharmaceutical product compounding procedures and other records required by this Section are readily available for inspection by the Board or its designee.

**Historical Note**

Adopted effective August 5, 1997 (Supp. 97-3). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4).

**R4-23-411. Pharmacist-administered or Intern-administered Immunizations**

**A.** Authorization to administer immunizations, vaccines, and emergency medications, as defined at A.R.S. § 32-1974(N), to an eligible adult patient or eligible minor patient. As used in this Section, "eligible adult patient" means an eligible patient 13 years of age or older and "eligible minor patient" means an eligible patient at least three years of age but less than 13 years of age. A pharmacist or an intern in the presence of and under the immediate personal supervision of a pharmacist may administer, without a prescription, immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient, if:
1. Both the pharmacist and intern meet the qualifications and standards specified by A.R.S. § 32-1974 and this Section;
2. The Board authorizes both the pharmacist and intern as specified in subsection (D);
3. For an eligible adult patient, the immunization or vaccine is:
   a. Recommended for adults by the United States Centers for Disease Control and Prevention; or
   b. Recommended by the United States Centers for Disease Control and Prevention's Health Information for International Travel;
4. For an eligible adult patient, the immunization or vaccine is not on the Arizona Department of Health Services list specified in A.A.C. R9-6-1301 as required under A.R.S. § 32-1974(I);
5. For an eligible minor patient, the immunization or vaccine is for influenza or a booster dose as described under A.R.S. § 32-1974(B)(2); and
6. For an eligible minor patient, any immunizations or vaccines other than influenza or a booster dose as described under A.R.S. § 32-1974(B)(2) are administered in response to a public health emergency declared by the Governor under A.R.S. § 36-787.

**B.** A pharmacist or an intern in the presence of and under the immediate personal supervision of a pharmacist, may administer, with a prescription, any immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient, if:
1. Both the pharmacist and intern meet the qualifications and standards specified by A.R.S. § 32-1974 and this Section; and
2. The Board authorizes both the pharmacist and intern as specified in subsection (D).

**C.** A pharmacist or intern who is authorized to administer immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient shall:
1. Not delegate the authority to any other pharmacist, intern, or employee not specifically authorized by rule; and
2. Maintain their current certificate for inspection by the Board or its designee or review by the public.

**D.** Qualifications to administer immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient. After receipt of a completed application form, the Board shall authorize the administration of immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient by a pharmacist or intern who meets the following qualifications:
1. Has a current license to practice pharmacy in this state,
2. Successfully completes a training program specified in subsection (E), and
3. Has a current certificate in basic cardiopulmonary resuscitation.

**E.** Immunizations training program requirements. A training program for pharmacists or interns to administer immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient shall include the following courses of study:
1. Basic immunology and the human immune response;
2. Mechanics of immunity, adverse effects, dose, and administration schedule of available vaccines;
3. Response to an emergency situation as a result of the administration of an immunization, vaccine, or medication including administering an emergency medication to counteract the adverse effects of the immunization, vaccine, or medication given;
4. Administration of intramuscular injections;
5. Other immunization administration methods; and
6. Recordkeeping and reporting requirements specified in subsection (F).

**F.** Recordkeeping and reporting requirements.
1. A pharmacist or intern authorized under this Section to administer immunizations, vaccines, and emergency medications to an eligible patient shall provide to the pharmacy the following information and documentation regarding each immunization, vaccine, or emergency medication administered:
   a. The name, address, and date of birth of the patient;
   b. The date of administration and site of injection;
   c. The name, dose, manufacturer's lot number, and expiration date of the vaccine, immunization, or emergency medication;
   d. The name and address of the patient's identified primary-care provider or physician;

e. The name of the pharmacist or intern administering the immunization, vaccine, or emergency medication;
f. A record of the pharmacist's or intern's consultation with the patient determining that the patient is an eligible patient as defined in R4-23-110;
g. Consultation or other professional information provided to the patient by the pharmacist or intern;
h. The name and date of the immunization or vaccine information sheet provided to the patient; and
i. For an immunization or vaccine given to an eligible minor patient, a consent form signed by the minor's parent or guardian.

2. As required under A.R.S. § 32-1974(F)(1), the pharmacist or intern shall provide a written or electronic report to the patient's primary-care provider or physician containing the documentation required in subsection (F)(1)(a) through (d). The pharmacy shall document the time and date the report is sent and make the record of compliance with this subsection available in the pharmacy or on request, within 72 hours, for inspection by the Board or its designee.
3. A pharmacy's pharmacist-in-charge or permittee shall maintain the records required in subsection (F)(1) in the pharmacy or database for a minimum of seven years from the administration date.

**G.** Confidentiality of records. A pharmacist, intern, pharmacy permittee, or pharmacist-in-charge shall comply with applicable state and federal privacy statutes and rules when releasing patient health information.

**H.** Pharmacist-administered or intern-administered adult immunizations that require a prescription order. A pharmacist or intern authorized by the Board to administer adult immunizations or vaccines shall not administer any immunization or vaccine listed in A.A.C. R9-6-1301 without a prescription order. In addition to filing a prescription order as required in A.R.S. § 32-1964, a pharmacist or pharmacy intern who administers an immunization or vaccine listed in A.A.C. R9-6-1301 shall comply with the recordkeeping requirements of subsection (F)(1).

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3967, effective November 13, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 279, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3674, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 15 A.A.R. 1930, effective November 3, 2009 (Supp. 09-4). Amended by final rulemaking at 17 A.A.R. 2596, effective February 4, 2012 (Supp. 11-4). Amended by final rulemaking at 23 A.A.R. 211, effective March 5, 2017 (Supp. 17-1). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 28 A.A.R. 994 (May 13, 2022), effective July 2, 2022 (Supp. 22-2).

**R4-23-412. Emergency Refill Prescription Dispensing**

**A.** When a state of emergency is declared under A.R.S. § 32-1910(A) or (B) and the state of emergency results in individuals being unable to refill existing prescriptions, a pharmacist may work in the affected county, city, or town and may dispense a one-time emergency refill prescription of up to a 30-day supply of a prescribed medication to an affected individual if both of the following apply:
1. In the pharmacist's professional opinion the medication is essential to the maintenance of life or to the continuation of therapy, and
2. The pharmacist makes a good faith effort to reduce the information to a written prescription marked "emergency prescription" and files and maintains the prescription as required by law.

**B.** If the state of emergency declared under A.R.S. § 32-1910(A) or (B) continues for at least 21-days after the pharmacist dispenses an emergency prescription under subsection (A), the pharmacist may dispense one additional emergency refill prescription of up to a 30-day supply of the prescribed medication if the pharmacist complies with subsection (A)(2).

**C.** A pharmacist's authority to dispense emergency prescriptions under this Section ends when the declared state of emergency is terminated.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

**R4-23-413. Temporary Recognition of Nonresident Licensure**

**A.** When a state of emergency is declared under A.R.S. § 32-1910(A) or (B):
1. A pharmacist who is not licensed in this state, but who is currently licensed in another state, may dispense prescription medications in those affected counties, cities, or towns in this state during the time that a declared state of emergency exists under A.R.S. § 32-1910(A) or (B) if both of the following apply:
   a. The pharmacist provides proof of current licensure in another state, and
   b. The pharmacist is engaged in a relief effort during a state of emergency.
2. Acting under the direct supervision of a pharmacist, a pharmacy technician or pharmacy intern not licensed in this state, but currently licensed or registered in another state, may assist a pharmacist in dispensing prescription medications in affected counties, cities, or towns in this state during the time that a declared state of emergency exists under A.R.S. § 32-1910(A) or (B) if both of the following apply:
   a. The pharmacy technician or pharmacy intern provides proof of current licensure or registration in another state, and
   b. The pharmacy technician or pharmacy intern is engaged in a relief effort during a state of emergency.

**B.** The recognition of nonresident licensure or registration shall end with the termination of the declared state of emergency.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

**R4-23-414. Reserved**

**R4-23-415. Impaired Licensees – Treatment and Rehabilitation**

**A.** The Board may contract with qualified organizations to operate a program for the treatment and rehabilitation of licensees impaired as the result of alcohol or other drug abuse, pursuant to A.R.S. § 32-1932.01.

**B.** Participants in the program are either "confidential" or "known." Confidential participants are self-referred and may remain unidentified to the Board, subject to maintaining compliance with their program contract. Known participants are under Board order to complete a minimum tenure in the program. After a known participant completes the minimum tenure, the Board may terminate the Board order and reinstate the participant's license to practice pharmacy.

**C.** The program contract with a qualified organization shall include as a minimum the following:

1. Duties and responsibilities of each party.
2. Duration, not to exceed two years, of contract and terms of compensation.
3. Quarterly reports from the program administrator to the Board indicating:
   a. Identity of participants;
      i. By name, if a known participant; or
      ii. By case number, if a confidential participant;
   b. Status of each participant, including;
      i. Clinical findings;
      ii. Diagnosis and treatment recommendations;
      iii. Program activities; and
      iv. General recovery and rehabilitation program information.
4. The program administrator shall report immediately to the Board the name of any impaired licensee who poses a danger to self or others.
5. The program administrator shall report to the Board, as soon as possible, the name of any impaired licensee:
   a. Who refuses to submit to treatment,
   b. Whose impairment is not substantially alleviated through treatment, or
   c. Who violates the terms of their contract.
6. The program administrator shall periodically provide informational programs to the profession, including approved continuing education programs on the topic of drug and chemical impairment, treatment, and rehabilitation.

**D.** Under A.R.S. § 32-1903(F), the Board may publish the names of participants under current Board orders.

**E.** The Board or its executive director may request the treatment records for any participant. The program administrator shall provide treatment records within 10 working days of receiving a written request from the Board or its executive director for such records. Upon request of the program administrator or the Board or its executive director, a program participant shall authorize a drug and alcohol treatment facility or program or a private practitioner or treatment program to release the participant's records to the program administrator or the Board or its executive director.

**F.** On the recommendation of the program administrator or a Board member and by mutual consent, the program administrator, Board member, Board staff, and program participant may meet informally to discuss program compliance.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 467, effective January 4, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 3611, effective November 8, 2008 (Supp. 08-3).

**R4-23-416. Reserved**

**R4-23-417. Reserved**

**R4-23-418. Reserved**

**R4-23-419. Reserved**

**R4-23-420. Reserved**

**R4-23-421. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-422. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-423. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-424. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-425. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-426. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-427. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-428. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-429. Repealed**

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section

repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

## ARTICLE 5. CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

*New Article 5, consisting of Sections R4-23-501 through R4-23-505, made effective August 2, 2014 (Supp. 14-2).*

*Article 5, consisting of Sections R4-23-501 through R4-23-505, expired effective August 30, 2013 (Supp. 14-1).*

*Article 5, consisting of Sections R4-23-501 and R4-23-502, recodified to Article 8 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

*New Article 5, consisting of Sections R4-23-501 through R4-23-505, made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).*

### R4-23-501. Controlled Substances Prescription Monitoring (CSPMP) Program Registration and Database Access

**A.** Under A.R.S. § 36-2606, a medical practitioner who is issued a license under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 21, 25, or 29 and possesses a current DEA registration under the Federal Controlled Substances Act shall have a current CSPMP registration issued by the Board.

**B.** Application.
1. An applicant for CSPMP registration shall:
   a. Submit a completed application for CSPMP registration electronically or manually on a form furnished by the Board, and
   b. Submit with the application form the documents specified in the application form.
2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.

**C.** Registration. Within seven business days of receipt of a completed application specified in subsection (B), the Board office shall determine whether an application is complete. If the application is complete, the Board office shall issue a registration number and provide a current registration certificate to the applicant by mail or electronic transmission. If the application is incomplete, the Board office shall issue a written notice of incompleteness. An applicant with an incomplete application shall comply with the requirements of R4-23-202(F).

**D.** Registration renewal. As specified in A.R.S. § 36-2606(C), the Board shall automatically suspend the registration of any registrant that fails to renew the registration on or before May 1 of the year in which the renewal is due. The Board shall vacate a suspension if the registrant submits a renewal application. A suspended registrant with CSPMP database access credentials is prohibited from accessing information in the prescription monitoring program database.

**E.** CSPMP database access.
1. A medical practitioner that chooses to use the CSPMP database shall request access from the CSPMP Director by completing an access user registration form electronically. Upon receipt of the access user registration form, the CSPMP Director or designee shall issue access credentials provided the medical practitioner is in compliance with the registration requirements of this Section.
2. A pharmacist that chooses to use the CSPMP database shall request access from the CSPMP Director by completing an access user registration form electronically. Upon receipt of the access user registration form, the CSPMP Director or designee shall issue access credentials provided the pharmacist has a current active pharmacist license.
3. A medical practitioner or pharmacist who is not licensed in Arizona may request access from the CSPMP Director by:
   a. Completing an access user registration form electronically;
   b. Printing the access user registration form;
   c. Having the access user registration form signed and notarized; and
   d. Mailing the notarized access user form along with a current copy of the applicant's nonresident state license and driver's license. Upon receipt of the notarized access user registration form and other required documents, the CSPMP Director or designee shall issue access credentials provided the nonresident licensed medical practitioner or pharmacist credentials show an current active license in another state.

**Historical Note**

Former Rule 5.2110; Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 4898, effective January 5, 2003 (Supp. 02-4). Recodified to R4-23-801 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 94, effective March 10, 2013 (Supp. 13-1). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

### R4-23-502. Requirements for Data Format and Transmission

**A.** Each dispenser shall submit to the Board or its designee by electronic means information regarding each prescription dispensed for a controlled substance listed in Schedules II, III, and IV of A.R.S. Title 36, Chapter 27, the Arizona Uniform Controlled Substances Act. The information reported shall conform to the August 31, 2005 Version 003, Release 000 ASAP Rules-based Standard Implementation Guide for Prescription Monitoring Programs published by the American Society for Automation in Pharmacy as specified in A.R.S. § 36-2608(B). The information submitted for each prescription shall include:
1. The name, address, telephone number, prescription number, and DEA registration number of the dispenser;
2. The name, address, gender, date of birth, and telephone number of the person or, if for an animal, the owner of the animal for whom the prescription is written;
3. The name, address, telephone number, and DEA registration number of the prescribing medical practitioner;
4. The quantity and National Drug Code (NDC) number of the Schedule II, III, or IV controlled substance dispensed;
5. The date the prescription was dispensed;
6. The number of refills, if any, authorized by the medical practitioner;
7. The date the prescription was issued;
8. The method of payment identified as cash or third party; and
9. Whether the prescription is new or a refill.

**B.** A dispenser shall submit the required information electronically unless the Board or its designee approves a waiver as specified in subsection (D).

**C.** A dispenser's electronic data transfer equipment including hardware, software, and internet connections shall meet the privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and A.R.S. § 12-2292, in addition to common internet industry standards for privacy and security. A dispenser shall ensure that each electronic transmission meets the following data protection requirements:

1. Data shall be at least 128-bit encryption in transmission and at rest; and
2. Data shall be transmitted via secure e-mail, telephone modem, diskette, CD-ROM, tape, secure File Transfer Protocol (FTP), Virtual Private Network (VPN), or other Board-approved media.

**D.** A dispenser who does not have an automated recordkeeping system capable of producing an electronic report in the Board established format may request a waiver from electronic reporting by submitting a written request to the Board or its designee. The Board or its designee shall grant the request if the dispenser agrees in writing to report the data by submitting a completed universal claim form supplied by the Board or its designee.

**E.** Unless otherwise approved by the Board, a dispenser shall report by the close of business on each Friday the required information for the previous week, Sunday through Saturday. If a Friday falls on a state holiday, the dispenser shall report the information on the following business day. The Board or its designee may approve a less frequent reporting period if a dispenser makes a showing that a less frequent reporting period will not reduce the effectiveness of the system or jeopardize the public health.

**Historical Note**

Former Rule 5.2510. Amended by final rulemaking at 8 A.A.R. 4898, effective January 5, 2003 (Supp. 02-4). Recodified to R4-23-802 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-503. Access to Controlled Substances Prescription Monitoring Program Data**

**A.** Except as provided in A.R.S. § 36-2604(B) and (C) and this Section, prescription information submitted to the Board or its designee is confidential and is not subject to public inspection.

**B.** The Board or its designee shall review the prescription information collected under A.R.S. Title 36, Chapter 28 and R4-23-502. If the Board or its designee has reason to believe an act of unprofessional or illegal conduct has occurred, the Board or its designee shall notify the appropriate professional licensing board or law enforcement or criminal justice agency and provide the prescription information required for an investigation.

**C.** The Board or its designee is authorized to release data collected by the program to the following:

1. A person who is authorized to prescribe or dispense a controlled substance to assist that person to provide medical or pharmaceutical care to a patient or to evaluate a patient;
2. An individual who requests the individual's own controlled substance prescription information under A.R.S. § 12-2293;
3. A professional licensing board established under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 21, 25, or 29. Except as required under subsection (B), the Board or its designee shall provide this information only if the requesting board states in writing that the information is necessary for an open investigation or complaint;
4. A local, state, or federal law enforcement or criminal justice agency. Except as required under subsection (B), the Board or its designee shall provide this information only if the requesting agency states in writing that the information is necessary for an open investigation or complaint;
5. The Arizona Health Care Cost Containment System Administration regarding individuals who are receiving services under A.R.S. Title 36, Chapter 29. Except as required under subsection (B), the Board or its designee shall provide this information only if the Administration states in writing that the information is necessary for an open investigation or complaint;
6. A person serving a lawful order of a court of competent jurisdiction;
7. A person who is authorized to prescribe or dispense a controlled substance and who performs an evaluation on an individual under A.R.S. § 23-1026; and
8. The Board staff for purposes of administration and enforcement of A.R.S. Title 36, Chapter 28 and this Article.

**D.** The Board or its designee may provide data to public or private entities for statistical, research, or educational purposes after removing information that could be used to identify individual patients or persons who received prescriptions from dispensers.

**Historical Note**

Former Rules 5.3500, 5.3520, 5.3540, 5.3550, 5.3560, 5.3570, 5.3580, 5.3590, 5.4110, and 5.6110; Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-504. Computerized Central Database Tracking System Task Force**

**A.** The Board shall appoint a task force to help it administer the computerized central database tracking system as specified in A.R.S. § 36-2603.

**B.** The Task Force shall meet at least once each year and at the call of the chairperson to establish the procedures and conditions relating to the release of prescription information specified in A.R.S. § 36-2604 and R4-23-503.

**C.** The Task Force shall determine:

1. The information to be screened;
2. The frequency and thresholds for screening; and
3. The parameters for using the information to notify medical practitioners, patients, and pharmacies to educate and provide for patient management and treatment options.

**D.** The Board shall review and approve the procedures and conditions established by the Task Force as needed but at least once every calendar year.

**Historical Note**

Former Rule 5.7010; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-505. Reports**

**A.** Before releasing prescription monitoring program data, the Board or its designee shall receive a written or electronic request for controlled substance prescription information.

**B.** A person authorized to access CSPMP data under R4-23-503(C)(1) through (7) shall submit a written or electronic request that:
1. Specifies the information requested for the report;
2. For a medical practitioner, provides a statement that the report's purpose is to provide medical or pharmaceutical care to a patient or to evaluate a patient;
3. For an individual obtaining the individual's own controlled substance prescription information, provides a form of non-expired government-issued photo identification;
4. For a professional licensing board, states that the information is necessary for an open investigation or complaint;
5. For a local, state, or federal law enforcement or criminal justice agency, states that the information is necessary for an open investigation or complaint;
6. For the AHCCCS Administration, states that the information is necessary for an open investigation or complaint; and
7. For a person serving a lawful order of a court of competent jurisdiction, provides a copy of the court order.

**C.** The Board or its designee may provide reports through U.S. mail, other common carrier, facsimile, or secured electronic media or may allow reports to be picked up in-person at the Board office.

**Historical Note**

Former Rules 5.7100, 5.8100, 5.8500, 5.9100, and 5.9500; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-506. Repealed**

**Historical Note**

Adopted effective December 3, 1974 (Supp. 75-1). Repealed effective August 24, 1992 (Supp. 92-3).

## ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

**R4-23-601. General Provisions**

**A.** Permit required to sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical. A person shall have a current Board permit to:
1. Sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical in Arizona; or
2. Sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical from outside Arizona and ship the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona.

**B.** A medical practitioner is exempt from subsection (A) to administer a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical for the emergency needs of a patient.

**C.** Permit fee. Permits are issued biennially on an odd- and even-year expiration based on the assigned permit number. The fee, specified in R4-23-205, is not refundable unless the Board fails to comply with the permit time frames established in R4-23-602.

**D.** Record of receipt and disposal of narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.
1. Every person manufacturing a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, including repackaging or relabeling, shall prepare and retain for no fewer than three years the manufacturing, repackaging, or relabeling date for each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical.
2. Every person receiving, selling, delivering, or disposing of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical shall record and retain for no fewer than three years the following information:
   a. The name, strength, dosage form, and quantity of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical received, sold, delivered, or disposed;
   b. The name, address, and license or permit number, if applicable, of the person from whom each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is received;
   c. The name, address, and license or permit number, if applicable, of the person to whom each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is sold or delivered, or of the person who disposes of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
   d. The receipt, sale, deliver, or disposal date of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical.
3. The record required in this subsection shall be available for inspection by the Board or its compliance officer during regular business hours.
4. If the record required in this subsection is stored in a centralized recordkeeping system and not immediately available for inspection, a permittee, manager, or pharmacist-in-charge shall provide the record within four working days of the Board's or its compliance officer's request.

**E.** Narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals damaged by water, fire, or from human or animal consumption or use. A person shall not sell or offer

to sell any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical damaged by water, fire, or from human or animal consumption or use.

**F.** At least 14 days before there is a change in ownership, as defined at R4-23-110, of a license or permit issued under this Chapter, the new licensee or permittee shall apply to the Board for a new license or permit.

**Historical Note**

Former Rules 6.1100, 6.1200, 6.1300, 6.1400, and 6.1500. Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (C) effective August 9, 1983 (Supp. 83-4). Amended subsection (C) effective August 12, 1988 (Supp. 88-3). Amended by final rulemaking at 6 A.A.R. 4656, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-602. Permit Application Process and Time frames**

**A.** A person applying for a permit shall:
1. Submit a completed application for the desired permit electronically or manually on a form furnished by the Board, and
2. Submit with the application form:
   a. The documents specified in the application form, and
   b. The permit fee specified in R4-23-205.

**B.** The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.

**C.** Time frames for permits.
1. The Board office shall finish an administrative completeness review within 60 days from the date the application form is received.
   a. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application form.
   b. If the application form is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 60-day time frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
   c. If the Board office does not provide the applicant with written notice regarding administrative completeness, the application form shall be deemed complete 60 days after receipt by the Board office.
2. An applicant with an incomplete application form shall submit to the Board office all of the missing information within 90 days of service of the notice of incompleteness.
   a. If an applicant cannot submit all missing information within 90 days of service of the notice of incompleteness, the applicant may send a written request for an extension to the Board office postmarked or delivered no later than 90 days from service of the notice of incompleteness;
   b. The written request for an extension shall document the reasons the applicant is unable to meet the 90-day deadline; and
   c. The Board office shall review the request for an extension of the 90-day deadline and grant the request if the Board office determines an extension of the 90-day deadline will enable the applicant to assemble and submit the missing information. An extension shall be for no more than 30 days. The Board office shall notify the applicant in writing of its decision to grant or deny the request for an extension.
3. If an applicant fails to submit a complete application form within the time allowed, the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a permit shall submit a new application and fee as specified in subsection (A).
4. For a nonprescription drug permit applicant, a compressed medical gas distributor permit applicant, and a durable medical equipment and compressed medical gas supplier permit applicant, the Board office shall issue a permit on the day the Board office determines an administratively complete application form is received.
5. Except as described in subsection (C)(4), from the date on which the administrative completeness review of an application form is finished, the Board office shall complete a substantive review of the applicant's qualifications in no more than 120 days.
   a. If an applicant is found to be ineligible, the Board office shall issue a written notice of denial to the applicant.
   b. If an applicant is found to be eligible, the Board office shall recommend to the Board that the applicant be issued a permit. Upon receipt of the Board office's recommendation, the Board shall either issue a permit to the applicant or if the Board determines the applicant does not meet eligibility requirements, return the matter to the Board office.
   c. If the Board office finds deficiencies during the substantive review of the application form, the Board office shall issue a written request to the applicant for additional documentation.
   d. The 120-day time frame for a substantive review for the issuance or denial of a permit is suspended from the date of the written request for additional documentation until the date all documentation is received. The applicant shall submit the additional documentation according to subsection (C)(2).
   e. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time frame may be extended once for no more than 45 days.
6. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time frames for permits:
   a. Administrative completeness review time frame: 60 days.
   b. Substantive review time frame:
      i. Nonprescription drug permit, compressed medical gas distributor permit, and durable medical equipment and compressed medical gas supplier permit: none.
      ii. Except as described in subsection (C)(6)(b)(i): 120 days.
   c. Overall time frame:
      i. Nonprescription drug permit, compressed medical gas distributor permit, and durable medical

equipment and compressed medical gas supplier permit: 60 days.

ii. Except as described in subsection (C)(6)(c)(i): 180 days.

**D.** Permit renewal.

1. To renew a permit, a permittee shall submit a completed application for permit renewal electronically or manually on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1931, the permit is suspended. The permittee shall pay a penalty as provided in A.R.S. § 32-1931 and R4-23-205 to vacate the suspension.
3. Time frames for permit renewals. The Board office shall follow the time frames established in subsection (C).

**E.** Display of permit. A permittee shall conspicuously display the permit in the location to which it applies.

**Historical Note**

Former Rules 6.2100, 6.2200, 6.2300, 6.2400, 6.2500, 6.2600, 6.2610, 6.2620, 6.2630, 6.2640, and 6.2650. Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Repealed effective August 12, 1988 (Supp. 88-3). New Section adopted effective August 5, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

### R4-23-603. Resident-Nonprescription Drugs, Retail

**A.** Permit. A person, including the following, shall not sell or distribute a nonprescription drug without a current Board-issued permit:

1. A grocer;
2. Other non-pharmacy retail outlet; or
3. Mobile or non-fixed location retailer, such as a swap-meet vendor.

**B.** A medical practitioner licensed under A.R.S. Title 32 is exempt from the requirements of subsection (A).

**C.** Application. To obtain a permit to sell a nonprescription drug, a person shall submit:

1. A completed application form and fee as specified in R4-23-602; and
2. Documentation of compliance with local zoning laws, if required by the Board.

**D.** Drug sales. A nonprescription drug permittee:

1. Shall sell a drug only in the original container packaged and labeled by the manufacturer; and
2. Shall not package, repackage, label, or relabel any drug.

**E.** Inspection. A nonprescription drug permittee shall consent to inspection during business hours by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.

**F.** Quality control. A nonprescription drug permittee shall:

1. Ensure that all drugs stocked, sold, or offered for sale are:
   a. Kept clean;
   b. Protected from contamination, excessive heat, cold, sunlight, and other deteriorating factors;
   c. In compliance with federal law; and
   d. Received from a supplier with a current Board-issued permit as specified in R4-23-601(A).
2. Develop and implement a program to ensure that:
   a. Any expiration-dated drug is reviewed regularly;
   b. Any drug, that exceeds its expiration date, is deteriorated or damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
   c. Any quarantined drug is destroyed or returned to its source of supply.

**G.** Notification. A nonprescription drug permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, e-mail or mailing address, or business name.

**H.** Change of ownership. A nonprescription drug permittee shall comply with R4-23-601(F).

**I.** Relocation. No less than 30 days before an existing nonprescription drug permittee relocates, the permittee shall submit a completed application for relocation electronically or manually on a form furnished by the Board, and the documentation required in subsection (C).

**J.** Records. A nonprescription drug permittee shall:

1. Retain records of the receipt and disposal of nonprescription drugs as required in R4-23-601(D), and
2. Comply with the requirements of A.R.S. § 32-1977 and federal law for the retail sale of methamphetamine precursors.

**K.** Permit renewal. To renew a nonprescription drug permit, the permittee shall comply with R4-23-602(D).

**L.** Nonprescription drug vending machine outlet. In addition to the requirements of R4-23-601, R4-23-602, and subsections (A) through (K), a person selling or distributing a nonprescription drug in a vending machine shall comply with the following requirements:

1. Each individual vending machine is considered an outlet and shall have a Board-issued nonprescription drug permit;
2. Each nonprescription-drug-permitted vending machine shall display in public view an identification seal, furnished by the Board, containing the permit number, vending machine's serial number, owner's name, and telephone contact number;
3. Each nonprescription-drug-permitted vending machine is assigned a specific location that is within a weather-tight structure, protected from direct sunlight, and maintained at a temperature not less than 59° F and not greater than 86° F;
4. Each nonprescription drug sold in a vending machine is packaged and labeled in the manufacturer's original FDA-approved container;
5. A nonprescription-drug-permitted vending machine is subject to inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901 as follows:
   a. The owner, manager, or other staff of the nonprescription drug permittee shall provide access to the contents of the vending machine within 24 hours of a request from a Board compliance officer or other authorized officer of the law; or
   b. The Board compliance staff shall have independent access to the vending machine;
6. Before relocating or retiring a nonprescription-drug-permitted vending machine, the owner or manager shall notify the Board in writing. The notice shall include:
   a. Permit number;
   b. Vending machine's serial number;

c. Action planned (relocate or retire); and
d. If retiring a vending machine, the disposition of the nonprescription drug contents of the vending machine;

7. The sale or distribution of a precursor chemical or regulated chemical in a vending machine is prohibited; and
8. Under no circumstance may expired drugs be sold or distributed.

**Historical Note**

Adopted effective August 10, 1978 (Supp. 78-4). Amended subsection (D) paragraph (1) and added subsection (G) effective April 20, 1982 (Supp. 82-2). Amended effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective August 5, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-604. Resident Drug Manufacturer**

**A.** Permit. A person shall not manufacture, package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical without a current Board-issued drug manufacturer permit.

**B.** Application. To obtain a permit to operate a drug manufacturing firm in Arizona, a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.

**C.** Before issuing a drug manufacturer permit, the Board shall:
1. Receive and approve a completed permit application;
2. Interview the applicant and manager, if different from the applicant, at a Board meeting; and
3. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer.

**D.** Notification. A resident drug manufacturer permittee shall notify the Board of changes involving the drug list, address, telephone number, business name, or manager, including manager's telephone number. The resident drug manufacturer permittee shall submit using the permittee's online profile or a written notice by mail, fax, or e-mail to the Board office within 24 hours of the change.

**E.** Change of ownership. A resident drug manufacturer permittee shall comply with R4-23-601(F).

**F.** Before an existing resident drug manufacturer permittee relocates, the drug manufacturer permittee shall submit the application packet described in subsection R4-23-604(B), excluding the fee. The facility at the new location shall pass a final inspection by a Board compliance officer before operations begin.

**G.** No later than 14 days after the change occurs, a resident drug manufacturer permittee shall submit the application described under subsection R4-23-604(B), excluding the fee, for any change of officers in a corporation.

**H.** Manufacturing and distribution.
1. A drug manufacturer permittee shall manufacture and distribute a drug only:
   a. To a pharmacy, drug manufacturer, or full-service or nonprescription drug wholesaler currently permitted by the Board;
   b. To a medical practitioner currently licensed as a medical practitioner as defined in A.R.S. § 32-1901; or
   c. To a properly permitted, registered, licensed, or certified person or firm of another jurisdiction.
2. Before manufacturing and distributing a drug that is not listed on a drug manufacturer's permit application, the drug manufacturer permittee shall send to the Board office a written request to amend the permit application, including documentation of FDA approval to manufacture the drug not listed on the original permit application. If a request to amend a permit application includes the documentation required in this subsection, the Board or its designee shall approve the request to amend within 30 days of receipt.

**I.** A drug manufacturer permit is subject to denial, suspension, probation, or revocation under A.R.S. § 32-1927.02.

**J.** Current Good Manufacturing Practice. A drug manufacturer permittee is required under federal law to follow the good manufacturing practice requirements of 21 CFR 210 through 211.

**K.** Records. A drug manufacturer permittee shall:
1. Establish and implement written procedures for maintaining records pertaining to production, process control, labeling, packaging, quality control, distribution, complaints, and any information required by federal or state law;
2. Retain the records required by this Article and 21 CFR 210 through 211 for at least two years after distribution of a drug or one year after the expiration date of a drug, whichever is longer; and
3. Make the records required by this Article and 21 CFR 210 through 211 available within 48 hours for review by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.

**L.** Inspections. A drug manufacturer permittee shall make the drug manufacturer's facility available for inspection by the Board or its compliance officer under A.R.S. § 32-1904.

**M.** Nonresident drug manufacturer. A nonresident drug manufacturer shall comply with the requirements of R4-23-607.

**N.** Manufacturing radiopharmaceuticals. Before manufacturing a radiopharmaceutical, a drug manufacturer permittee shall:
1. Comply with the regulatory requirements of the Arizona Radiation Regulatory Agency, the U.S. Nuclear Regulatory Commission, the FDA, and this Section; and
2. Hold a current Arizona Radiation Regulatory Agency Radioactive Materials License. If a drug manufacturer permittee who manufactures radiopharmaceuticals fails to maintain a current Arizona Radiation Regulatory Agency Radioactive Materials License, the permittee's drug manufacturer permit shall be immediately suspended pending a hearing by the Board.

**Historical Note**

Former Rules 6.4001, 6.4002, 6.4003, 6.4004, 6.4005, 6.4006, 6.4007, 6.4008, 6.4009, 6.4100, 6.4110, 6.4111, 6.4115, 6.4116, 6.4120, 6.4122, 6.4190, 6.4191, 6.4200, 6.4250, 6.4300, 6.4350, 6.4355, 6.4360, 6.4400, 6.4401, 6.4403, 6.4410, 6.4430, 6.4450, 6.4500, 6.4510, 6.4530, 6.4533, 6.4600, 6.4610, 6.4640, 6.4660, 6.4700, 6.4710, and 6.4750. Adopted effective December 3, 1974 (Supp. 75-1). Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (B) paragraph (2) effective April 20, 1982 (Supp. 82-2). Amended subsections (B), (G), (K) and (L) effective August 12, 1988 (Supp. 88-3).

Amended effective August 24, 1992 (Supp. 92-3). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 7 A.A.R. 3815, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 702, effective June 1, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-605. Resident Drug Wholesaler Permit**

**A.** Permit. A person shall not operate a business or firm for the wholesale distribution of any drug, device, precursor chemical, or regulated chemical without a current Board-issued full-service or nonprescription drug wholesale permit.

**B.** Application.
1. To obtain a permit to operate a full-service or nonprescription drug wholesale firm in Arizona, a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.
2. Before issuing a full-service or nonprescription drug wholesale permit, the Board shall:
   a. Receive and approve a completed permit application;
   b. Interview the applicant and the designated representative, if different from the applicant, at a Board meeting;
   c. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer; and
   d. For a full-service drug wholesale permit, issue a fingerprint clearance to a qualified designated representative, as specified in subsection (L). If the fingerprint clearance of a designated representative for a full-service drug wholesale permit applicant is denied, the full-service drug wholesale permit applicant shall appoint another designated representative and submit the documentation, fingerprints, and fee specified in the application required in subsection (B).

**C.** Notification. A resident full-service or nonprescription drug wholesale permittee shall notify the Board of changes involving the type of drugs sold or distributed, address, telephone number, business name, or manager or designated representative, including the manager's or designated representative's telephone number.
1. The resident full-service or nonprescription drug wholesale permittee shall submit using the permittee's online profile or a written notice by mail, fax, or e-mail to the Board office within 10 days of the change.
2. For a change of designated representative, a resident full-service drug wholesale permittee shall submit the documentation, fingerprints, and fee specified in the application required in subsection (B).

**D.** Change of ownership. A resident full-service or nonprescription drug wholesale permittee shall comply with R4-23-601(F).

**E.** Before an existing resident full-service or nonprescription drug wholesaler permittee relocates, the resident full-service or nonprescription drug wholesale permittee shall submit the application required under subsection (B), excluding the fee. The facility at the new location shall pass a final inspection by a Board compliance officer before operations begin.

**F.** No later than 14 days after the change occurs, a resident full-service or nonprescription drug wholesale permittee shall submit the application described under subsection (B), excluding the fee, for any change of officers in a corporation.

**G.** Distribution restrictions. In addition to the requirements of this subsection, a resident full-service wholesale permittee shall comply with the distribution restrictions specified in A.R.S. § 32-1983.
1. Records.
   a. A full-service drug wholesale permittee shall:
      i. Maintain records to ensure full accountability of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical including dates of receipt and sales, names, addresses, and DEA registration numbers, if required, of suppliers or sources of merchandise, and customer names, addresses, and DEA registration numbers, if required;
      ii. File the records required in subsection (G)(1)(a)(i) in a readily retrievable manner for a minimum of three years;
      iii. Make the records required in subsection (G)(1)(a)(i) available upon request during regular business hours for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5). Records kept at a central location apart from the business location and not electronically retrievable shall be made available within two business days; and
      iv. In addition to the records requirements of subsection (G)(1)(a)(i), comply with the retention of track and trace documents required under the Drug Supply Chain and Security Act for all prescription-only drugs that leave the normal distribution channel as defined in A.R.S. § 32-1981.
   b. A nonprescription drug wholesale permittee shall:
      i. Maintain records to ensure full accountability of any nonprescription drug, precursor chemical, or regulated chemical including dates of receipt and sales, names, addresses, and DEA registration numbers, if required, of suppliers or sources of merchandise, and customer names, addresses, and DEA registration numbers, if required;
      ii. File the records required in subsection (G)(1)(b)(i) in a readily retrievable manner for a minimum of three years; and
      iii. Make the records required in subsection (G)(1)(b)(i) available upon request during regular business hours for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5). Records kept at a central location apart from the business location and not electronically retrievable shall be made available within two business days.
2. Drug sales.
   a. A full-service drug wholesale permittee shall:
      i. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemi-

cal, except in the original container packaged and labeled by the manufacturer or repackager;
ii. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
iii. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, or prescription-only drug or device, to anyone except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
iv. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
v. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or within two business days from the date of a request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
vi. Maintain a copy of the current permit or license of each person that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
vii. Provide permit and license records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).

b. A nonprescription drug wholesale permittee shall:
i. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical except in the original container packaged and labeled by the manufacturer or repackager;
ii. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;
iii. Not sell or distribute any nonprescription drug, precursor chemical, or regulated chemical to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
iv. Maintain a record of the current permit or license of each person that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
v. Provide permit and license records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).

c. Nothing in this subsection shall be construed to prevent the return of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to the original source of supply.

3. Out-of-state drug sales.
a. A full-service drug wholesale permittee shall:
i. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical except in the original container packaged and labeled by the manufacturer or repackager;
ii. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
iii. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone except a person that is properly permitted, registered, licensed, or certified in another jurisdiction;
iv. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
v. Maintain a copy of the current permit, registration, license, or certificate of each person that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
vi. Provide permit, registration, license, and certificate records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5); and

b. A nonprescription drug wholesale permittee shall:
i. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical except in the original container packaged and labeled by the manufacturer or repackager;
ii. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;
iii. Not sell or distribute any nonprescription drug, precursor chemical, or regulated chemical to anyone except a person that is properly permitted, registered, licensed, or certified in another jurisdiction;
iv. Maintain a record of the current permit, registration, license, or certificate of each person that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and

v. Provide permit, registration, license, or certificate records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).

4. Cash-and-carry sales.
   a. A full-service drug wholesale permittee shall complete a cash-and-carry sale or distribution of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical only after:
      i. Verifying the validity of the order;
      ii. Verifying the identity of the pick-up person for each transaction by confirming that the person represented placed the cash-and-carry order; and
      iii. For a prescription-only drug order, verifying that the cash-and-carry sale or distribution is used only to meet the immediate needs of a particular patient of the person that placed the cash-and-carry order; and
   b. A nonprescription drug wholesale permittee shall complete a cash-and-carry sale or distribution of any nonprescription drug, precursor chemical, or regulated chemical only after:
      i. Verifying the validity of the order; and
      ii. Verifying the identity of the pick-up person for each transaction by confirming that the person represented placed the cash-and-carry order.

**H.** Prescription-only drug returns or exchanges. A full-service drug wholesale permittee shall ensure that any prescription-only drug returned or exchanged by a pharmacy or chain pharmacy warehouse under A.R.S. § 32-1983(A) meets the following criteria:
1. The prescription-only drug is not adulterated or counterfeited, except an adulterated or counterfeited prescription-only drug that is the subject of an FDA or manufacturer recall may be returned for destruction or subsequent return to the manufacturer;
2. The quantity of prescription-only drug returned or exchanged does not exceed the quantity of prescription-only drug that the full-service drug wholesale permittee or a full-service drug wholesale permittee under common ownership sold to the pharmacy or chain pharmacy warehouse; and
3. The pharmacy or chain pharmacy warehouse provides documentation that:
   a. Lists the name, strength, and manufacturer of the prescription-only drug being returned or exchanged; and
   b. States that the prescription-only drug was maintained in compliance with storage conditions prescribed on the drug label or manufacturer's package insert.

**I.** Returned, outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, and contraband drugs.
1. Except as specified in subsection (H)(1) for a prescription-only drug, a full-service drug wholesale permittee shall ensure that the return of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical meets the following criteria.
   a. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, or otherwise deemed unfit for human or animal consumption shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
   b. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical whose immediate or sealed outer or secondary containers or product labeling are misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA. When the immediate or sealed outer or secondary containers or product labeling are determined to be misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, the full-service drug wholesale permittee shall provide notice of the misbranding, counterfeiting, or contrabanding or suspected misbranding, counterfeiting, or contrabanding within three business days of the determination to the Board, FDA, and manufacturer or wholesale distributor from which the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical was acquired.
   c. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that has been opened or used, but is not adulterated, misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be identified as opened or used, or both, and quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it

was acquired as authorized by the Board and the FDA.

d. If the conditions under which a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA, except as provided in subsection (I)(1)(d)(i).
   i. If examination, testing, or other investigation proves that the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical meets appropriate standards of safety, identity, strength, quality, and purity, it does not have to be destroyed or returned to the manufacturer or wholesale distributor.
   ii. In determining whether the conditions under which a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, the full-service drug wholesale permittee shall consider, among other things, the conditions under which the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been held, stored, or shipped before or during its return and the condition of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical and the condition of its container, carton, or product labeling as a result of storage or shipping.

e. For any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical identified under subsections (I)(1)(a) or (b), the full-service drug wholesale permittee shall ensure that the identified item or items and other evidence of criminal activity, and accompanying documentation is retained and not destroyed until its disposition is authorized by the Board and the FDA.

2. A nonprescription drug wholesale permittee shall ensure that the return of any nonprescription drug, precursor chemical, or regulated chemical meets the following criteria.

a. Any nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, or otherwise deemed unfit for human or animal consumption shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.

b. Any nonprescription drug, precursor chemical, or regulated chemical whose immediate or sealed outer or secondary containers or product labeling are misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA. When the immediate or sealed outer or secondary containers or product labeling are determined to be misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, the nonprescription drug wholesale permittee shall provide notice of the misbranding, counterfeiting, or contrabanding or suspected misbranding, counterfeiting, or contrabanding within three business days of the determination to the Board, FDA, and manufacturer or wholesale distributor from which the nonprescription drug, precursor chemical, or regulated chemical was acquired.

c. Any nonprescription drug, precursor chemical, or regulated chemical that has been opened or used, but is not adulterated, misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, shall be identified as opened or used, or both, and quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.

d. If the conditions under which a nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the nonprescription drug, precursor chemical, or regulated chemical, the nonprescription drug, precursor chemical, or regulated chemical shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was

acquired as authorized by the Board and the FDA, except as provided in subsection (I)(2)(d)(i).

i. If examination, testing, or other investigation proves that the nonprescription drug, precursor chemical, or regulated chemical meets appropriate standards of safety, identity, strength, quality, and purity, the nonprescription drug, precursor chemical, or regulated chemical does not need to be destroyed or returned to the manufacturer or wholesale distributor.

ii. In determining whether the conditions under which a nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the nonprescription drug, precursor chemical, or regulated chemical, the nonprescription drug wholesale permittee shall consider, among other things, the conditions under which the nonprescription drug, precursor chemical, or regulated chemical has been held, stored, or shipped before or during its return and the condition of the nonprescription drug, precursor chemical, or regulated chemical and the condition of its container, carton, or product labeling as a result of storage or shipping.

e. For any nonprescription drug, precursor chemical, or regulated chemical identified under subsections (I)(2)(a) or (b), the nonprescription drug wholesale permittee shall ensure that the identified item or items and other evidence of criminal activity, and accompanying documentation is retained and not destroyed until its disposition is authorized by the Board and the FDA.

3. A full-service drug wholesale permittee and nonprescription drug wholesale permittee shall comply with the recordkeeping requirements of subsection (G) for all outdated, damaged, deteriorated, adulterated, misbranded, counterfeited and contraband narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.

**J.** Facility. A full-service or nonprescription drug wholesale permittee shall:

1. Ensure that the facility occupied by the full-service or nonprescription drug wholesale permittee is of adequate size and construction, well-lighted inside and outside, adequately ventilated, and kept clean, uncluttered, and sanitary;
2. Ensure that the permittee's warehouse facility:
   a. Is secure from unauthorized entry; and
   b. Has an operational security system designed to provide protection against theft;
3. In a full-service drug wholesale facility, ensure that only authorized personnel may enter areas where any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is kept;
4. In a nonprescription drug wholesale facility, ensure that only authorized personnel may enter areas where any nonprescription drug, precursor chemical, or regulated chemical is kept;
5. In a full-service drug wholesale facility, ensure that any thermolabile narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is stored in an area where room temperature is maintained in compliance with storage conditions prescribed on the product label;
6. In a nonprescription drug wholesale facility, ensure that any thermolabile nonprescription drug, precursor chemical, or regulated chemical is stored in an area where room temperature is maintained in compliance with storage conditions prescribed on the product label;
7. Make the facility available for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5) during regular business hours;
8. In a full-service drug wholesale facility, provide a quarantine area for storage of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, otherwise deemed unfit for human or animal consumption, or that is in an open container; and
9. In a nonprescription drug wholesale facility, provide a quarantine area for storage of any nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, otherwise deemed unfit for human or animal consumption, or that is in an open container.

**K.** Quality controls.

1. A full-service drug wholesale permittee shall:
   a. Ensure that any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that meets the criteria specified in subsection (I)(1) is not sold, distributed, or delivered to any person for human or animal consumption;
   b. Ensure that a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is not manufactured, packaged, repackaged, labeled, or relabeled by any of its employees;
   c. Ensure that any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical stocked, sold, offered for sale, or delivered is:
      i. Kept clean,
      ii. Protected from contamination and other deteriorating environmental factors, and
      iii. Stored in a manner that complies with applicable federal and state law and official compendium storage requirements;
   d. Maintain manual or automatic temperature and humidity recording devices or logs to document conditions in areas where any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is stored; and
   e. Develop and implement a program to ensure that:
      i. Any expiration-dated narcotic or other controlled substance, prescription-only drug or

device, nonprescription drug, precursor chemical, or regulated chemical is reviewed regularly;

ii. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that has less than 120 days remaining on the expiration date, or is deteriorated, damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and

iii. Any quarantined narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired.

2. A nonprescription drug wholesale permittee shall:
   a. Ensure that any nonprescription drug, precursor chemical, or regulated chemical that meets the criteria specified in subsection (I)(2) is not sold, distributed, or delivered to any person for human or animal consumption;
   b. Ensure that a nonprescription drug, precursor chemical, or regulated chemical is not manufactured, packaged, repackaged, labeled, or relabeled by any of its employees;
   c. Ensure that any nonprescription drug, precursor chemical, or regulated chemical stocked, sold, offered for sale, or delivered is:
      i. Kept clean,
      ii. Protected from contamination and other deteriorating environmental factors, and
      iii. Stored in a manner that complies with applicable federal and state law and official compendium storage requirements;
   d. Maintain manual or automatic temperature and humidity recording devices or logs to document conditions in areas where any nonprescription drug, precursor chemical, or regulated chemical is stored; and
   e. Develop and implement a program to ensure that:
      i. Any expiration-dated nonprescription drug, precursor chemical, or regulated chemical is reviewed regularly;
      ii. Any nonprescription drug, precursor chemical, or regulated chemical that has fewer than 120 days remaining on the expiration date, or is deteriorated, damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
      iii. Any quarantined nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired.

**L.** Fingerprint clearance.

1. After receiving the state and federal criminal history record of a designated representative, the Board shall compare the record with the list of criminal offenses that preclude a designated representative from receiving a fingerprint clearance. If the designated representative's criminal history record does not contain any of the offenses listed in subsection (L)(2), the Board shall issue the designated representative a fingerprint clearance.
2. The Board shall not issue a fingerprint clearance to a designated representative who is awaiting trial for or who has been convicted of committing or attempting or conspiring to commit one or more of the following offenses in this state or the same or similar offenses in another state or jurisdiction:
   a. Unlawfully administering intoxicating liquors, controlled substances, dangerous drugs, or prescription-only drugs;
   b. Sale of peyote;
   c. Possession, use, or sale of marijuana, dangerous drugs, prescription-only drugs, or controlled substances;
   d. Manufacture or distribution of an imitation controlled substance;
   e. Manufacture or distribution of an imitation prescription-only drug;
   f. Possession or possession with intent to use an imitation controlled substance;
   g. Possession or possession with intent to use an imitation prescription-only drug; or
   h. A felony offense involving sale, distribution, or transportation of, offer to sell, transport, or distribute, or conspiracy to sell, transport, or distribute marijuana, dangerous drugs, prescription-only drugs, or controlled substances.
3. If the Board determines, after conducting a state and federal criminal history record check, that it is not authorized to issue a fingerprint clearance, the Board shall notify the full-service drug wholesale applicant or permittee that employs the designated representative that the Board is not authorized to issue a fingerprint clearance. This notice shall include the criminal history information on which the denial was based. This criminal history information is subject to dissemination restrictions under A.R.S. § 41-1750 and federal law.

**Historical Note**

Former Rules 6.5110, 6.5120, 6.5130, 6.5140, 6.5210, 6.5220, 6.5230, 6.5240, 6.5310, 6.5320, 6.5410, and 6.5420. Amended effective August 10, 1978 (Supp. 78-4). Amended effective April 20, 1982 (Supp. 82-2). Amended subsection (A) effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective August 24, 1992 (Supp. 92-3). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 232, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 11 A.A.R. 4270, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4). Amended by final rulemaking at 19 A.A.R. 702, effective June 1, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-606. Resident-Pharmacy Permit: Community, Hospital, and Limited Service**

**A.** Permit. A person shall not operate a pharmacy in Arizona without a current Board-issued pharmacy permit.

**B.** Application.

1. To obtain a permit to operate a pharmacy in Arizona, a person shall submit a completed application, on a form

available from the Board, and the fee specified in R4-23-205.

2. Before issuing a pharmacy permit, the Board shall:
   a. Receive and approve a completed permit application; and
   b. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer.
3. Before issuing a pharmacy permit, the Board may interview the applicant and the pharmacist-in-charge, if different from the applicant, at a Board meeting based on the need for additional information.

**C.** Notification. A pharmacy permittee shall notify the Board office within 10 days of changes involving the type of pharmacy operated, telephone or fax number, e-mail or mailing address, business name, or staff pharmacist. A pharmacy permittee shall provide the Board office immediate notice of a change of the pharmacist-in-charge.

**D.** If any nonprescription drugs are sold outside the pharmacy area when the pharmacy area is closed, the pharmacy permittee shall ensure that the business has a current, Board-issued nonprescription drug permit as required in Section R4-23-603.

**E.** Change of ownership. A pharmacy permittee shall comply with R4-23-601(F).

**F.** Relocation or remodel.
1. No fewer than 30 days before the relocation or remodel of an existing pharmacy, the pharmacy permittee shall submit, electronically or manually, a completed application for remodel or relocation using the form specified under subsection (B). A fee is not required with an application for remodel or relocation.
2. The new or remodeled facility shall pass a final inspection by a Board compliance officer before operations begin.

**G.** Permit renewal. To renew a pharmacy permit, the permittee shall comply with R4-23-602(D).

**Historical Note**

Former Rules 6.6010, 6.6020, 6.6030, 6.6040, 6.6050, 6.6060, 6.6071, 6.6072, 6.6073, 6.6074, 6.6075, and 6.6076. Amended effective August 10, 1978 (Supp. 78-4). Amended subsections (G) and (H) effective April 20, 1982 (Supp. 82-2). Amended subsection (L) effective July 2, 1982 (Supp. 82-4). Amended subsections (G) and (H) effective August 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Section heading amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-607. Nonresident Permits**

**A.** Permit. A person that is not a resident of Arizona shall not sell or distribute any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona without possessing both:
1. A current Board-issued nonresident pharmacy permit, nonresident manufacturer permit, nonresident full-service or nonprescription drug wholesale permit, or nonresident nonprescription drug permit; and
2. A current equivalent license or permit issued by the licensing authority in the jurisdiction where the person resides.

**B.** Application. To obtain a nonresident pharmacy, nonresident manufacturer, nonresident full-service or nonprescription drug wholesale, or nonprescription drug permit, a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.

**C.** Notification. A permittee shall submit notification of any change required in this subsection using the permittee's online profile or as a written notice by mail, fax, or e-mail to the Board office within 10 days of the change.
1. Nonresident pharmacy. A nonresident pharmacy permittee shall notify the Board of changes involving the type of pharmacy operated, address, telephone number, business name, or pharmacist-in-charge.
2. Nonresident manufacturer. A nonresident manufacturer permittee shall notify the Board of changes involving listed drugs, address, telephone number, business name, or manager, including manager's telephone number.
3. Nonresident drug wholesaler. A nonresident full-service or nonprescription drug wholesale permittee shall notify the Board of changes involving the types of drugs sold or distributed, address, telephone number, business name, or manager or designated representative, including the manager's or designated representative's telephone number. For a change of designated representative, a nonresident full-service drug wholesale permittee shall submit the documentation, fingerprints, and fee required with the application under subsection (B).
4. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall notify the Board of changes involving permit category, address, telephone number, business name, or manager, including manager's telephone number.

**D.** Change of ownership. A nonresident permittee shall comply with R4-23-601(F).

**E.** Drug sales.
1. Nonresident pharmacy. A nonresident pharmacy permittee shall:
   a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device to anyone in Arizona except:
      i. A pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board;
      ii. A medical practitioner currently licensed under A.R.S. Title 32; or
      iii. An Arizona resident upon receipt of a valid prescription order for the resident;
   b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except:
      i. A pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board;
      ii. A medical practitioner currently licensed under A.R.S. Title 32; or
      iii. An Arizona resident either upon receipt of a valid prescription order for the resident or in the original container packaged and labeled by the manufacturer;
   c. Except for a drug sale that results from the receipt and dispensing of a valid prescription order for an Arizona resident, maintain a copy of the current permit or license of each person in Arizona that buys,

receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and

d. Provide permit and license records upon request, if immediately available, or in no fewer than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.

2. Nonresident manufacturer. A nonresident manufacturer permittee shall:
   a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device to anyone in Arizona except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   c. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
   d. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
3. Nonresident full-service drug wholesaler. In addition to complying with the distributions restrictions specified in A.R.S. § 32-1983, a nonresident full-service drug wholesale permittee shall:
   a. Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
   b. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
   c. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
   d. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   e. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   f. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
   g. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
4. Nonresident nonprescription drug wholesaler. A nonresident nonprescription drug wholesale permittee shall:
   a. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
   b. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
   c. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
   d. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
   e. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
5. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall not:
   a. Sell, distribute, give away, or dispose of a nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except in the original container packaged and labeled by the manufacturer;
   b. Package, repackage, label, or relabel any drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona; or
   c. Sell, distribute, give away, or dispose of any drug, precursor chemical, or regulated chemical to anyone in Arizona that exceeds its expiration date, is contaminated or deteriorated from excessive heat, cold, sunlight, moisture, or other factors, or does not comply with federal law.

**F.** When selling or distributing any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona, a nonresident pharmacy, nonresident manufacturer, nonresident full-service or nonprescription drug wholesale, or nonprescription drug permittee shall comply with federal law, the permittee's resident state drug law, and this Section.

**Historical Note**
Former Rules 6.6110, 6.6120, and 6.6130; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective July 24, 1985 (Supp. 85-4). New Section adopted by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 10 A.A.R. 232, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-608. Change of Personnel and Responsibility**

**A.** A community, hospital, or limited-service pharmacy permittee shall give the Board:
1. Notice by mail, facsimile, or electronic mail within ten days of employing or terminating a pharmacist; and
2. Immediate notice of designating or terminating a pharmacist-in-charge.

**B.** Responsibility of ownership and management. The owner and management of a pharmacy shall:
1. Ensure that pharmacists, interns, and other pharmacy employees comply with state and federal laws and administrative rules; and
2. Not overrule a pharmacist in matters of pharmacy ethics and interpreting laws pertaining to the practice of pharmacy or the distribution of drugs and devices.

**C.** The Board may suspend or revoke a pharmacy permit if the owner or management of a pharmacy violates subsection (B).

**Historical Note**
Former Rules 6.6140 and 6.6150; Amended subsection (A) effective August 9, 1983 (Supp. 83-4). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3).

**R4-23-609. Pharmacy Area of Community Pharmacy**

**A.** Minimum area of community pharmacy. The minimum area of a community pharmacy, the actual area primarily devoted to stocking drugs restricted to pharmacists, and to the compounding and dispensing of prescription medication, exclusive of office area or other support function area, shall not be less than 300 square feet. A maximum of three pharmacy personnel may practice or work simultaneously in the minimum area. The pharmacy permittee shall provide an additional 60 square feet of floor area for each additional pharmacist, graduate intern, pharmacy intern, pharmacy technician, pharmacy technician trainee, or support personnel who may practice or work simultaneously. All of the allotted square footage area, including adequate shelving, shall lend itself to efficient pharmaceutical practice and permit free movement and visual surveillance of personnel by the pharmacist.

**B.** Compounding and dispensing counter. On or after January 6, 2004, a pharmacy permit applicant or remodel or relocation applicant shall provide a compounding and dispensing counter that provides a minimum of three square feet of pharmacy counter working area of not less than 16 inches in depth and 24 inches in length for the practice of one pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee. For each additional pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee practicing simultaneously, there shall be an additional three square feet of pharmacy counter working area of not less than 16 inches in depth and 24 inches in length. The Board shall determine a pharmacy's total required compounding and dispensing counter area by multiplying the maximum number of personnel allowed in the pharmacy area using the requirements specified in subsection (A) by three square feet per person. A pharmacy permittee or pharmacist-in-charge may operate the pharmacy with a total pharmacy counter working area specified in subsection (A) that is equal to the actual maximum number of pharmacists, graduate interns, pharmacy interns, pharmacy technicians, and pharmacy technician trainees, working simultaneously in the pharmacy area times three square feet per person.

**C.** Working area for compounding and dispensing counter. The aisle floor area used by the pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee at the compounding and dispensing counter shall extend the full length of the counter and be clear and continuous for a minimum of 36 inches from any counter, fixture, or structure.

**D.** Area for patient counseling. On or after April 1, 1995, a pharmacy permit applicant or remodel or relocation applicant shall provide a separate and distinct patient counseling area that provides patient privacy. This subsection does not apply to a pharmacy exempt from the requirements of R4-23-402(B).

**E.** Narcotic cabinet or safe. To prevent diversion, narcotics and other controlled substances may be:
1. Kept in a separate locked cabinet or safe, or
2. Dispersed throughout the pharmacy's prescription-only drug stock.

**F.** Building security standard of community pharmacy area. The pharmacy area shall be enclosed by a permanent barrier or partition from floor or counter to structural ceiling or roof, with entry doors that can be securely locked. The barrier shall be designed so that only a pharmacist can access the area where prescription-only drugs, narcotics, and other controlled substances are stored, compounded and dispensed. The permanent barrier may be constructed of other than a solid material. If constructed of a material other than a solid, the openings or interstices of the material shall not be large enough to permit removal of items in the pharmacy area through the barrier. Any material used in the construction of the permanent barrier must be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent. The pharmacy permittee shall submit plans and specifications of the permanent barrier to the Board for approval.

**G.** Drug storage and security.
1. The pharmacy permittee shall ensure that drugs and devices are stored in a dry, well-lit, ventilated, and clean and orderly area. The pharmacy permittee shall maintain the drug storage area at temperatures that ensure the integrity of the drugs before dispensing as stated in the official compendium defined in A.R.S. § 32-1901(55) or the manufacturer's or distributor's labeling.

2. If the pharmacy permittee needs additional storage area for drugs that are restricted to sale by a pharmacist, the pharmacy permittee shall ensure that the area is contained by a permanent barrier from floor or counter to structural ceiling or roof. The pharmacy permittee shall lock all doors and gates to the drug storage area. Only a pharmacist with a key is permitted to enter the storage area, except in an extreme emergency.

**H.** A pharmacy permittee or pharmacist-in-charge shall ensure that the pharmacy working counter area is protected from unauthorized access while the pharmacy is open for business by a barrier not less than 66 inches in height or another method approved by the Board or its designee.

**Historical Note**

Former Rules 6.6210, 6.6220, 6.6230, 6.6240, 6.6250, 6.6310, 6.6320, and 6.6330; Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 19 A.A.R. 97, effective March 10, 2013 (Supp. 13-1).

**R4-23-610. Community Pharmacy Personnel and Security Procedures**

**A.** Every pharmacy shall have a pharmacist designated as the "pharmacist-in-charge."
1. The pharmacist-in-charge shall ensure the communication and compliance of Board directives to the management, other pharmacists, interns, and technicians of the pharmacy.
2. The pharmacist-in-charge shall:
   a. Ensure that all pharmacy policies and procedures required under 4 A.A.C. 23 are prepared, implemented, and complied with;
   b. Review biennially and, if necessary, revise all pharmacy policies and procedures required under 4 A.A.C. 23;
   c. Document the review required under subsection (A)(2)(b);
   d. Ensure that all pharmacy policies and procedures required under 4 A.A.C. 23 are assembled as a written or electronic manual; and
   e. Make all pharmacy policies and procedures required under 4 A.A.C. 23 available in the pharmacy for employee reference and inspection by the Board or its staff.

**B.** Personnel permitted in the pharmacy area of a community pharmacy include pharmacists, graduate interns, pharmacy interns, compliance officers, drug inspectors, peace officers acting in their official capacity, other persons authorized by law, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel. Pharmacy interns, graduate interns, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel shall be permitted in the pharmacy area only when a pharmacist is on duty, except in an extreme emergency as defined in R4-23-110.
1. The pharmacist-in-charge shall comply with the minimum area requirements as described in R4-23-609 for a community pharmacy and for compounding and dispensing counter area.
2. A pharmacist employed by a pharmacy shall ensure that the pharmacy is physically secure while the pharmacist is on duty.

**C.** In a community pharmacy, a pharmacist shall ensure that the pharmacy area, and any additional storage area for drugs that is restricted to access only by a pharmacist is locked when a pharmacist is not present, except in an extreme emergency.

**D.** A pharmacist is the only person permitted by the Board to unlock the pharmacy area or any additional storage area for drugs restricted to access only by a pharmacist, except in an extreme emergency.

**E.** A pharmacy permittee or pharmacist-in-charge shall ensure that any prescription-only drugs and controlled substances received in an area outside the pharmacy area are immediately transferred unopened to the pharmacy area. The pharmacist-in-charge shall ensure that any prescription-only drug and controlled substance shipments are opened and marked by pharmacy personnel in the pharmacy area under the supervision of a pharmacist, graduate intern, or pharmacy intern.

**F.** A pharmacy permittee or pharmacist-in-charge may provide a small opening or slot through which a written prescription order or prescription medication container to be refilled may be left in the prescription area when the pharmacist is not present.

**G.** A pharmacist shall ensure that prescription medication is not left outside the prescription area or picked up by the patient when the pharmacist is not present by either:
1. Delivering the prescription medication to the patient, or
2. Securing the prescription medication inside the locked pharmacy, except when using an automated storage and distribution system that complies with the requirements of R4-23-614.

**Historical Note**

Former Rules 6.6410, 6.6420, 6.6430, 6.6440, 6.6450, 6.6460, 6.6470, 6.6480, and 6.6490; Amended subsection (F), deleted subsection (I) effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 2631, effective September 8, 2007 (Supp. 07-3).

**R4-23-611. Pharmacy Facilities**

**A.** Facilities. A pharmacy permittee or pharmacist-in-charge shall ensure that:
1. A pharmacy's facilities are constructed according to state and local laws and ordinances;
2. A pharmacy facility's:
   a. Walls, ceilings, windows, floors, shelves, and equipment are clean and in good repair and order; and
   b. Counters, shelves, aisles, and open spaces are not cluttered;
3. Adequate trash receptacles are provided and emptied periodically during the day;
4. A pharmacy facility of any pharmacy permit issued or pharmacy remodeled after February 1, 2014 provides access to toilet facilities either:
   a. Within the pharmacy area, or

b. No further than a walking distance of 100 feet from the pharmacy area or an alternative distance approved by the Board or its designee;
5. The toilet facilities are maintained in a sanitary condition and in good repair;
6. All professional personnel and staff of the pharmacy keep themselves and their apparel clean while in the pharmacy area;
7. No animals, except licensed assistant animals and guard animals, are allowed in the pharmacy;
8. The pharmacy facility is kept free of insects and rodents; and
9. There is a sink with hot and cold running water, other than a sink in a toilet facility, within the pharmacy area for use in preparing drug products.

**B.** Supply of drugs and chemicals. A pharmacy permittee or pharmacist-in-charge shall ensure that:
1. A pharmacy maintains a stock of drugs and chemicals that:
   a. Are sufficient to meet the normal demands of the trading area or patient base the pharmacy serves; and
   b. Meet all standards of strength and purity as established by the official compendiums;
2. All stock, materials, drugs, and chemicals held for ultimate sale or supply to the consumer are not contaminated;
3. Policies and procedures are developed, implemented, and complied with to prevent the sale or use of a drug or chemical:
   a. That exceeds its expiration date;
   b. That is deteriorated or damaged by reason of age, heat, light, cold, moisture, crystallization, chemical reaction, rupture of coating, disintegration, solidification, separation, discoloration, change of odor, precipitation, or other change as determined by organoleptic examination or by other means;
   c. That is improperly labeled;
   d. Whose container is defective; or
   e. That does not comply with federal law; and
4. The policies and procedures described in subsection (B)(3):
   a. Are made available in the pharmacy for employee reference and inspection by the Board or its designee; and
   b. Provide the following:
      i. Any expiration-dated drug or chemical is reviewed regularly;
      ii. Any drug or chemical that exceeds its expiration date, is deteriorated or damaged, improperly labeled, has a defective container, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
      iii. Any quarantined drug or chemical is properly destroyed or returned to its source of supply.

**Historical Note**

Former Rules 6.6510, 6.6520, 6.6530, 6.6540, 6.6550, 6.6560, 6.6570, 6.6580, 6.6600, 6.6610, 6.6620, 6.6630, 6.6640, 6.6650, and 6.6660; Amended subsection (B) effective August 9, 1983 (Supp. 83-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 4165, effective February 1, 2014 (Supp. 13-4).

**R4-23-612. Equipment**

A pharmacy permittee or pharmacist-in-charge shall ensure that a pharmacy has the necessary equipment to allow a pharmacist to practice the profession of pharmacy, including the following:
1. Adequate refrigeration equipment dedicated to the storage of drugs and biologicals;
2. A C-V controlled substance register, if C-V controlled substances are sold without an order of a medical practitioner;
3. Graduates in assorted sizes;
4. One mortar and pestle, not required if the pharmacy permittee states in the application that compounding will not be performed in the pharmacy;
5. Spatulas of assorted sizes including one nonmetallic;
6. Prescription balance, Class A with weights or an electronic balance of equal or greater accuracy, not required if the pharmacy permittee states in the application that compounding will not be performed in the pharmacy;
7. One ointment tile or equivalent, not required if the pharmacy permittee states in the application that compounding will not be performed in the pharmacy
8. A current hard-copy or access to a current electronic-copy of the Arizona Pharmacy Act and administrative rules and Arizona Controlled Substance Act;
9. A professional reference library consisting of a minimum of one current reference or text, in hard-copy or electronic media, addressing the following subject areas:
   a. Pharmacology or toxicology,
   b. Therapeutics,
   c. Drug compatibility, and
   d. Drug product equivalency;
10. An assortment of labels, including prescription labels, transfer labels for controlled substances, and cautionary and warning labels;
11. A red C stamp as defined in R4-23-110, if C-III, C-IV, and C-V controlled substance invoices are not filed separately from other invoices;
12. Current antidote and drug interaction information; and
13. Regional poison control phone number prominently displayed in the pharmacy area.

**Historical Note**

Former Rule 6.6670; Former Section R4-23-612 repealed, new Section R4-23-612 adopted effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3). Amended by final rulemaking at 19 A.A.R. 4165, effective February 1, 2014 (Supp. 13-4).

**R4-23-613. Procedure for Discontinuing a Pharmacy**

**A.** A pharmacy permittee or pharmacist-in-charge shall provide written notice to the Board and the Drug Enforcement Administration (D.E.A.) at least 14 days before discontinuing operation of the pharmacy. The notice shall contain the following information:
1. Name, address, pharmacy permit number, and D.E.A. registration number of the pharmacy discontinuing business;
2. Name, address, pharmacy permit number (if applicable), and D.E.A. registration number (if applicable) of the licensee, permittee, or registrant to whom any narcotic or

other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical will be sold or transferred;

3. Name and address of the location where the discontinuing pharmacy's records of purchase and disbursement of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical will be kept and the person responsible for the records. These records shall be kept for a minimum of three years from the date the pharmacy is discontinued;
4. Name and address of the location where the discontinuing pharmacy's prescription files and patient profiles will be kept and the person responsible for the files and profiles. These records shall be kept for a minimum of seven years from the date the last original or refill prescription was dispensed; and
5. The proposed date of discontinuing business operations.

**B.** The pharmacy permittee shall ensure that all pharmacy signs and symbols are removed from both the inside and outside of the premises.

**C.** The pharmacy permittee or pharmacist-in-charge shall ensure that all state permits and certificates of registration are returned to the Board office and that D.E.A. registration certificates and unused D.E.A. Schedule II order forms are returned to the D.E.A. Regional Office in Phoenix.

**D.** The pharmacist-in-charge of the pharmacy discontinuing business shall ensure that:

1. Only a pharmacist has access to the prescription-only drugs and controlled substances until they are transferred to the licensee, permittee, or registrant listed in subsection (A)(2);
2. All narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals are removed from the premises on or before the date the pharmacy is discontinued; and
3. All controlled substances are transferred as follows:
   a. Take an inventory of all controlled substances that are transferred using the procedures in R4-23-1003;
   b. Include a copy of the inventory with the controlled substances that are transferred;
   c. Keep the original of the inventory with the discontinued pharmacy's records of narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical purchase and disbursement for a minimum of three years from the date the pharmacy is discontinued;
   d. Use a D.E.A. form 222 to transfer any Schedule II controlled substances; and
   e. Transfer controlled substances that need destruction in the same manner as all other controlled substances.

**E.** Upon receipt of outdated or damaged controlled substances from a discontinued pharmacy, the licensee, permittee, or registrant described in subsection (A)(2) shall contact a D.E.A. registered reverse distributor for proper destruction of outdated or damaged controlled substances. If there are controlled substances a reverse distributor will not accept, the licensee, permittee, or registrant shall then contact the Board office and request an inspection for the purpose of drug destruction.

**F.** During the three-year record retention period specified in subsection (A)(3), the person described in subsection (A)(3) shall provide to the Board upon its request a discontinued pharmacy's records of the purchase and disbursement of narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.

**G.** During the seven-year record retention period specified in subsection (A)(4), the person described in subsection (A)(4) shall provide to the Board upon its request a discontinued pharmacy's records of prescription files and patient profiles.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

**R4-23-614. Automated Storage and Distribution System**

**A.** Before using an automated storage and distribution system, a pharmacy permittee or pharmacist-in-charge shall:

1. Ensure that the automated storage and distribution system and the policies and procedures comply with subsection (B); and
2. Notify the Board in writing of the intent to use an automated storage and distribution system, including the type or name of the system.

**B.** A pharmacy permittee or pharmacist-in-charge shall establish policies and procedures for appropriate performance and use of the automated storage and distribution system that:

1. Ensure that the automated storage and distribution system is in good working order while maintaining appropriate recordkeeping and security safeguards;
2. Ensure that an automated storage and distribution system used by the pharmacy that allows access to drugs or devices by a patient:
   a. Only contains prescriptions that:
      i. Do not require oral consultation as specified in R4-23-402(B); and
      ii. Are properly labeled and verified by a pharmacist before placement into the automated storage and distribution system and subsequent release to patients;
   b. Allows a patient to choose whether or not to use the system;
   c. Is located either in a wall of a properly permitted pharmacy or within 20 feet of a properly permitted pharmacy if the automated storage and distribution system is secured against the wall or floor in such a manner that prevents the automated storage and distribution system's unauthorized removal;
   d. Provides a method to identify the patient and only release that patient's prescriptions;
   e. Is secure from access and removal of drugs or devices by unauthorized individuals;
   f. Provides a method for a patient to obtain a consultation with a pharmacist if requested by the patient; and
   g. Does not allow the system to dispense refilled prescriptions if a pharmacist determines that the patient requires oral counseling as specified in R4-23-402(B);
3. Ensure that an automated storage and distribution system used by the pharmacy that allows access to drugs or

devices only by authorized licensed personnel for the purposes of administration based on a valid prescription order or medication order:
a. Provides for adequate security to prevent unauthorized individuals from accessing or obtaining drugs or devices; and
b. Provides for the filling, stocking, or restocking of all drugs or devices in the system only by a Board licensee or other authorized licensed personnel; and
4. Implement an ongoing quality assurance program that monitors compliance with the established policies and procedures of the automated storage and distribution system and federal and state law.

**C.** A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that the policies and procedures required under subsection (B) are prepared, implemented, and complied with;
2. Review biennially and, if necessary, revise the policies and procedures required under subsection (B);
3. Document the review required under subsection (C)(2);
4. Assemble the policies and procedures as a written or electronic manual; and
5. Make the policies and procedures available for employee reference and inspection by the Board or its staff within the pharmacy and at any location outside the pharmacy where the automated storage and distribution system is used.

**D.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using an automated storage and distribution system if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), or (C).

**Historical Note**
New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1).

**R4-23-615. Mechanical Storage and Counting Device for a Drug in Solid, Oral Dosage Form**

**A.** A pharmacy permittee or pharmacist-in-charge shall ensure that a mechanical storage and counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist complies with the following method to identify the contents of the device:
1. The drug name and strength are affixed to the front of each cell or cassette of the device;
2. A paper or electronic log is kept for each cell or cassette that contains:
a. An identification of the cell or cassette by the drug name and strength or the number of the cell or cassette;
b. The drug's manufacturer or National Drug Code (NDC) number;
c. The expiration date and lot number from the manufacturer's stock bottle that is used to fill the cell or cassette. If multiple lot numbers of the same drug are added to a cell or cassette, each lot number and expiration date shall be documented, and the earliest expiration date shall become the expiration date of the mixed lot of drug in the cell or cassette;
d. The date the cell or cassette is filled;
e. Documentation of the identity of the licensee who placed the drug into the cell or cassette; and
f. If the licensee who filled the cell or cassette is not a pharmacist, documentation of the identity of the pharmacist who supervised the non-pharmacist licensee who filled the cell or cassette; and
3. The paper or electronic log is available in the pharmacy for inspection by the Board or its designee for not less than two years.

**B.** A pharmacy permittee or pharmacist-in-charge shall ensure that any drug previously counted by a mechanical storage and counting device for a drug in a solid, oral dosage form that has not left the pharmacy is not returned to the drug's cell, cassette, or stock bottle, unless the drug return method is approved by the Board or its designee as specified in subsection (G). This subsection does not prevent a pharmacy permittee or pharmacist-in-charge from using a manual or mechanical counting device to count and dispense a previously counted drug that has not left the pharmacy if the previously counted drug is dispensed before its beyond-use-date.

**C.** A pharmacy permittee or pharmacist-in-charge shall ensure the accuracy of any mechanical storage and counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist by documenting completion of the following:
1. Training in the maintenance, calibration, and use of the mechanical storage and counting device for each employee who uses the mechanical storage and counting device;
2. Maintenance and calibration of the mechanical storage and counting device as recommended by the device's manufacturer; and
3. Routine quality assurance and accuracy validation testing for each mechanical storage and counting device.

**D.** A pharmacy permittee or pharmacist-in-charge shall ensure that the documentation required in subsection (C) is available for inspection by the Board or its designee.

**E.** A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that policies and procedures for the performance and use of a mechanical storage and counting device for a drug in a solid, oral dosage form are prepared, implemented, and complied with;
2. Review biennially and, if necessary, revise the policies and procedures required under subsection (E)(1);
3. Document the review required under subsection (E)(2);
4. Assemble the policies and procedures as a written or electronic manual; and
5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.

**F.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using a mechanical storage and counting device for a drug in a solid, oral dosage form if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), (C), (D), or (E).

**G.** Returning a drug previously counted by a mechanical storage and counting device for a drug in a solid, oral dosage form that has not left the pharmacy to the drug's cell or cassette.
1. Before returning a drug previously counted by a mechanical storage and counting device that has not left the pharmacy to the drug's cell or cassette, a pharmacy permittee or pharmacist-in-charge shall:

a. Apply for approval from the Board or its designee for the drug return method to be used in returning the drug;
b. Develop a drug return method that uses technology, such as bar coding, to prevent drug return errors;
c. Provide documentation depicting the drug return method;
d. Demonstrate the drug return method for a Board Compliance Officer; and
e. Receive approval from the Board or its designee for the drug return method to be used in returning the drug.

2. Before approving a request to waive the drug return prohibition in subsection (B), the Board or its designee shall:
a. Receive a request in writing from the pharmacy permittee or pharmacist-in-charge;
b. Review the documentation of the drug return method; and
c. Receive a satisfactory inspection report from a Board Compliance Officer that the drug return method uses technology to prevent drug return errors.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 3677, effective November 8, 2008 (Supp. 08-3).

**R4-23-616. Mechanical Counting Device for a Drug in Solid, Oral Dosage Form**

**A.** A pharmacy permittee or pharmacist-in-charge shall ensure the accuracy of any mechanical counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist by documenting completion of the following:
1. Training in the maintenance, calibration, and use of the mechanical counting device for each employee who uses the mechanical counting device;
2. Maintenance and calibration of the mechanical counting device as recommended by the device's manufacturer; and
3. Routine quality assurance and accuracy validation testing for each mechanical counting device.

**B.** A pharmacy permittee or pharmacist-in-charge shall ensure that the documentation required in subsection (A) is available for inspection by the Board or its designee.

**C.** A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that policies and procedures for the performance and use of a mechanical counting device for a drug in a solid, oral dosage form are prepared, implemented, and complied with;
2. Review biennially and, if necessary, revise the policies and procedures required under subsection (C)(1);
3. Document the review required under subsection (C)(2);
4. Assemble the policies and procedures as a written or electronic manual; and
5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.

**D.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using a mechanical counting device for a drug in a solid, oral dosage form if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), or (C).

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1).

**R4-23-617. Temporary Pharmacy Facilities or Mobile Pharmacies**

**A.** Pharmacies located in declared disaster areas, nonresident pharmacies, and pharmacies licensed or permitted in another state but not licensed or permitted in this state, if necessary to provide pharmacy services during a declared state of emergency, may arrange to temporarily locate to a temporary pharmacy facility or mobile pharmacy or relocate to a temporary pharmacy facility or mobile pharmacy if the pharmacist-in-charge of the temporary pharmacy facility or mobile pharmacy ensures that:
1. The pharmacy is under the control and management of the pharmacist-in-charge or a supervising pharmacist designated by the pharmacist-in-charge;
2. The pharmacy is located within or adjacent to the declared disaster area;
3. The Board is notified of the pharmacy's location;
4. The pharmacy is properly secured to prevent theft and diversion of drugs;
5. The pharmacy's records are maintained in accordance with Arizona statutes and rules; and
6. The pharmacy stops providing pharmacy services when the declared state of emergency ends, unless it possesses a current resident pharmacy permit issued by the Board under A.R.S. §§ 32-1929, 32-1930, and 32-1931.

**B.** The Board shall have the authority to approve or deny temporary pharmacy facilities, mobile pharmacies, and shall make arrangements for appropriate monitoring and inspection of the temporary pharmacy facilities and mobile pharmacies on a case-by-case basis.

**C.** A temporary pharmacy facility wishing to permanently operate at its temporary site shall apply for and have received a permit issued under A.R.S. §§ 32-1929, 32-1930, and 32-1931 by following the application process under R4-23-606.

**D.** A mobile pharmacy, placed in operation during a declared state of emergency, shall not operate permanently.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

**R4-23-618. Reserved**

**R4-23-619. Reserved**

**R4-23-620. Continuous Quality Assurance Program**

**A.** Each pharmacy permittee shall implement or participate in a continuous quality assurance (CQA) program. A pharmacy permittee meets the requirements of this Section if it holds a current general, special or rural general hospital license from the Arizona Department of Health Services and is any of the following:
1. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare or Medicaid programs;
2. Accredited by the Joint Commission on the Accreditation of Healthcare Organizations; or
3. Accredited by the American Osteopathic Association.

**B.** A pharmacy permittee or the pharmacist-in-charge shall ensure that:

1. The pharmacy develops, implements, and utilizes a CQ program consistent with the requirements of this Section and A.R.S. § 32-1973;
2. The medication error data generated by the CQA program is utilized and reviewed on a regular basis, as required by subsection (D); and
3. Training records, policies and procedures, and other program records or documents, other than medication error data, are maintained for a minimum of two years in the pharmacy or in a readily retrievable manner.

**C.** A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that policies and procedures for the operation and management of the pharmacy's CQA program are prepared, implemented, and complied with;
2. Review biennially and, if necessary, revise the policies and procedures required under subsection (C)(1);
3. Document the review required under subsection (C)(2);
4. Assemble the policies and procedures as a written or electronic manual; and
5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.

**D.** The policies and procedures shall address a planned process to:
1. Train all pharmacy personnel in relevant phases of the CQA program;
2. Identify and document medication errors;
3. Record, measure, and analyze data collected to:
   a. Assess the causes and any contributing factors relating to medication errors, and
   b. Improve the quality of patient care;
4. Utilize the findings from subsections (D)(2) and (3) to develop pharmacy systems and workflow processes designed to prevent or reduce medication errors; and
5. Communicate periodically, and at least annually, with pharmacy personnel to review CQA program findings and inform pharmacy personnel of any changes made to pharmacy policies, procedures, systems, or processes as a result of CQA program findings.

**E.** The Board's regulatory oversight activities regarding a pharmacy's CQA program are limited to inspection of the pharmacy's CQA policies and procedures and enforcing the pharmacy's compliance with those policies and procedures.

**F.** A pharmacy's compliance with this Section shall be considered by the Board as a mitigating factor in the investigation and evaluation of a medication error.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2603, effective December 2, 2012 (Supp. 12-4).

**R4-23-621. Shared Services**

**A.** Before participating in shared services, a pharmacy shall have either a current resident or non-resident pharmacy permit issued by the Board.

**B.** A pharmacy may provide or utilize shared services functions only if the pharmacies involved:
1. Have the same owner, or
2. Have a written contract or agreement that outlines the services provided and the shared responsibilities of each party in complying with federal and state pharmacy statutes and rules, and
3. Share a common electronic file or technology that allows access to information necessary or required to perform shared services in conformance with the pharmacy act and the Board's rules.

**C.** Notifications to patients.
1. Before using shared services provided by another pharmacy, a pharmacy permittee shall:
   a. Notify patients that their orders may be processed or filled by another pharmacy; and
   b. Provide the name of that pharmacy or, if the pharmacy is part of a network of pharmacies under common ownership and any of the network pharmacies may process or fill the order, notify the patient of this fact. The notification may be provided through a one-time written notice to the patient or through use of a sign in the pharmacy.
2. If an order is delivered directly to the patient by a filling pharmacy and not returned to the requesting pharmacy, the filling pharmacy permittee shall ensure that the following is placed on the prescription container or on a separate sheet delivered with the prescription container:
   a. The local, and if applicable, the toll-free telephone number of the pharmacy utilizing shared services that has access to the patient's records; and
   b. A statement that conveys to the patient or patient's care-giver the following information: "Written information about this prescription has been provided for you. Please read this information before you take the medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer these questions at (insert the local and toll-free telephone numbers of the pharmacy utilizing shared services that has access to the patient's records)."
3. The provisions of subsection (C) do not apply to orders delivered to patients in facilities where a licensed health care professional is responsible for administering the prescription medication to the patient.

**D.** A pharmacy permittee engaged in shared services shall:
1. Maintain manual or electronic records that identify, individually for each order processed, the name, initials, or identification code of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, and pharmacy technician trainee who took part in the order interpretation, order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, therapeutic intervention, or refill authorization functions performed at that pharmacy;
2. Maintain manual or electronic records that identify, individually for each order filled or dispensed, the name, initials, or identification code of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, and pharmacy technician trainee who took part in the filling, dispensing, and counseling functions performed at that pharmacy;
3. Report to the Board as soon as practical the results of any disciplinary action taken by another state's pharmacy regulatory agency involving shared services;
4. Maintain a mechanism for tracking the order during each step of the processing and filling procedures performed at the pharmacy;
5. Provide for adequate security to protect the confidentiality and integrity of patient information; and
6. Provide for inspection of any required record or information within 72 hours of any request by the Board or its designee.

**E.** Each pharmacy permittee that provides or utilizes shared services shall develop, implement, review, revise, and comply with joint policies and procedures for shared services in the manner described in R4-23-610(A)(2). Each pharmacy permittee is required to maintain only those portions of the joint policies and procedures that relate to that pharmacy's operations. The policies and procedures shall:

1. Outline the responsibilities of each of the pharmacies;
2. Include a list of the name, address, telephone numbers, and all license and permit numbers of the pharmacies involved in shared services; and
3. Include policies and procedures for:
   a. Notifying patients that their orders may be processed or filled by another pharmacy and providing the name of that pharmacy;
   b. Protecting the confidentiality and integrity of patient information;
   c. Dispensing orders when the filled order is not received or the patient comes in before the order is received;
   d. Maintaining required manual or electronic records to identify the name, initials, or identification code and specific activity or activities of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee who performed any shared services;
   e. Complying with federal and state laws; and
   f. Operating a continuous quality improvement program for shared services, designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

**F.** Nothing in this Section shall prohibit an individual pharmacist licensed in Arizona, who is an employee of or under contract with a pharmacy, or an Arizona-licensed graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee, working under the supervision of the pharmacist, from accessing that pharmacy's electronic database from inside or outside the pharmacy and performing the order processing functions permitted by the pharmacy act, if both of the following conditions are met:

1. The pharmacy establishes controls to protect the confidentiality and integrity of patient information; and
2. None of the database is duplicated, downloaded, or removed from the pharmacy's electronic database.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 19 A.A.R. 97, effective March 10, 2013 (Supp. 13-1).

**R4-23-622. Reserved**

**R4-23-623. Reserved**

**R4-23-624. Reserved**

**R4-23-625. Reserved**

**R4-23-626. Reserved**

**R4-23-627. Reserved**

**R4-23-628. Reserved**

**R4-23-629. Reserved**

**R4-23-630. Reserved**

**R4-23-631. Reserved**

**R4-23-632. Reserved**

**R4-23-633. Reserved**

**R4-23-634. Reserved**

**R4-23-635. Reserved**

**R4-23-636. Reserved**

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**R4-23-650. Reserved**

**R4-23-651. Definitions**

The following definitions apply to R4-23-651 through R4-23-659:

"Administration" means the giving of a dose of medication to a patient as a result of an order of a medical practitioner.

"Direct copy" means an electronic, facsimile or carbonized copy.

"Dispensing for hospital inpatients" means the interpreting, evaluating, and implementing a medication order including preparing for delivery a drug or device to an inpatient or inpatient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, an inpatient (hereafter referred to as "dispensing").

"Drug distribution" means the delivery of drugs other than "administering" or "dispensing."

"Emergency medical situation" means a condition of emergency in which immediate drug therapy is required for the preservation of health, life, or limb of a person or persons.

"Floor stock" means a supply of essential drugs not labeled for a specific patient and maintained and controlled by the pharmacy at a patient care area for the purpose of timely administration to a patient of the hospital.

"Formulary" means a continually revised compilation of pharmaceuticals (including ancillary information) that reflects the current clinical judgment of the medical staff.

"Hospital pharmacy" means a pharmacy, as defined in A.R.S. § 32-1901, that holds a current permit issued by the Board pursuant to A.R.S. § 32-1931, and is located in a hospital as defined in A.R.S. § 32-1901.

"Inpatient" means any patient who receives non-self-administered drugs from a hospital pharmacy for use while within a facility owned by the hospital.

"Intravenous admixture" means a sterile parenteral solution to which one or more additional drug products have been added.

"Medication order" means a written, electronic, or verbal order from a medical practitioner or a medical practitioner's authorized agent for administration of a drug or device.

"On-call" means a pharmacist is available to:

Consult or provide drug information regarding drug therapy or related issues; or

Dispense a medication order and review a patient's medication order for pharmaceutical and therapeutic feasibility under R4-23-653(E)(2) before any drug is administered to a patient, except as specified in R4-23-653(E)(1).

"Patient care area" means any area for the primary purpose of providing a physical environment that is owned by or operated in conjunction with a hospital, for a patient to obtain health care services, except those areas where a physician, dentist, veterinarian, osteopath, or other medical practitioner engages primarily in private practice.

"Repackaged drug" means a drug product that is transferred by pharmacy personnel from an original manufacturer's container to another container properly labeled for subsequent dispensing.

"Satellite pharmacy" means a work area in a hospital setting under the direction of a pharmacist that is a remote extension of a centrally licensed hospital pharmacy and owned by and dependent upon the centrally licensed hospital pharmacy for administrative control, staffing, and drug procurement.

"Single unit" means a package of medication that contains one discrete pharmaceutical dosage form.

"Supervision" means the process by which a pharmacist directs the activities of hospital pharmacy personnel to a sufficient degree to ensure that all activities are performed accurately, safely, and without risk of harm to patients.

**Historical Note**

Former Rules 6.7110, 6.7120, and 6.7130; Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (B) effective April 20, 1982 (Supp. 82-2). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-652. Hospital Pharmacy Permit**

**A.** The following rules are applicable to all hospitals as defined by A.R.S. § 32-1901 and hospital pharmacies as defined by R4-23-651.

**B.** Before opening a hospital pharmacy, a person shall obtain a pharmacy permit as specified in R4-23-602 and R4-23-606.

**C.** Discontinued hospitals. If a hospital license is discontinued by the state Department of Health Services, the pharmacy permittee or pharmacist-in-charge shall follow the procedures described in R4-23-613 for discontinuing a pharmacy.

**Historical Note**

Former Rules 6.7210, 6.7220, 6.7230, 6.7231, 6.7232, and 6.7233. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-653. Personnel: Professional or Technician**

**A.** Each hospital pharmacy shall be directed by a pharmacist who is licensed to engage in the practice of pharmacy in Arizona and is referred to as the Director of Pharmacy. The Director of Pharmacy shall be the pharmacist-in-charge, as defined in A.R.S. § 32-1901 or shall appoint a pharmacist-in-charge. The Director of Pharmacy and the pharmacist-in-charge, if a different individual, shall:
1. Be responsible for all the activities of the hospital pharmacy and for meeting the requirements of the Arizona Pharmacy Act and these rules;
2. Ensure that the policies and procedures required by these rules are prepared, implemented, and complied with;
3. Review biennially and, if necessary, revise the policies and procedures required under these rules;
4. Document the review required under subsection (A)(3);
5. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee; and
6. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its designee.

**B.** In all hospitals, a pharmacist shall be in the hospital during the time the pharmacy is open for pharmacy services, except for an extreme emergency as defined in R4-23-110. Pharmacy services shall be provided for a minimum of 40 hours per week, unless an exception for less than the minimum hours is made upon written request by the hospital and with express permission of the Board or its designee.

**C.** In a hospital where the pharmacy is not open 24 hours per day for pharmacy services, a pharmacist shall be "on-call" as defined in R4-23-651 when the pharmacy is closed.

**D.** The Director of Pharmacy may be assisted by other personnel approved by the Director of Pharmacy in order to operate the pharmacy competently, safely, and adequately to meet the needs of the hospital's patients.

**E.** Pharmacists. A pharmacist or a pharmacy intern or graduate intern under the supervision of a pharmacist shall perform the following professional practices:
1. Verify a patient's medication order before administration of a drug to the patient, except:
   a. In an emergency medical situation; or
   b. In a hospital where the pharmacy is open less than 24 hours a day for pharmacy services, a pharmacist shall verify a patient's medication order within four hours of the time the pharmacy opens for pharmacy services;
2. Verify a medication order's pharmaceutical and therapeutic feasibility based upon:
   a. The patient's medical condition,
   b. The patient's allergies,
   c. The pharmaceutical and therapeutic incompatibilities, and
   d. The recommended dosage limits;
3. Measure, count, pour, or otherwise prepare and package a drug needed for dispensing, except a pharmacy technician or pharmacy technician trainee may measure, count, pour, or otherwise prepare and package a drug needed for dispensing under the supervision of a pharmacist accord-

ing to written policies and procedures approved by the Board or its designee;

4. Compound, admix, combine, or otherwise prepare and package a drug needed for dispensing, except a pharmacy technician may compound, admix, combine, or otherwise prepare and package a drug needed for dispensing under the supervision of a pharmacist according to written policies and procedures approved by the Board or its designee;
5. Verify the accuracy, correct procedure, compounding, admixing, combining, measuring, counting, pouring, preparing, packaging, and safety of a drug prepared and packaged by a pharmacy technician or pharmacy technician trainee according to subsections (E)(3) and (4) and according to the policies and procedures in subsection (G);
6. Supervise drug repackaging and check the completed repackaged product as specified in R4-23-402(A);
7. Supervise training and education in aseptic technique and drug incompatibilities for all personnel involved in the admixture of parenteral products within the hospital pharmacy;
8. Consult with the medical practitioner regarding the patient's drug therapy or medical condition;
9. When requested by a medical practitioner, patient, patient's agent, or when the pharmacist deems it necessary, provide consultation with a patient regarding the medication order, patient's profile, or overall drug therapy;
10. Monitor a patient's drug therapy for safety and effectiveness;
11. Provide drug information to patients and health care professionals;
12. Manage the activities of pharmacy technicians, pharmacy technician trainees, other personnel, and systems to ensure that all activities are performed accurately, safely, and without risk of harm to patients;
13. Verify the accuracy of all aspects of the original, completed medication order; and
14. Ensure compliance by pharmacy personnel with a quality assurance program developed by the hospital.

**F.** Pharmacy technicians and pharmacy technician trainees. Before working as a pharmacy technician or pharmacy technician trainee, an individual shall meet the eligibility and licensure requirements prescribed in 4 A.A.C. 23, Article 11

**G.** Pharmacy technician policies and procedures. Before employing a pharmacy technician or pharmacy technician trainee, a Director of Pharmacy or pharmacist-in-charge shall develop the policies and procedures required under R4-23-1104.

**H.** Pharmacy technician training program.

1. A Director of Pharmacy or pharmacist-in-charge shall comply with the training program requirements of R4-23-1105 based on the needs of the hospital pharmacy;
2. A pharmacy technician or pharmacy technician trainee shall:
   a. Perform only those tasks for which training and competency have been demonstrated; and
   b. Not perform professional practices reserved for a pharmacist, graduate intern, or pharmacy intern in subsection (E), except as specified in subsections (E)(3) and (4).

**I.** Supervision. A hospital pharmacy's Director of Pharmacy and the pharmacist-in-charge, if a different individual, shall supervise all of the activities and operations of a hospital pharmacy. A pharmacist shall supervise all functions and activities of pharmacy technicians, pharmacy technician trainees, and other hospital pharmacy personnel to ensure that all functions and activities are performed competently, safely, and without risk of harm to patients.

**Historical Note**

Former Rules 6.7310 and 6.7320; Amended effective August 10, 1978 (Supp. 78-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-654. Absence of Pharmacist**

**A.** If a pharmacist will not be on duty in the hospital, the Director of Pharmacy or pharmacist-in-charge shall arrange, before the pharmacist's absence, for the medical staff and other authorized personnel of the hospital to have access to drugs in the remote drug storage area defined in R4-23-110 or in the hospital pharmacy if a drug is not available in a remote drug storage area and is required to treat the immediate needs of a patient. A pharmacist shall be on-call during all absences.

**B.** If a pharmacist will not be on duty in the hospital pharmacy, the Director of Pharmacy or pharmacist-in-charge shall arrange, before the pharmacist's absence, for the medical staff and other authorized personnel of the hospital to have telephone access to an on-call pharmacist.

**C.** The hospital pharmacy permittee shall ensure that the hospital pharmacy is not without a pharmacist on duty in the hospital for more than 72 consecutive hours.

**D.** Remote drug storage area. The Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate committee of the hospital:

1. Develop and maintain an inventory listing of the drugs to be included in a remote drug storage area; and
2. Develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures that ensure proper storage, access, and accountability for drugs in a remote drug storage area.

**E.** Access to hospital pharmacy. If a drug is not available from a remote drug storage area and the drug is required to treat the immediate needs of a patient whose health may be compromised, the drug may be obtained from the hospital pharmacy according to the requirements of this subsection.

1. The Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate committee of the hospital, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures to ensure that access to the hospital pharmacy during the pharmacist's absence conforms to the following requirements:
   a. Access is delegated to only one supervisory nurse in each shift;
   b. The policy and name of supervisory nurse is communicated in writing to the medical staff of the hospital;
   c. Access is delegated only to a nurse who has received training from the Director of Pharmacy, pharmacist-in-charge, or Director's designee in the procedures required for proper access, drug removal, and recordkeeping; and

d. Access is delegated by the supervisory nurse to another nurse only in an emergency.

2. If a nurse to whom authority is delegated to access the hospital pharmacy removes a drug from the hospital pharmacy, the nurse shall:
   a. Record the following information on a form or by another method approved by the Board or its designee:
      i. Patient's name;
      ii. Drug name, strength, and dosage form;
      iii. Quantity of drug removed; and
      iv. Date and time of removal;
   b. Sign or initial, if a corresponding signature is on file in the hospital pharmacy, the form recording the drug removal;
   c. Attach the original or a direct copy of the medication order for the drug to the form recording the drug removal; and
   d. Place the form recording the drug removal conspicuously in the hospital pharmacy.
3. Within four hours after a pharmacist returns from an absence, the pharmacist shall verify all records of drug removal that occurred during the pharmacist's absence according to R4-23-653(E).

**Historical Note**
Former Rules 6.7410, 6.7420, 6.7430, 6.7440, 6.7450, and 6.7460; Amended subsection (A) effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-655. Physical Facility**

**A.** General. A hospital pharmacy permittee shall ensure that the hospital pharmacy has sufficient equipment and physical facilities for proper compounding, dispensing, and storage of drugs, including parenteral preparations.

**B.** Minimum area of hospital pharmacy. The minimum area of a hospital pharmacy depends on the type of hospital, the number of beds, and the pharmaceutical services provided. Any hospital pharmacy permit issued or hospital pharmacy remodeled after January 31, 2003 shall provide a minimum hospital pharmacy area, the actual area primarily devoted to drug dispensing and preparation functions, exclusive of bulk drug storage, satellite pharmacy, and office areas that is not less than 500 square feet. The minimum area requirement, not including unusable area, may be varied upon approval by the Board for out-of-the-ordinary conditions or for systems that require less space.

**C.** The Board may also require that a hospital pharmacy permittee or applicant provide:
1. More than the minimum area if equipment, inventory, personnel, or other factors cause crowding to a degree that interferes with safe pharmacy practice;
2. Additional dispensing, preparation, or storage areas because of the increased number of specific drugs prescribed per day, the increased use of intravenous and irrigating solutions, and the increased use of disposable and prepackaged products;
3. Additional dispensing, preparation, or storage areas to handle investigational drugs, emergency drug kits, chemotherapeutics, alcohol and other flammables, poisons, external preparations, and radioisotopes, and to accommodate quality control procedures; and
4. Additional office space to provide for an increased number of personnel, a drug information library, a poison information library, research support, teaching and conferences, and a waiting area.

**D.** Hospital pharmacy area. A hospital pharmacy permittee shall ensure that the hospital pharmacy area is enclosed by a permanent barrier or partition from floor to ceiling with entry doors that can be securely locked, constructed according to R4-23-609(F).

**E.** Hospital pharmacy storage areas. The hospital pharmacy permittee, Director of Pharmacy, or pharmacist-in-charge shall ensure that all undispensed or undistributed drugs are stored in designated areas within the hospital pharmacy or other locked areas under the control of a pharmacist that ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

**Historical Note**
Former Rules 6.7471, 6.7472, 6.7473, 6.7474, and 6.7490; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to Table 1 ("spare feet" changed to "square feet") (Supp. 91-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 11 A.A.R. 462, effective March 5, 2005 (Supp. 05-1).

**R4-23-656. Sanitation and Equipment**

A hospital pharmacy permittee or Director of Pharmacy shall ensure that a hospital pharmacy:
1. Has a professional reference library consisting of hardcopy or electronic media appropriate for the scope of pharmacy services provided by the hospital;
2. Has a sink, other than a sink in a toilet facility, that:
   a. Has hot and cold running water;
   b. Is within the hospital pharmacy area for use in preparing drug products; and
   c. Is maintained in a sanitary condition and in good repair;
3. Maintains a room temperature within a range compatible with the proper storage of drugs;
4. Has a refrigerator and freezer with a temperature maintained within a range compatible with the proper storage of drugs requiring refrigeration or freezing; and
5. Has a designated area for a laminar air flow hood and other supplies required for the preparation of sterile products as specified in R4-23-670.

**Historical Note**
Former Rule 6.7480. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-657. Security**

**A.** Personnel security standards. A Director of Pharmacy shall ensure that:
1. No one is permitted in the pharmacy unless a pharmacist is present except as provided in this Section and R4-23-654. If only one pharmacist is on duty in the pharmacy and that pharmacist must leave the pharmacy for an emergency or patient care duties, nonpharmacist personnel may remain in the pharmacy to perform duties as outlined

in R4-23-653, provided that all C-II controlled substances are secured to prohibit access by other than a pharmacist, and that the pharmacist remains available in the hospital;

2. All hospital pharmacy areas are kept locked by key or programmable lock to prevent access by unauthorized personnel; and
3. Pharmacists, pharmacy or graduate interns, pharmacy technicians, pharmacy technician trainees, and other personnel working in the pharmacy wear identification badges, including name and position, whenever on duty.

**B.** Prescription blank security. The Director of Pharmacy shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for the safe distribution and control of prescription blanks bearing identification of the hospital.

**Historical Note**

Former Rule 6.7500; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-658. Drug Distribution and Control**

**A.** General. The Director of Pharmacy or pharmacist-in-charge shall in consultation with the medical staff, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with written policies and procedures for the effective operation of a drug distribution system that optimizes patient safety.

**B.** Responsibility. The Director of Pharmacy is responsible for the safe and efficient procurement, dispensing, distribution, administration, and control of drugs, including the following:

1. In consultation with the appropriate department personnel and medical staff committee, develop a medication formulary for the hospital;
2. Proper handling, distribution, and recordkeeping of investigational drugs; and
3. Regular inspections of drug storage and preparation areas within the hospital.

**C.** Physician orders. A Director of Pharmacy or pharmacist-in-charge shall ensure that:

1. Drugs are dispensed from the hospital pharmacy only upon a written order, direct copy or facsimile of a written order, or verbal order of an authorized medical practitioner; and
2. A pharmacist reviews the original, direct or facsimile copy, or verbal order before an initial dose of medication is administered, except as specified in R4-23-653(E)(1).

**D.** Labeling. A Director of Pharmacy or pharmacist-in-charge shall ensure that all drugs distributed or dispensed by a hospital pharmacy are packaged in appropriate containers and labeled as follows:

1. For use inside the hospital.
   a. Labels for all single unit packages contain at a minimum, the following information:
      i. Drug name, strength, and dosage form;
      ii. Lot number and beyond-use-date; and
      iii. Appropriate auxiliary labels;
   b. Labels for repackaged preparations contain at a minimum the following information:
      i. Drug name, strength, and dosage form;
      ii. Lot number and beyond-use-date;
      iii. Appropriate auxiliary labels; and
      iv. Mechanism to identify pharmacist accountable for repackaging;
   c. Labels for all intravenous admixture preparations contain at a minimum the following information:
      i. Patient's name and location;
      ii. Name and quantity of the basic parenteral solution;
      iii. Name and amount of drug added;
      iv. Date of preparation;
      v. Beyond-use-date and time;
      vi. Guidelines for administration;
      vii. Appropriate auxiliary label or precautionary statement; and
      viii. Initials of pharmacist responsible for admixture preparation; and
2. For use outside the hospital. Any drug dispensed to a patient by a hospital pharmacy that is intended for self-administration outside of the hospital is labeled as specified in A.R.S. §§ 32-1963.01(C) and 32-1968(D) and A.A.C. R4-23-402.

**E.** Controlled substance accountability. A Director of Pharmacy or pharmacist-in-charge shall ensure that effective policies and procedures are developed, implemented, reviewed, and revised in the same manner described in R4-23-653(A) and complied with regarding the use, accountability, and recordkeeping of controlled substances in the hospital, including the use of locked storage areas when controlled substances are stored in patient care areas.

**F.** Emergency services dispensing. If a hospital permits dispensing of drugs from the emergency services department when the pharmacy is unable to provide this service, the Director of Pharmacy, in consultation with the appropriate department personnel and medical staff committee shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with written policies and procedures for dispensing drugs for outpatient use from the hospital's emergency services department. The policies and procedures shall include the following requirements:

1. Drugs are dispensed only to patients who have been admitted to the emergency services department;
2. Drugs are dispensed only by an authorized medical practitioner, not a designee or agent;
3. The nature and type of drugs available for dispensing are designed to meet the immediate needs of the patients treated within the hospital;
4. Drugs are dispensed only in quantities sufficient to meet patient needs until outpatient pharmacy services are available;
5. Drugs are prepackaged by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist in suitable containers and appropriately prelabeled with the drug name, strength, dosage form, quantity, manufacturer, lot number, beyond-use-date, and any appropriate auxiliary labels;
6. Upon dispensing, the authorized medical practitioner completes the label on the prescription container that complies with the requirements of R4-23-658(D); and
7. The hospital pharmacy maintains a dispensing log, hard-copy prescription, or electronic record, approved by the Board or its designee and includes the patient name and address, drug name, strength, dosage form, quantity,

directions for use, medical practitioner's signature or identification code, and DEA registration number, if applicable.

**Historical Note**
Former Rules 6.7610, 6.7620, and 6.7710; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to subsection (I)(5) ("unnecessary" changed to "necessary") (Supp. 91-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-659. Administration of Drugs**

**A.** Self-administration. A hospital shall not allow self-administration of medications by a patient unless the Director of Pharmacy or pharmacist-in-charge, in consultation with the appropriate department personnel and medical staff committee, develops, implements, reviews, and revises in the same manner described in R4-23-653(A) and complies with policies and procedures for self-administration of medications by a patient. The policies and procedures shall specify that self-administration of medications, if allowed, occurs only when:
1. Specifically ordered by a medical practitioner, and
2. The patient is educated and trained in the proper manner of self-administration.

**B.** Drugs brought in by a patient. If a hospital allows a patient to bring a drug into the hospital and before a patient brings a drug into the hospital, the Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate department personnel and medical staff committee, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for a patient-owned drug brought into the hospital. The policies and procedures shall specify the following criteria for a patient-owned drug brought into the hospital:
1. When policy allows the administration of a patient-owned drug, the drug is not administered to the patient unless:
   a. A pharmacist or medical practitioner identifies the drug, and
   b. A medical practitioner writes a medication order specifying administration of the identified patient-owned drug; and
2. If a patient-owned drug will not be used during the patient's hospitalization, the hospital pharmacy's personnel shall:
   a. Package, seal, and give the drug to the patient's agent for removal from the hospital; or
   b. Package, seal, and store the drug for return to the patient at the time of discharge from the hospital.

**C.** Drug samples. The Director of Pharmacy or pharmacist-in-charge is responsible for the receipt, storage, distribution, and accountability of drug samples within the hospital, including developing, implementing, reviewing, and revising in the same manner described in R4-23-653(A) and complying with specific policies and procedures regarding drug samples.

**Historical Note**
Former Rules 6.7720, 6.7730, 6.7740, 6.7760, 6.7770, 6.7780, 6.7800, 6.7810, 6.7820, 6.7830, 6.7840, 6.7850, 6.7871, 6.7872, and 6.7873; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to Section heading ("rules" changed to "roles") (Supp. 91-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-660. Investigational Drugs**

The Director of Pharmacy or pharmacist-in-charge shall ensure that:
1. The following information concerning an investigational drug is available for use by hospital personnel:
   a. Composition,
   b. Pharmacology,
   c. Adverse reactions,
   d. Administration guidelines, and
   e. All other available information concerning the drug, and
2. An investigational drug is:
   a. Properly stored in, labeled, and dispensed from the pharmacy, and
   b. Not dispensed before the drug is approved by the appropriate medical staff committee of the hospital.

**Historical Note**
Former Rules 6.7881, 6.7882, and 6.7883; Amended subsection (A) effective Aug. 9, 1983 (Supp. 83-4). Repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-661. Repealed**

**Historical Note**
Former Rules 6.7910, 6.7920, 6.7930, 6.7940, and 6.7950. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-662. Repealed**

**Historical Note**
Adopted effective February 7, 1990 (Supp. 90-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-663. Repealed**

**Historical Note**
Adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-664. Repealed**

**Historical Note**
Adopted effective February 7, 1990 (Supp. 90-1). Subsection label removed (Supp. 91-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-665. Reserved**

**R4-23-666. Reserved**

**R4-23-667. Reserved**

**R4-23-668. Reserved**

**R4-23-669. Reserved**

**R4-23-670. Sterile Pharmaceutical Products**

**A.** In addition to the minimum area requirement of R4-23-609(A) and R4-23-655(B) and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall provide a minimum sterile pharmaceutical product compounding area that is not less than 100 square feet of contiguous floor area, except any pharmacy permit issued or pharmacy remodeled before November 1, 2006 may continue to use a sterile pharmaceutical product compounding area that is not less that 60 square feet of contiguous floor area, until a pharmacy ownership change occurs that requires issuance of a new permit or the pharmacy is remodeled. The pharmacy permittee or the pharmacist-in-charge shall ensure that the sterile pharmaceutical product compounding area:

1. Is dedicated to the purpose of preparing and compounding sterile pharmaceutical products;
2. Is isolated from other pharmacy functions;
3. Restricts entry or access;
4. Is free from unnecessary disturbances in air flow;
5. Is made of non-porous and cleanable floor, wall, and ceiling material; and
6. Meets the minimum air cleanliness standards of an ISO Class 7 environment as defined in R4-23-110, except an ISO class 7 environment is not required if all sterile pharmaceutical product compounding occurs within an ISO class 5 environment isolator, such as a glove box, pharmaceutical isolator, barrier isolator, pharmacy isolator, or hospital pharmacy isolator.

**B.** In addition to the equipment requirements in R4-23-611 and R4-23-612 or R4-23-656 and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall ensure that a pharmacist who compounds a sterile pharmaceutical product has the following equipment:

1. Environmental control devices capable of maintaining a compounding area environment equivalent to an "ISO class 5 environment" as defined in R4-23-110. Devices capable of meeting these standards include: laminar airflow hoods, hepa filtered zonal airflow devices, glove boxes, pharmaceutical isolators, barrier isolators, pharmacy isolators, hospital pharmacy isolators, and biological safety cabinets;
2. Disposal containers designed for needles, syringes, and other material used in compounding sterile pharmaceutical products and if applicable, separate containers to dispose of cytotoxic, chemotherapeutic, and infectious waste products;
3. Freezer storage units with thermostatic control and thermometer, if applicable;
4. Packaging or delivery containers capable of maintaining official compendial drug storage conditions;
5. Infusion devices and accessories, if applicable; and
6. In addition to the reference library requirements of R4-23-612, a current reference pertinent to the preparation of sterile pharmaceutical products.

**C.** Before compounding a sterile pharmaceutical product, the pharmacy permittee, limited-service pharmacy permittee, or pharmacist-in-charge shall:

1. Prepare, implement, and comply with policies and procedures for compounding and dispensing sterile pharmaceutical products,
2. Review biennially and if necessary revise the policies and procedures required under subsection (C)(1),
3. Document the review required under subsection (C)(2),
4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.

**D.** The assembled policies and procedures shall include, where applicable, the following subjects:

1. Supervisory controls and verification procedures to ensure the quality and safety of sterile pharmaceutical products;
2. Clinical services and drug monitoring procedures for:
   a. Patient drug utilization reviews;
   b. Inventory audits;
   c. Patient outcome monitoring;
   d. Drug information; and
   e. Education of pharmacy and other health professionals;
3. Controlled substances;
4. Supervisory controls and verification procedures for:
   a. Cytotoxics handling, storage, and disposal;
   b. Disposal of unused supplies and pharmaceutical products; and
   c. Handling and disposal of infectious wastes;
5. Pharmaceutical product administration, including guidelines for the first dosing of a pharmaceutical product;
6. Drug and component procurement;
7. Pharmaceutical product compounding, dispensing, and storage;
8. Duties and qualifications of professional and support staff;
9. Equipment maintenance;
10. Infusion devices and pharmaceutical product delivery systems;
11. Investigational drugs and their protocols;
12. Patient profiles;
13. Patient education and safety;
14. Quality management procedures for:
    a. Adverse drug reactions;
    b. Drug recalls;
    c. Expired pharmaceutical products;
    d. Beyond-use-dating for both standard-risk and substantial-risk sterile pharmaceutical products consistent with the requirements of R4-23-410(B)(3)(d);
    e. Temperature and other environmental controls;
    f. Documented process and product validation testing; and
    g. Semi-annual certification of the laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment, including documentation of routine cleaning and maintenance for each laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment; and
15. Sterile pharmaceutical product delivery requirements for:
    a. Shipment to the patient;
    b. Security; and
    c. Maintaining official compendial storage conditions.

**E.** Standard-risk sterile pharmaceutical product compounding. Before compounding a standard-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:
1. Compounding occurs only in an ISO class 5 environment within an ISO class 7 environment, and the ISO class 7 environment may have a specified prep area inside the environment;
2. Compounding sterile pharmaceutical products from sterile commercial drugs or sterile pharmaceutical otic or ophthalmic products from non-sterile ingredients occurs using procedures that involve only a few closed-system, basic, simple aseptic transfers and manipulations;
3. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
4. Each person who compounds completes an annual media-fill test to validate proper aseptic technique.

**F.** Substantial-risk sterile pharmaceutical product compounding. Before compounding a substantial-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:
1. Compounding parenteral or injectable sterile pharmaceutical products from non-sterile ingredients occurs only in an ISO class 5 environment within an ISO class 7 environment and the ISO class 7 environment shall not have a prep area inside the environment;
2. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
3. Each person who compounds completes a semi-annual media-fill test that simulates the most challenging or stressful conditions for compounding using dry non-sterile media to validate proper aseptic technique.

**Historical Note**
Adopted effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4).

**R4-23-671. General Requirements for Limited-service Pharmacy**

**A.** Before opening a limited-service pharmacy, a person shall obtain a permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and R4-23-606.

**B.** The limited-service pharmacy permittee shall secure the limited-service pharmacy by conforming with the following standards:
1. Permit no one to be in the limited-service pharmacy unless the pharmacist-in-charge or a pharmacist authorized by the pharmacist-in-charge is present;
2. Require the pharmacist-in-charge to designate in writing, by name, title, and specific area, those persons who will have access to particular areas of the limited-service pharmacy;
3. Implement procedures to guard against theft or diversion of drugs, including controlled substances; and
4. Require all persons working in the limited-service pharmacy to wear badges, with their names and titles, while on duty.

**C.** To obtain permission to deviate from the minimum area requirement set forth in R4-23-609, R4-23-673, or R4-23-682, a limited-service pharmacy permittee shall submit a written request to the Board and include documentation that the deviation will facilitate experimentation or technological advances in the practice of pharmacy as defined in A.R.S. § 32-1901. If the Board determines the requested deviation from the minimum area requirement will enhance the practice of pharmacy and benefit the public, the Board shall grant the requested deviation.

**D.** The Board shall require more than the minimum area in a limited-service pharmacy when the Board determines that equipment, personnel, or other factors in the limited-service pharmacy cause crowding that interferes with safe pharmacy practice.

**E.** Before dispensing from a limited-service pharmacy, the limited-service pharmacy permittee or pharmacist-in-charge shall:
1. Prepare, implement, and comply with written policies and procedures for pharmacy operations and drug dispensing and distribution,
2. Review biennially and if necessary revise the policies and procedures required under subsection (E)(1),
3. Document the review required under subsection (E)(2),
4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.

**Historical Note**
Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-672. Limited-service Correctional Pharmacy**

**A.** The limited-service pharmacy permittee shall ensure that the limited-service correctional pharmacy complies with the standards for area, personnel, security, sanitation, equipment, drug distribution and control, administration of drugs, drug source, quality assurance, investigational drugs, and inspections as set forth in R4-23-608, R4-23-609(A) through (D) and (F) through (H), R4-23-610(A), R4-23-611, R4-23-612, R4-23-653(E), R4-23-658(B) through (E), R4-23-659, and R4-23-660.

**B.** The pharmacist-in-charge of a limited-service correctional pharmacy shall authorize only pharmacists, interns, pharmacy technicians, pharmacy technician trainees, compliance officers, drug inspectors, peace officers, and correctional officers acting in their official capacities, other persons authorized by law, support personnel, and other designated personnel to be in the limited-service correctional pharmacy.

**C.** When no pharmacist will be on duty in the correctional facility, the pharmacist-in-charge shall arrange, before there is no pharmacist on duty, for the medical staff and other authorized

personnel of the correctional facility to have access to drugs in remote drug storage areas or, if a drug is not available in a remote drug storage area and is required to treat the immediate needs of a patient, in the limited-service correctional pharmacy.

1. The pharmacist-in-charge shall, in consultation with the appropriate committee of the correctional facility, develop and implement procedures to ensure that remote drug storage areas:
   a. Contain only properly labeled drugs that might reasonably be needed and can be administered safely during the pharmacist's absence,
   b. Contain drugs packaged only in amounts sufficient for immediate therapeutic requirements,
   c. Are accessible only with a physician's written order,
   d. Provide a written record of each drug withdrawn,
   e. Are inventoried at least once each week, and
   f. Are audited for compliance with the requirements of this rule at least once each month.
2. The pharmacist-in-charge shall, in consultation with the appropriate committee of the correctional facility, develop and implement procedures to ensure that access to the limited-service correctional pharmacy when no pharmacist is on duty conforms to the following requirements:
   a. Is delegated to only one nurse, who is in a supervisory position;
   b. Is communicated in writing to medical staff of the correctional facility;
   c. Is delegated only to a nurse who has received training from the pharmacist-in-charge in proper methods of access, removal of drugs, and recordkeeping procedures; and
   d. Is delegated by the supervisory nurse to another nurse only in an emergency.
3. When a nurse to whom authority to access the limited-service correctional pharmacy is delegated removes a drug from the limited-service correctional pharmacy, the nurse shall:
   a. Record the following information on a form:
      i. Patient's name,
      ii. Name of the drug and its strength and dosage form,
      iii. Dose prescribed,
      iv. Amount of drug removed, and
      v. Date and time of removal;
   b. Sign the form recording the drug removal;
   c. Attach the original or a direct copy of a physician's written order for the drug to the form recording the drug removal; and
   d. Place the form recording the drug removal conspicuously in the limited-service correctional pharmacy.
4. Within four hours after a pharmacist in the limited-service correctional pharmacy returns to duty following an absence in which the limited-service correctional pharmacy was accessed by a nurse to whom authority had been delegated, the pharmacist shall verify all records of drug removal according to R4-23-402.

**D.** When no pharmacist will be on duty in the correctional facility, the pharmacist-in-charge shall arrange, before there is no pharmacist on duty, for the medical staff and other authorized personnel of the correctional facility to have telephone access to a pharmacist.

**E.** The limited-service pharmacy permittee shall ensure that the limited-service correctional pharmacy is not without a pharmacist on duty for more than 96 consecutive hours.

**F.** In addition to the requirements of R4-23-671, the limited-service pharmacy permittee shall secure the limited-service correctional pharmacy as follows:
1. Permit no one to be in the limited-service correctional pharmacy unless a pharmacist is on duty except:
   a. As provided in subsection (C)(3) when a pharmacist is not on duty; or
   b. A pharmacy technician or pharmacy technician trainee may remain to perform duties in R4-23-1104(A), when a pharmacist is on duty and available in the correctional facility but temporarily absent from the pharmacy, provided:
      i. All controlled substances are secured in a manner that prohibits access by persons other than a pharmacist;
      ii. Activities performed by a pharmacy technician or pharmacy technician trainee while the pharmacist is temporarily absent are verified by the pharmacist immediately upon returning to the pharmacy;
      iii. Any drug measured, counted, poured, or otherwise prepared and packaged by a pharmacy technician or pharmacy technician trainee while the pharmacist is temporarily absent is verified by the pharmacist immediately upon returning to the pharmacy; and
      iv. Any drug that has not been verified by a pharmacist for accuracy is not dispensed, supplied, or distributed while the pharmacist is temporarily absent from the pharmacy; and
2. Provide keyed or programmable locks to all areas of the limited-service correctional pharmacy.

**G.** The pharmacist-in-charge of a limited-service correctional pharmacy shall ensure that the written policies and procedures for pharmacy operations and drug distribution within the correctional facility include the following:
1. Physicians' orders, prescription orders, or both;
2. Authorized abbreviations;
3. Formulary system;
4. Clinical services and drug utilization management including:
   a. Participation in drug selection,
   b. Drug utilization reviews,
   c. Inventory audits,
   d. Patient outcome monitoring,
   e. Committee participation,
   f. Drug information, and
   g. Education of pharmacy and other health professionals;
5. Duties and qualifications of professional and support staff;
6. Products of abuse and contraband medications;
7. Controlled substances;
8. Drug administration;
9. Drug product procurement;
10. Drug compounding, dispensing, and storage;
11. Stop orders;
12. Pass or discharge medications;
13. Investigational drugs and their protocols;
14. Patient profiles;
15. Quality management procedures for:

a. Adverse drug reactions;
b. Drug recalls;
c. Expired and beyond-use-date drugs;
d. Medication or dispensing errors;
e. Drug storage; and
f. Education of professional staff, support staff, and patients;

16. Recordkeeping;
17. Sanitation;
18. Security;
19. Access to remote drug storage areas by non-pharmacists; and
20. Access to limited-service correctional pharmacy by non-pharmacists.

**Historical Note**
Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4).

**R4-23-673. Limited-service Mail-order Pharmacy**

**A.** The limited-service pharmacy permittee shall design and construct the limited-service mail-order pharmacy to conform with the following requirements:
1. A dispensing area devoted to stocking, compounding, and dispensing prescription medications, which is physically separate from a non-dispensing area devoted to non-dispensing pharmacy services;
2. A dispensing area of at least 300 square feet if three or fewer persons work in the dispensing area simultaneously;
3. A dispensing area that provides 300 square feet plus 60 square feet for each person in excess of three persons if more than three persons work in the dispensing area simultaneously;
4. Space in the dispensing area permits efficient pharmaceutical practice, free movement of personnel, and visual surveillance by the pharmacist;
5. A non-dispensing area of at least 30 square feet for each person working simultaneously in the non-dispensing area; and
6. Space in the non-dispensing area permits free movement of personnel and visual surveillance by the pharmacist; or

**B.** The limited-service pharmacy permittee shall design and construct the limited-service mail-order pharmacy to conform with the following requirements:
1. A contiguous area in which both dispensing and non-dispensing pharmacy services are provided;
2. A contiguous area of at least 300 square feet if three or fewer persons work in the area simultaneously;
3. A contiguous area that provides 300 square feet plus 60 square feet for each person in excess of three persons if more than three persons work in the area simultaneously; and
4. Space in the contiguous area permits efficient pharmaceutical practice, free movement of personnel, and visual surveillance by the pharmacist.

**C.** The limited-service pharmacy permittee shall ensure that the limited-service mail-order pharmacy complies with the standards for area, personnel, security, sanitation, and equipment set forth in R4-23-608, R4-23-609(B) through (H), R4-23-610 (A) and (C) through (F), R4-23-611, and R4-23-612.

**D.** The pharmacist-in-charge of a limited-service mail-order pharmacy shall authorize only pharmacists, interns, pharmacy technicians, pharmacy technician trainees, compliance officers, drug inspectors, peace officers acting in their official capacities, support personnel, other persons authorized by law, and other designated personnel to be in the limited-service mail-order pharmacy.

**E.** The pharmacist-in-charge of a limited-service mail-order pharmacy shall ensure that prescription medication is delivered to the patient or locked in the dispensing area when a pharmacist is not present in the pharmacy.

**F.** In addition to the delivery requirements of R4-23-402, the limited-service pharmacy permittee shall, during regular hours of operation but not less than five days and a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist who has access to patient records at the limited-service mail-order pharmacy. The limited-service pharmacy permittee shall disclose this toll-free number on a label affixed to each container of drugs dispensed from the limited-service mail-order pharmacy.

**G.** The pharmacist-in-charge of a limited-service mail-order pharmacy shall ensure that the written policies and procedures for pharmacy operations and drug distribution include the following:
1. Prescription orders;
2. Clinical services and drug utilization management for:
   a. Drug utilization reviews,
   b. Inventory audits,
   c. Patient outcome monitoring,
   d. Drug information, and
   e. Education of pharmacy and other health professionals;
3. Duties and qualifications of professional and support staff;
4. Controlled substances;
5. Drug product procurement;
6. Drug compounding, dispensing, and storage;
7. Patient profiles;
8. Quality management procedures for:
   a. Adverse drug reactions,
   b. Drug recalls,
   c. Expired and beyond-use-date drugs,
   d. Medication or dispensing errors, and
   e. Education of professional and support staff;
9. Recordkeeping;
10. Sanitation;
11. Security;
12. Drug delivery requirements for:
   a. Transportation,
   b. Security,
   c. Temperature and other environmental controls,
   d. Emergency provisions, and
13. Patient education.

**Historical Note**
Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4).

**R4-23-674. Limited-service Long-term Care Pharmacy**

**A.** A limited-service pharmacy permittee shall ensure that the limited-service long-term care pharmacy complies with:
1. The general requirements of R4-23-671;
2. The professional practice standards of Article 4 and Article 11; and
3. The permits and drug distribution standards of R4-23-606 through R4-23-612, R4-23-670, and this Section.

**B.** If a limited-service long-term care pharmacy permittee contracts with a long-term care facility as a Provider Pharmacy, as defined in R4-23-110, the limited-service long-term care pharmacy permittee shall ensure that the long-term care consultant pharmacist and the pharmacist-in-charge of the limited-service long-term care pharmacy comply with R4-23-701, R4-23-701.01, R4-23-701.02, R4-23-701.03, R4-23-701.04, and this Section.

**C.** The limited-service long-term care pharmacy permittee or pharmacist-in-charge shall ensure that prescription medication is delivered to the patient's long-term care facility or locked in the dispensing area of the pharmacy when a pharmacist is not present in the pharmacy.

**D.** The pharmacist-in-charge of a limited-service long-term care pharmacy shall authorize only those individuals listed in R4-23-610(B) to be in the limited-service long-term care pharmacy.

**E.** In consultation with the long-term care facility's medical director and director of nursing, the long-term care consultant pharmacist and pharmacist-in-charge of the long-term care facility's provider pharmacy may develop, if necessary, a medication formulary for the long-term care facility that ensures the safe and efficient procurement, dispensing, distribution, administration, and control of drugs in the long-term care facility.

**F.** The limited-service long-term care pharmacy permittee or pharmacist-in-charge shall ensure that the written policies and procedures required in R4-23-671(E) include the following:

1. Clinical services and drug utilization management for:
   a. Drug utilization reviews,
   b. Inventory audits,
   c. Patient outcome monitoring,
   d. Drug information, and
   e. Education of pharmacy and other health professionals;
2. Controlled substances;
3. Drug compounding, dispensing, and storage;
4. Drug delivery requirements for:
   a. Transportation,
   b. Security,
   c. Temperature and other environmental controls, and
   d. Emergency provisions;
5. Drug product procurement;
6. Duties and qualifications of professional and support staff;
7. Emergency drug supply unit procedures;
8. Formulary, including development, review, modification, use, and documentation, if applicable;
9. Patient profiles;
10. Patient education;
11. Prescription orders, including:
    a. Approved abbreviations,
    b. Stop-order procedures, and
    c. Leave-of-absence and discharge prescription order procedures;
12. Quality management procedures for:
    a. Adverse drug reactions,
    b. Drug recalls,
    c. Expired and beyond-use-date drugs,
    d. Medication or dispensing errors, and
    e. Education of professional and support staff;
13. Recordkeeping;
14. Sanitation; and
15. Security.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-675. Limited-service Sterile Pharmaceutical Products Pharmacy**

**A.** The limited-service pharmacy permittee or the pharmacist-in-charge shall ensure that the limited-service sterile pharmaceutical products pharmacy complies with the standards for area, personnel, security, sanitation, equipment, sterile pharmaceutical products, and limited-service pharmacies established in R4-23-608, R4-23-609, R4-23-610, R4-23-611, R4-23-612, R4-23-670, and R4-23-671.

**B.** The pharmacist-in-charge of a limited-service sterile pharmaceutical products pharmacy shall authorize only pharmacists, interns, compliance officers, peace officers acting in their official capacities, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel to be in the limited-service sterile pharmaceutical products pharmacy.

**C.** The pharmacist-in-charge of a limited-service sterile pharmaceutical products pharmacy shall ensure that prescription medication is delivered to the patient or locked in the dispensing area when a pharmacist is not present in the pharmacy.

**D.** In addition to the delivery requirements of R4-23-402, the limited-service pharmacy permittee shall, during regular hours of operation, but not less than a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist who has access to patient records at the limited-service sterile pharmaceutical products pharmacy. The limited-service pharmacy permittee shall disclose this toll-free number on a label affixed to each container dispensed from the limited-service sterile pharmaceutical products pharmacy.

**E.** The limited-service pharmacy permittee or the pharmacist-in-charge shall ensure development, implementation, review and revision in the same manner described in R4-23-671(E) and compliance with policies and procedures for pharmacy operations, including pharmaceutical product compounding, dispensing, and distribution, that comply with the requirements of R4-23-402, R4-23-410, R4-23-670, and R4-23-671.

**F.** The non-dispensing roles of the pharmacist may include chart reviews, audits, drug therapy monitoring, committee participation, drug information, and in-service training of pharmacy and other health professionals.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). This Section was not amended as originally stated in the historical note published in Supp. 13-3; therefore the reference to the amendment has been removed (Supp. 18-2).

**R4-23-676. Third-party Logistics Provider Permit**

**A.** A person shall not provide logistics services, as described under A.R.S. § 32-1941(A), until the Board issues a third-party logistics provider permit for the facility.

**B.** A person that wants to provide logistics services shall obtain a Board-issued third-party logistics provider permit for each facility.

**C.** Application. To obtain a third-party logistics provider permit for a facility, a person shall submit a completed application, using a form available on the Board's website, and the fee specified in R4-23-205.
**D.** Change of ownership. A third-party logistics provider permittee shall comply with R4-23-601(F).
**E.** A third-party logistics provider permittee shall renew the permit as specified under R4-23-602(D).
**F.** The Board shall adhere to the time frames specified under R4-23-602(C) when processing an initial or renewal application for a third-party logistics provider permit.

**Historical Note**
New Section made by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-677. Automated Prescription-dispensing Kiosk Permit**
**A.** General provisions.
1. Only a person issued a Board permit under A.R.S. § 32-1929 to operate a pharmacy in Arizona may apply to the Board under A.R.S. § 32-1930 for a permit to operate an automated prescription-dispensing kiosk.
2. A pharmacy permittee described under subsection (A)(1) shall apply for a separate permit for each automated prescription-dispensing kiosk to be operated.
3. To obtain an automated prescription-dispensing kiosk permit, a pharmacy permittee shall submit a completed application, using a form available on the Board's website, and the fee specified in R4-23-205.
4. A pharmacy permittee to which the Board issues an automated prescription-dispensing kiosk permit shall designate a pharmacist in charge of the automated prescription-dispensing kiosk.
5. A pharmacy permittee to which the Board issues an automated prescription-dispensing kiosk permit shall not place the automated prescription-dispensing kiosk in a gas station or convenience store.

**B.** Policies and procedures. A pharmacy permittee to which the Board issues an automated prescription-dispensing kiosk permit shall:
1. Ensure policies and procedures are established for the appropriate performance and use of the automated prescription-dispensing kiosk. The policies and procedures shall address:
   a. Maintaining a record of each transaction in a manner that attaches the record to the permit number of the automated prescription-dispensing kiosk;
   b. Controlling access to the automated prescription-dispensing kiosk;
   c. Operating the automated prescription-dispensing kiosk;
   d. Training personnel who use the automated prescription-dispensing kiosk;
   e. Maintaining patient services when the automated prescription-dispensing kiosk is not operating or the prescribed drug or device is not available;
   f. Securing the automated prescription-dispensing kiosk against unauthorized removal of the kiosk or access to or removal of drugs or devices from the kiosk;
   g. Assuring a patient receives the pharmacy services necessary for appropriate pharmaceutical care including consultation with a pharmacist;
   h. Maintaining integrity of information in the system and patient confidentiality;
   i. Stocking and restocking the automated prescription-dispensing kiosk;
   j. Ensuring compliance with packaging and labeling requirements; and
   k. Removing drugs and devices from the automated prescription-dispensing kiosk without dispensing them and handling wasted or discarded drugs and devices;
2. Ensure the policies and procedures are implemented and complied with by all personnel using the automated prescription-dispensing kiosk;
3. Maintain the policies and procedures by:
   a. Reviewing the policies and procedures biennially and making needed revisions, if any;
   b. Documenting the review required under subsection (B)(3)(a);
   c. Assembling the policies and procedures as a written or electronic manual; and
   d. Making the policies and procedures available within the pharmacy permittee to which the Board issued an automated prescription-dispensing kiosk permit for reference by pharmacy personnel and inspection by the Board; and
4. Implement a quality assurance program to monitor compliance with the policies and procedures and all state and federal law.

**C.** Change of ownership. An automated prescription-dispensing kiosk permittee shall comply with R4-23-601(F).
**D.** An automated prescription-dispensing kiosk permittee shall renew the permit as specified under R4-23-602(D).
**E.** The Board shall adhere to the time frames specified under R4-23-602(C) when processing an initial or renewal application for an automated prescription-dispensing kiosk permit.

**Historical Note**
New Section made by final rulemaking at 25 A.A.R. 1012, effective June 1, 2019 (Supp. 19-2).

**R4-23-678. Reserved**

**R4-23-679. Reserved**

**R4-23-680. Reserved**

**R4-23-681. General Requirements for Limited-service Nuclear Pharmacy**
**A.** To be an authorized nuclear pharmacist, a pharmacist shall:
1. Hold a current pharmacist license issued by the Board; and
2. Be certified as a nuclear pharmacist by:
   a. The Board of Pharmaceutical Specialties, or
   b. A similar group recognized by the Arizona State Board of Pharmacy; or
3. Satisfy each of the following requirements:
   a. Meet minimal standards of training for status as an authorized user of radioactive material, as specified by the Arizona Radiation Regulatory Agency and the United States Nuclear Regulatory Commission;
   b. Submit certification of completion of a Board-approved nuclear pharmacy training program or other training program recognized by the Arizona Radiation Regulatory Agency, with 200 hours of didactic training in the following areas:
      i. Radiation physics and instrumentation,
      ii. Radiation protection,
      iii. Mathematics pertaining to the use and measurement of radioactivity,

iv. Radiation biology, and
v. Radiopharmaceutical chemistry;
c. Submit evidence of a minimum of 500 hours of clinical/practical nuclear pharmacy training under the supervision of an authorized nuclear pharmacist in the following areas:
i. Procuring radioactive materials;
ii. Compounding radiopharmaceuticals;
iii. Performing routine quality control procedures;
iv. Dispensing radiopharmaceuticals;
v. Distributing radiopharmaceuticals;
vi. Implementing basic radiation protection procedures; and
vii. Consulting and educating the nuclear medicine community, patients, pharmacists, other health professionals, and the general public; and
d. Submit written certification, signed by a preceptor who is an authorized nuclear pharmacist, that the above training was satisfactorily completed.

**B.** Radiopharmaceuticals are prescription-only drugs that require specialized techniques in their handling and testing, to obtain optimum results and minimize hazards.
1. A person shall not sell, barter, or otherwise dispose of, or be in possession of any radiopharmaceutical except under the conditions detailed in A.R.S. § 32-1929.
2. A person shall not manufacture, compound, sell, or dispense any radiopharmaceutical unless the person is a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with A.R.S. § 32-1961 and these rules, with the exception of the following, if the following are licensed by the Arizona Radiation Regulatory Agency to use radiopharmaceuticals in compliance with A.R.S. § 30-673;
a. A medical practitioner who administers a radiopharmaceutical to the medical practitioner's patient as provided in A.R.S. § 32-1921(A),
b. A hospital nuclear medicine department, and
c. A medical practitioner's office.
3. The Board shall cooperate with the Arizona Radiation Regulatory Agency and other interested state and federal agencies, in the enforcement of these rules for the protection of the public. This cooperation may include exchange of licensing and other information, joint inspections, and other activities where indicated.

**C.** In addition to compliance with all the applicable federal and state laws and rules governing drugs, whether radioactive or not, a limited-service nuclear pharmacy permittee shall comply with all laws and rules of the Arizona Radiation Regulatory Agency and the U.S. Nuclear Regulatory Commission, including emergency and safety provisions.

**D.** A limited-service nuclear pharmacy permittee shall comply with the education, experience, and licensing requirements of the Arizona Radiation Regulatory Agency.

**E.** A limited-service nuclear pharmacy permittee shall ensure that radiopharmaceuticals are transferred only to a person or firm that holds a current Radioactive Materials License issued by the Arizona Radiation Regulatory Agency.

**Historical Note**

Adopted effective December 3, 1974 (Supp. 75-1). Amended subsections (A), (C) and (D) effective Aug. 12, 1988 (Supp. 88-3). Amended effective July 8, 1997 (Supp. 97-3).

**R4-23-682. Limited-service Nuclear Pharmacy**

**A.** Before operating a limited-service nuclear pharmacy, a person shall obtain a permit in compliance with A.R.S. §§ 32-1929, 32-1930, and 32-1931, and R4-23-606.

**B.** A permit to operate a limited-service nuclear pharmacy shall be issued only to a person who is or employs an authorized nuclear pharmacist and holds a current Arizona Radiation Regulatory Agency Radioactive Materials License. A limited-service nuclear pharmacy permittee that fails to maintain a current Arizona Radiation Regulatory Agency Radioactive Materials License shall be immediately suspended pending revocation by the Board. A limited-service nuclear pharmacy permittee shall have copies of Arizona Radiation Regulatory Agency inspection reports available upon request for Board inspection.
1. A limited-service nuclear pharmacy permittee shall designate an authorized nuclear pharmacist as the pharmacist-in-charge. The pharmacist-in-charge shall be responsible to the Board:
a. For the operations of the pharmacy related to the practice of pharmacy and distribution of drugs and devices;
b. For communicating Board directives to the management, pharmacists, interns, and other personnel of the pharmacy; and
c. For the pharmacy's compliance with all federal and state pharmacy laws and rules.
2. An authorized nuclear pharmacist shall directly supervise all personnel performing tasks in the preparation and distribution of radiopharmaceuticals and ancillary drugs.
3. An authorized nuclear pharmacist shall be present whenever the limited-service nuclear pharmacy is open for business.

**C.** A limited-service nuclear pharmacy permittee shall ensure that the limited-service nuclear pharmacy complies with the standards for personnel, area, security, sanitation, and general requirements in R4-23-608, R4-23-609, R4-23-610, R4-23-611, and R4-23-671.
1. A limited-service nuclear pharmacy shall contain separate areas for:
a. Preparing and dispensing radiopharmaceuticals,
b. Receiving and shipping radiopharmaceuticals,
c. Storing radiopharmaceuticals, and
d. Decaying radioactive waste.
2. The Board may require more than the minimum area in instances where equipment, inventory, personnel, or other factors cause crowding to a degree that interferes with safe pharmacy practice.

**D.** The pharmacist-in-charge shall designate in writing, by title and specific area, the persons who may have access to particular pharmacy areas.

**E.** A limited-service nuclear pharmacy permittee shall maintain records of acquisition, inventory, and disposition of radiopharmaceuticals, other radioactive substances, and other drugs in accordance with federal and state statutes and rules.
1. A prescription order, in addition to the requirements in A.R.S. § 32-1968(C) and R4-23-407(A), shall contain:
a. The date and time of calibration of the radiopharmaceutical,
b. The name of the procedure for which the radiopharmaceutical is prescribed, and
c. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product.

2. The lead container used to store and transport a radiopharmaceutical shall have a label that, in addition to the requirements in A.R.S. § 32-1968(D), includes:
   a. The date and time of calibration of the radiopharmaceutical,
   b. The name of the radiopharmaceutical,
   c. The molybdenum 99 content to USP limits,
   d. The name of the procedure for which the radiopharmaceutical is prescribed,
   e. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product,
   f. The words "Caution: Radioactive Material," and
   g. The standard radiation symbol.
3. The radiopharmaceutical container shall have a label that includes:
   a. The date and time of calibration of the radiopharmaceutical;
   b. The name of the patient, recorded before dispensing, if the radiopharmaceutical is therapeutic or for a blood product;
   c. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product;
   d. The name of the radiopharmaceutical;
   e. The dose of radiopharmaceutical;
   f. The serial number;
   g. The words "Caution: Radioactive Material"; and
   h. The standard radiation symbol.

**F.** The following minimum requirements are in addition to the requirements of the Arizona Radiation Regulatory Agency, the applicable U.S. Nuclear Regulatory Commission regulations, and the applicable regulations of the federal Food and Drug Administration. A limited-service nuclear pharmacy permittee shall provide:
1. In addition to the minimum pharmacy area requirements in R4-23-609:
   a. An area for the storing, compounding, and dispensing of radiopharmaceuticals completely separate from pharmacy areas for nonradioactive drugs;
   b. A minimum of 80 sq. ft. for a hot lab and storage area; and
   c. A minimum of 300 sq. ft. of compounding and dispensing area;
2. The following equipment:
   a. Fume hood, approved by the Arizona Radiation Regulatory Agency;
   b. Laminar flow hood;
   c. Dose calibrator;
   d. Refrigerator;
   e. Prescription balance, Class A, and weights or an electronic balance of equal or greater accuracy;
   f. Well scintillation counter;
   g. Incubator oven;
   h. Microscope;
   i. An assortment of labels, including prescription labels and cautionary and warning labels;
   j. Glassware necessary for compounding and dispensing radiopharmaceuticals as required by the Arizona Radiation Regulatory Agency;
   k. Other equipment necessary for radiopharmaceutical quality control for products compounded or dispensed as required by the Arizona Radiation Regulatory Agency;
   l. Current antidote and drug interaction information; and
   m. Regional poison control phone number prominently displayed in the pharmacy area;
3. Supplies necessary for compounding and dispensing radiopharmaceuticals as required by the Arizona Radiation Regulatory Agency;
4. A professional reference library consisting of a minimum of one current reference or text addressing each of the following subject areas:
   a. Therapeutics,
   b. Nuclear pharmacy practice, and
   c. Imaging;
5. Current editions and supplements of:
   a. A.R.S. §§ 30-651 through 30-696 pertaining to the Arizona Radiation Regulatory Agency,
   b. Rules of the Arizona Radiation Regulatory Agency,
   c. Regulations of the federal Food and Drug Administration pertaining to radioactive drugs,
   d. Arizona Pharmacy Act and rules,
   e. Arizona Uniform Controlled Substances Act, and
   f. Radiological Health Handbook.

**G.** The pharmacist-in-charge of a limited-service nuclear pharmacy shall prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for pharmacy operations and drug distribution.

**H.** The written policies and procedures of a limited-service nuclear pharmacy shall include the following:
1. Prescription orders;
2. Clinical services and drug utilization management including:
   a. Drug utilization reviews,
   b. Inventory audits,
   c. Patient outcome monitoring,
   d. Drug information, and
   e. Education of pharmacy and other health professionals;
3. Duties and qualifications of professional and support staff;
4. Radioactive material handling, storage, and disposal;
5. Drug product procurement;
6. Drug compounding, dispensing, and storage;
7. Investigational drugs and their protocols;
8. Patient profiles;
9. Quality management procedures for:
   a. Adverse drug reaction reports;
   b. Drug recall;
   c. Expired and beyond-use-date drugs;
   d. Medication or dispensing errors;
   e. Radiopharmaceutical quality assurance;
   f. Radiological health and safety;
   g. Drug storage and disposition; and
   h. Education of professional staff, support staff, and patients;
10. Recordkeeping;
11. Sanitation;
12. Security;
13. Drug delivery requirements for:
   a. Transportation,
   b. Security,
   c. Radiological health and safety procedures,
   d. Temperature and other environmental controls, and
   e. Emergency provisions; and

14. Patient education.

**Historical note**

Adopted effective July 8, 1997 (Supp. 97-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-683. Reserved**

**R4-23-684. Reserved**

**R4-23-685. Reserved**

**R4-23-686. Reserved**

**R4-23-687. Reserved**

**R4-23-688. Reserved**

**R4-23-689. Reserved**

**R4-23-690. Reserved**

**R4-23-691. Repealed**

**Historical Note**

Adopted effective Dec. 3, 1974 (Supp. 75-1). Amended effective Aug. 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Repealed effective July 8, 1997 (Supp. 97-3).

**R4-23-692. Compressed Medical Gas (CMG) Distributor-Resident or Nonresident**

**A.** Permit.

1. A person shall not manufacture, process, transfill, package, or label a compressed medical gas in Arizona, or manufacture, process, transfill, package, or label a compressed medical gas outside Arizona and ship into Arizona without a current Board-issued resident or nonresident compressed medical gas distributor permit.
2. Before operating as a compressed medical gas distributor, a person shall register with the FDA as a medical gas manufacturer and comply with the drug listing requirements of the federal act.

**B.** Application. To obtain a resident or nonresident CMG distributor permit, a person shall submit to the Board a completed application form and the fee specified in R4-23-205.

1. A resident CMG distributor permit applicant shall include documentation of compliance with local zoning laws, if required by the Board.
2. A nonresident CMG distributor permit applicant that resides in a jurisdiction that issues an equivalent license or permit shall include a copy of the equivalent license or permit.

**C.** Notification. A resident or nonresident CMG distributor permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, e-mail or mailing address, or business name.

**D.** Change of ownership. A resident or nonresident CMG distributor permittee shall comply with R4-23-601(F).

**E.** Relocation.

1. No fewer than 30 days before a resident CMG distributor permittee relocates, the permittee shall electronically or manually submit a completed application for relocation using a form furnished by the Board, and the documentation required in subsection (B). A fee is not required with an application for relocation.
2. A nonresident CMG distributor permittee shall provide written notice by mail, fax, or e-mail to the Board office no fewer than 10 days before relocating.

**F.** A resident or nonresident CMG distributor permittee is authorized to sell or distribute a compressed medical gas under a compressed medical gas order only to durable medical equipment and compressed medical gas suppliers and other entities that are registered, licensed, or permitted to use, administer, or distribute compressed medical gases.

**G.** Facility. A resident or nonresident CMG distributor permittee shall ensure the facility is clean, uncluttered, sanitary, temperature controlled, and secure from unauthorized access.

**H.** Current Good Manufacturing Practice: A resident or nonresident CMG distributor permittee is required under federal law to follow the good manufacturing practice requirements of 21 CFR parts 210 and 211.

**I.** Records: A resident or nonresident CMG distributor permittee shall:

1. Establish and implement written procedures for maintaining records pertaining to production, transfilling, process control, labeling, packaging, quality control, distribution, returns, recalls, training of personnel, complaints, and any information required by federal or state law.
2. Retain the records required by Section R4-23-601, this Section, and 21 CFR parts 210 and 211 for not fewer than three years or one year after the expiration date of the compressed medical gas, whichever is longer.
3. Make the records required by Section R4-23-601, this Section, and 21 CFR parts 210 and 211 available for inspection by the Board or its compliance officer, or if stored in a centralized recordkeeping system apart from the inspection location and not electronically retrievable, provide the records within four working days of a request by the Board or its compliance officer.

**J.** Inspection.

1. A resident CMG distributor permittee shall make the CMG distributor's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.
2. Within 10 days from the date of a request by the Board or its staff, a nonresident CMG distributor permittee shall provide a copy of the most recent inspection report completed by the permittee's resident licensing authority or the FDA or a copy of the most recent inspection report completed by a third-party auditor approved by the permittee's resident licensing authority or the Board or its designee. The Board may inspect, or may employ a third-party auditor to inspect, a nonresident permittee as specified in A.R.S. § 32-1904.

**K.** Permit renewal. To renew a CMG distributor permit, the permittee shall comply with R4-23-602(D).

**L.** Nothing in this Section shall be construed to prohibit the emergency administration of oxygen by licensed health-care personnel, emergency medical technicians, first responders, fire fighters, law enforcement officers, and other emergency personnel trained in the proper use of emergency oxygen.

**Historical Note**

Adopted effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 19 A.A.R. 97, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-693. Durable Medical Equipment (DME) and Com-**

**pressed Medical Gas (CMG) Supplier-Resident or Nonresident**

**A.** Permit. A person shall not sell, lease, or supply durable medical equipment or a compressed medical gas to a patient or consumer in Arizona for use in a home or residence without a current Board-issued resident or nonresident durable medical equipment and compressed medical gas supplier permit.
1. The permit requirements of this Section do not apply to the following unless there is a separate business entity engaged in the business of providing durable medical equipment or a compressed medical gas to a patient or consumer for use in a home or residence:
   a. A medical practitioner licensed under A.R.S. Title 32;
   b. A hospital, long-term care facility, hospice, or other health-care facility using durable medical equipment or a compressed medical gas in the normal course of treating a patient; and
   c. A pharmacy.
2. Nothing in this Section shall be construed to prohibit a person with a current Board-issued nonprescription drug permit from the retail sale of nonprescription drugs or devices.

**B.** Application. To obtain a resident or nonresident DME and CMG supplier permit, a person shall submit a completed application form and fee specified in R4-23-205.
1. A resident DME and CMG supplier permit applicant shall include documentation of compliance with local zoning laws, if required by the Board.
2. A nonresident DME and CMG supplier permit applicant that resides in a jurisdiction that issues an equivalent license or permit shall include a copy of the equivalent license or permit.

**C.** Notification. A resident or nonresident DME and CMG supplier permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, email or mailing address, or business name.

**D.** Change of ownership. A resident or nonresident DME and CMG supplier permittee shall comply with R4-23-601(F).

**E.** Relocation.
1. No fewer than 30 days before a resident DME and CMG supplier permittee relocates, the permittee shall submit a completed application for relocation electronically or manually on a form furnished by the Board, and the documentation required in subsection (B). A fee is not required with an application for relocation.
2. A nonresident DME and CMG supplier permittee shall provide written notice by mail, fax, or e-mail to the Board office no fewer than 10 days before relocating.

**F.** Orders. A resident or nonresident DME and CMG supplier shall sell, lease, or provide:
1. Durable medical equipment that is a prescription-only device, as defined in A.R.S. § 32-1901, only under a prescription or medication order from a medical practitioner; and
2. A compressed medical gas only under a compressed medical gas order from a medical practitioner.

**G.** Restriction. A DME and CMG supplier permit authorizes the permittee to procure, possess, and provide a prescription-only device or compressed medical gas to a patient or consumer as specified in subsection (F). A DME and CMG supplier permit does not authorize the permittee to procure, possess, or provide narcotics or other controlled substances, prescription-only drugs other than compressed medical gases, precursor chemicals, or regulated chemicals.

**H.** Facility. A resident or nonresident DME and CMG supplier permittee shall ensure the facility is clean, uncluttered, sanitary, temperature controlled, and secure from unauthorized access. A permittee shall maintain separate and identified storage areas in the facility and in delivery vehicles for clean, dirty, contaminated, or damaged durable medical equipment or compressed medical gases.

**I.** A resident or nonresident DME and CMG supplier permittee shall not manufacture, process, transfill, package, or label a compressed medical gas, except as stated in subsection (K).

**J.** Records. A resident or nonresident DME and CMG supplier permittee shall establish and implement written procedures for maintaining records about acquisition, distribution, returns, recalls, training of personnel, maintenance, cleaning, and complaints.

**K.** A permittee shall:
1. Ensure a prescription order, medication order, or compressed medical gas order is obtained as specified in subsection (F);
2. Ensure each compressed medical gas container supplied by the permittee contains a label bearing the name and address of the permittee;
3. Ensure all appropriate warning labels are present on the durable medical equipment or compressed medical gas;
4. Retain the records required by Section R4-23-601 and this Section for not fewer than three years, or if supplying a compressed medical gas, one year after the expiration date of the compressed medical gas, whichever is longer; and
5. Make the records required by Section R4-23-601 and this Section available for inspection by the Board or its compliance officer, or if stored in a centralized recordkeeping system apart from the inspection location and not electronically retrievable for inspection, provide the records within four working days of a request by the Board or its staff.

**L.** Inspection.
1. A resident DME and CMG supplier permittee shall make the DME and CMG supplier's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.
2. Within 10 days from the date of a request by the Board or its staff, a nonresident DME and CMG supplier permittee shall provide a copy of the most recent inspection report completed by the permittee's resident licensing authority, or a copy of the most recent inspection report completed by a third-party auditor approved by the permittee's resident licensing authority or the Board or its designee. The Board may inspect, or may employ a third-party auditor to inspect, a nonresident permittee as specified in A.R.S. § 32-1904.

**M.** Permit renewal. To renew a resident or nonresident DME and CMG supplier permit, the permittee shall comply with in R4-23-602(D).

**N.** Nothing in this Section shall be construed to prohibit the emergency administration of oxygen by licensed health-care personnel, emergency medical technicians, first responders, fire fighters, law enforcement officers, and other emergency personnel trained in the proper use of emergency oxygen.

**Historical Note**

Adopted effective January 12, 1998 (Supp. 98-1).
Amended by final rulemaking at 20 A.A.R. 1364,

effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

## ARTICLE 7. NON-PHARMACY LICENSED OUTLETS – GENERAL PROVISIONS

**R4-23-701. Long-term Care Facilities Pharmacy Services: Consultant Pharmacist**

**A.** The long-term care consultant pharmacist as defined in R4-23-110 shall:
1. Possess a valid Arizona pharmacist license issued by the Board;
2. Ensure the provision of pharmaceutical patient care services as defined in R4-23-110;
3. Review the distribution and storage of drugs and devices and assist the facility in establishing policies and procedures for the distribution and storage of drugs and devices;
4. Provide resident evaluation programs that relate to monitoring the therapeutic response and utilization of all drugs and devices prescribed or administered to residents, using as guidelines the most current indicators established by the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services as required in 42 CFR 483.60 (revised October 1, 2010, incorporated by reference and on file with the Board. This incorporated material contains no future editions or amendments.).
5. Serve as a resource for pharmacy-related education services within the facility;
6. Participate in quality management of resident care in the facility; and
7. Communicate with the provider pharmacy regarding areas of mutual concern and resolution.

**B.** A long-term care consultant pharmacist shall ensure that:
1. When a provider pharmacy is not open for business, arrangements are made in advance by the long-term care consultant pharmacist, in cooperation with the pharmacist-in-charge of the provider pharmacy and the director of nursing and medical staff of the long-term care facility, for providing emergency drugs for the licensed nursing staff to administer to the residents of the facility using an emergency drug supply unit located at the facility;
2. The label and packaging of prescription-only and nonprescription drugs intended for use within a long-term care facility complies with state and federal law; and
3. The long-term care facility:
   a. Stores controlled substances listed in A.R.S. § 36-2513 in a separately locked and permanently affixed compartment, unless the facility uses a single-unit package medication distribution system; and
   b. Maintains accurate records of controlled substance administration or ultimate disposition.

**C.** The long-term care consultant pharmacist shall:
1. Ensure availability of records and reports designed to provide the data necessary to evaluate the drug use of each long-term care facility resident that include the following:
   a. Provider pharmacy patient profiles and long-term care facility medication administration records;
   b. Reports of suspected adverse drug reactions;
   c. Inspection reports of drug storage areas with emphasis on detecting outdated drugs; and
   d. Accountability reports, that include:
      i. Date and time of administration,
      ii. Name of the person who administered the drug,
      iii. Documentation and verification of any wasted or partial doses,
      iv. Exception reports for refused doses, and
      v. All drug destruction forms; and
2. Identify and report drug irregularities and dispensing errors to the prescriber, the director of nursing of the facility, and the provider pharmacy.

**D.** A long-term care consultant pharmacist or pharmacist-in-charge of a provider pharmacy shall ensure that:
1. Discontinued or outdated drugs, including controlled substances, are destroyed or disposed of in a timely manner using methods consistent with federal, state, and local requirements and subject to review by the Board or its staff; and
2. Drug containers with illegible or missing labels are:
   a. Identified; and
   b. Replaced or relabeled by a pharmacist employed by the pharmacy that dispensed the prescription medication.

**Historical Note**

Former Rules 6.8110, 6.8120, 6.8130, 6.8140, 6.8150, 6.8160, and 6.8170; Amended effective Aug. 10, 1978 (Supp. 78-4). Section repealed, new Section adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-701.01. Long-term Care Facilities Pharmacy Services: Provider Pharmacy**

The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that:
1. A prescription medication is provided only by a valid prescription order for an individual long-term care facility resident, properly labeled for that resident, as specified in this subsection. Nothing in this Section shall prevent a provider pharmacy from supplying nonprescription drugs in a manufacturer's unopened container or emergency drugs using an emergency drug supply unit as specified in R4-23-701.02;
2. A prescription medication label for a long-term care facility resident complies with A.R.S. §§ 32-1968 and 36-2525 and contains:
   a. The drug name, strength, dosage form, and quantity; and
   b. The beyond-use-date;
3. Only a pharmacist employed by the pharmacy that dispensed the prescription medication may, through the exercise of professional judgment, relabel or alter a prescription medication label that is illegible or missing;
4. The provider pharmacy develops and implements drug recall policies and procedures that protect the health and safety of facility residents. The drug recall procedures shall include immediate discontinuation of any patient level recalled drug and notification of the prescriber and director of nursing of the facility; and
5. Drugs previously dispensed to a resident of the long-term care facility by another pharmacy, and drugs previously dispensed by the provider pharmacy, are not repackaged.

**Historical Note**
Adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-701.02. Long-term Care Facilities Pharmacy Services: Emergency Drugs**

**A.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that:
1. An emergency drug supply unit is available within the long-term care facility,
2. Drugs contained in an emergency drug supply unit remain the property of the provider pharmacy, and
3. Controlled substance drugs contained in an emergency drug supply unit are included in all inventories required under A.R.S. § 36-2523(B) and R4-23-1003(A).

**B.** An emergency drug supply unit shall meet the following criteria:
1. The drugs are necessary to meet the immediate and emergency therapeutic needs of long-term care facility residents as determined by the provider pharmacy's pharmacist-in-charge in consultation with the long-term care facility's medical director and nursing director;
2. The purpose of the emergency drug supply unit in a long-term care facility is not to relieve a provider pharmacy of the responsibility for timely provision of the resident's routine drug needs, but to ensure that an emergency drug supply unit is available for facility residents in need of immediate and emergency therapeutic drugs; and
3. The drugs are provided in a manufacturer's unit of use package or are prepackaged and labeled to include the drug name, strength, dosage form, manufacturer, lot number, and expiration date and provider pharmacy's name, address, telephone number, and pharmacist's initials.

**C.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that an emergency drug supply unit:
1. Is stored in an area that:
   a. Is temperature controlled; and
   b. Prevents unauthorized access;
2. Contains on the exterior of the emergency drug supply unit a label to indicate that the contents are for emergency use only;
3. Contains on the exterior of the emergency drug supply unit a complete list of the contents of the unit by drug name, strength, dosage form, and quantity and the provider pharmacy's name, address, and telephone number;
4. Contains on the exterior of the emergency drug supply unit a label that indicates the date of the earliest drug expiration date;
5. Contains on the exterior of the emergency drug supply unit a label that indicates the date of and pharmacist responsible for the last inspection of the emergency drug supply unit; and
6. Is secured with a tamper-evident seal, or is locked and sealed in a manner that obviously reveals when the unit has been opened or tampered with.

**D.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for the storage and use of an emergency drug supply unit in a long-term care facility;
2. Make the policies and procedures available in the provider pharmacy and long-term care facility for employee reference and inspection by the Board or its staff;
3. Ensure that the written policies and procedures include the following:
   a. Drug removal procedures that require:
      i. The long-term care facility's personnel receive a valid prescription order for each drug removed from the emergency drug supply unit,
      ii. The long-term care facility's personnel notify the provider pharmacy when a drug is removed from the emergency drug supply unit,
   b. Outdated drug replacement procedures, and
   c. Security and inspection procedures;
4. Exchange or restock the emergency drug supply unit weekly, or more often as necessary, to ensure the availability of an adequate supply of emergency drugs within the long-term care facility. Restocking of the emergency drug supply unit at the facility shall be completed by an Arizona licensed pharmacist employed by the provider pharmacy, or by an Arizona licensed intern, graduate intern, technician or technician trainee under the direct onsite supervision of an Arizona licensed pharmacist; and
5. Educate pharmacy and long-term care facility personnel in the storage and use of an emergency drug supply unit.

**E.** In addition to the requirements of subsections (A) through (D), an automated emergency drug supply unit may be used provided:
1. The pharmacy permittee or pharmacist-in-charge of the provider pharmacy notifies the Board or its staff in writing of the intent to use an automated emergency drug supply unit, including the name and type of unit;
2. The provider pharmacy is notified electronically when the automated emergency drug supply unit has been accessed;
3. All events involving the access of the automated emergency drug supply unit are recorded electronically and maintained for not less than two years;
4. The provider pharmacy is capable of producing a report of all transactions of the automated emergency drug supply unit including a single drug usage report as required in R4-23-408(B)(5) on inspection by the Board or its staff;
5. The provider pharmacy develops written policies and procedures for:
   a. Accessing the automated emergency drug supply unit in the event of a system malfunction or downtime,
   b. Authorizing and modifying user access,
   c. An ongoing quality assurance program that includes:
      i. Training in the use of the automated emergency drug supply unit for all authorized users,
      ii. Maintenance and calibration of the automated emergency drug supply unit as recommended by the device manufacturer; and
6. Documentation of the requirements of subsection (E)(5)(c)(ii) is maintained for inspection by the Board or its staff for not less than two years.

**F.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge of a provider pharmacy from using an automated emergency drug supply unit if the pharmacy permittee or pharmacy permittee's employees do not comply with the requirements of subsections (A) through (E).

**Historical Note**

Adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-701.03. Long-term Care Facilities Pharmacy Services: Emergency Drug Prescription Order**

The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that every emergency drug prescription order is evaluated according to the requirements of R4-23-402(A) by a pharmacist within 72 hours of the first dose of drug administered by long-term care facility personnel under the emergency drug prescription order.

**Historical Note**

Adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1).

**R4-23-701.04. Long-term Care Facilities Pharmacy Services: Automated Dispensing Systems**

**A.** Before using an automated dispensing system as defined in R4-23-110, a pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Notify the Board or its staff in writing of the intent to use an automated dispensing system, including the name and type of system;
2. Obtain a separate controlled substances registration at the location of each long-term care facility at which an automated dispensing system containing controlled substances will be located as required by federal law; and
3. Maintain copies of the registrations required under subsection (A)(2) at the provider pharmacy for inspection by the Board or its staff.

**B.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure:
1. Drugs contained in an automated dispensing system remain the property of the provider pharmacy,
2. Controlled substance drugs contained in an automated dispensing system are included in all inventories required under A.R.S. § 36-2523(B) and R4-23-1003(A),
3. Schedule II drugs are not stocked in an automated dispensing system, and
4. A separate emergency drug supply unit is available in the long-term care facility to meet the requirements of R4-23-701.02.

**C.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Ensure that policies and procedures as required in subsection (D) for the use of an automated dispensing system in a long-term care facility are prepared, implemented, and complied with;
2. Review biennially and, if necessary, revise the policies and procedures required under subsection (D);
3. Document the review required under subsection (C)(2);
4. Assemble the policies and procedures as a written or electronic manual; and
5. Make the policies and procedures available for employee reference and inspection by the Board or its staff within the pharmacy and at any location outside of the pharmacy where the automated dispensing system is used.

**D.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure the written policies and procedures include:
1. Drug removal procedures that include the following:
   a. A drug is provided only by a valid prescription order for an individual long-term care facility resident;
   b. A drug is dispensed from an automated dispensing system only after a pharmacist has:
      i. Reviewed and verified the resident's prescription order as required by R4-23-402(A), and
      ii. Electronically authorized the access for that drug for that particular resident, and
   c. The automated dispensing system labels each individual drug packet with a resident specific label that complies with R4-23-701.01(2) and contains the resident's room number or facility identification number; and
2. Security procedures that include the following:
   a. The pharmacy permittee or pharmacist-in-charge of the provider pharmacy is responsible for authorizing user access, including adding and removing users and modifying user access;
   b. Each authorized user is a licensee of the Board or authorized licensed personnel of the long-term care facility; and
   c. The automated dispensing system is secured at the long-term care facility by electronic or mechanical means or a combination thereof designed to prevent unauthorized access;
3. Drug stocking procedures that include the following:
   a. Automated dispensing systems that use non-removable containers that do not allow prepackaging of the container as set out in subsection (D)(3)(b):
      i. Are stocked at the long-term care facility by an Arizona licensed pharmacist employed by the provider pharmacy, or by an Arizona licensed intern, graduate intern, technician or technician trainee under the direct onsite supervision of an Arizona licensed pharmacist; and
      ii. Utilize bar code or other technologies to ensure the correct drug is placed in the correct canister or container; and
   b. Automated dispensing systems that use removable containers may be stocked at the long-term care facility by an authorized user provided:
      i. The prepackaging of the container occurs at the provider pharmacy;
      ii. A pharmacist verifies the container has been properly filled and labeled, and the container is secured with a tamper-evident seal;
      iii. The individual containers are transported to the long-term care facility in a secure, tamper-evident shipping container; and
      iv. The automated dispensing system uses microchip, bar-coding, or other technologies to ensure the containers are accurately loaded in the automated dispensing system; and
4. Recordkeeping and report procedures that include the following:
   a. All events involving the access of the automated dispensing system are recorded electronically and maintained for not less than two years;

b. The provider pharmacy is capable of producing a report of all transactions of the automated dispensing system including:
i. A single drug usage report that complies with R4-23-408(B)(5); and
ii. An authorized user history including date and time of access and type of transaction; and
c. The provider pharmacy has procedures to safeguard the storage, packaging, and distribution of drugs by monitoring:
i. Current inventory;
ii. Expiration dates;
iii. Controlled substance dispensing;
iv. Re-dispense requests; and
v. Wastage.

**E.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Ensure that an electronic log is kept for each container fill that includes:
a. An identification of the container by drug name and strength, and container number;
b. The drug's manufacturer or National Drug Code (NDC) number;
c. The expiration date and lot number from the manufacturer's stock bottle that is used to fill the container. If multiple lot numbers of the same drug are added to a container, each lot number and expiration date shall be documented;
d. The date the container is filled;
e. Documentation of the identity of the licensee who placed the drug into the container; and
f. If the licensee who filled the container is not a pharmacist, documentation of the identity of the pharmacist who supervised the non-pharmacist licensee; and
2. Maintain the electronic log for inspection by the Board or its staff for not less than two years.

**F.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Implement an ongoing quality assurance program that monitors performance of the automated dispensing system and compliance with the established policies and procedures that includes:
a. Training in the use of the automated dispensing system for all authorized users,
b. Maintenance and calibration of the automated dispensing system as recommended by the device manufacturer,
c. Routine accuracy validation testing no less than every three months, and
d. Downtime and malfunction procedures to ensure the timely provision of medication to the long-term care facility resident, and
2. Maintain documentation of the requirements of subsections (F)(1)(b) and (F)(1)(c) for inspection by the Board or its staff for not less than two years.

**G.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using an automated dispensing system in a long-term care facility if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A) through (F).

**Historical Note**
New Section made by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-702. Hospice Inpatient Facilities**

**A.** If a pharmacy permittee contracts to provide pharmacy services to the patients of a hospice inpatient facility as defined in R4-23-110, the pharmacy permittee shall ensure that:
1. A prescription medication is provided only by a valid prescription order for an individual hospice inpatient facility patient, properly labeled for that patient, as specified in this subsection. Nothing in this section shall prevent a provider pharmacy from supplying non-prescription drugs in a manufacturer's unopened container;
2. A prescription medication label for a hospice inpatient facility patient complies with A.R.S. §§ 32-1968 and 36-2525 and contains:
a. The drug name, strength, dosage form, and quantity; and
b. The beyond-use date; and
3. If the label on the hospice inpatient facility patient's drug container becomes damaged or soiled, a pharmacist employed by the pharmacy that dispensed the drug container, through the exercise of professional judgment, may relabel the drug container. Only a pharmacist is permitted to label a drug container or alter the label of a drug container.

**B.** A pharmacist may help hospice inpatient facility personnel develop written policies and procedures for the procurement, administration, storage, control, recordkeeping, and disposal of drugs in the facility.

**C.** The provider pharmacy may contract with the hospice inpatient facility to provide pharmacist services at the facility that include evaluation of the patient's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.

**D.** A provider pharmacy that places an emergency drug supply unit at a hospice inpatient facility shall comply with the requirements of R4-23-701.02.

**E.** A pharmacy shall not place an automated dispensing system as defined in R4-23-701.04 in a hospice inpatient facility.

**F.** Drugs previously dispensed to a patient of the hospice inpatient facility by another pharmacy, and drugs previously dispensed by the provider pharmacy, shall not be repackaged.

**Historical Note**
Former Rules 6.8210, 6.8211, 6.8212, 6.8213, 6.8214, 6.8221, 6.8222, 6.8223, 6.8824, 6.8231, 6.8232, 6.8233, 6.8241, 6.8242, and 6.8243; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective December 18, 1992 (Supp. 92-4). New Section made by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-703. Assisted Living Facilities**

**A.** Before dispensing, selling, or delivering a prescription or non-prescription drug to an assisted living facility resident, a pharmacy permittee shall verify the assisted living facility has a current and active license issued by the Arizona Department of Health Services.

**B.** A pharmacy permittee shall ensure that, except as provided under subsection (C):
1. A controlled substance prescription drug is dispensed, sold, or delivered to an assisted living facility resident only after receiving a valid prescription order for the controlled substance prescription drug from the resident's medical practitioner; and

2. The controlled substance prescription drug is labeled in accordance with A.R.S. §§ 32-1963.01, 32-1968, and 36-2525 and includes the beyond-use date on the label.

**C.** A pharmacy permittee may dispense, sell, or deliver to an assisted living facility resident a Schedule III, IV, or V controlled substance prescription if the pharmacy permittee:

1. Receives a written or oral prescription order for the Schedule III, IV, or V controlled substance from:
   a. The resident's medical practitioner,
   b. An individual licensed by the Arizona Board of Nursing who is acting within the scope of practice of the individual's license, or
   c. The manager or a caregiver of the assisted living facility if the resident's medical practitioner has a written agreement with the assisted living facility designating a representative of the assisted living facility as an agent of the medical practitioner and a licensed medical practitioner provided the prescription order;
2. Complies with subsection (D)(2); and
3. Labels the Schedule III, IV, or V controlled substance as specified under subsection (B)(2).

**D.** A pharmacy permittee may dispense, sell, or deliver to an assisted living facility resident a non-controlled substance prescription or non-prescription drug if the pharmacy permittee:

1. Receives a written or oral prescription order for the non-controlled substance prescription or non-prescription drug from:
   a. The resident's medical practitioner,
   b. An individual licensed by the Arizona Board of Nursing who is acting within the scope of practice of the individual's license, or
   c. An assisted living facility manager or caregiver acting under the authority of a licensed medical practitioner;
2. Determines the written or oral prescription order:
   a. Meets the requirements of R4-23-407, and
   b. Includes the name and title of the individual transmitting the prescription order; and
3. Labels the non-narcotic prescription or non-prescription drug in accordance with A.R.S. §§ 32-1963.01 and 32-1968 and includes the beyond-use date on the label.

**E.** If the label on an assisted living facility resident's drug container becomes damaged or soiled, a pharmacist employed by the pharmacy permittee that dispensed the drug container, through the exercise of professional judgment, may relabel the drug container. Only a pharmacist is permitted to label a drug container or alter the label of a drug container.

**F.** A pharmacist may help assisted living facility personnel develop written policies and procedures regarding procuring, administering, storing, controlling, keeping records, and disposing of drugs in the facility and provide information concerning safe and effective supervision of drug self-administration.

**G.** A pharmacy permittee shall not place an emergency drug supply unit as described in R4-23-701.02 or an automated dispensing system as described in R4-23-701.04 in an assisted living facility.

**H.** A pharmacist shall not repackage a drug previously dispensed to an assisted living facility resident.

**Historical Note**

Former Rules 6.8310, 6.8320, 6.8330, 6.8340, 6.8350, 6.8360, and 6.8370; Amended effective August 10, 1978 (Supp. 78-4). Amended by final rulemaking at 5 A.A.R. 2561, effective July 16, 1999 (Supp. 99-3). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2424, effective October 14, 2017 (Supp. 17-3).

**R4-23-704. Customized Patient Medication Packages**

In lieu of dispensing two or more prescribed drugs in separate containers, a pharmacist may, with the consent of the patient, the patient's caregiver, the prescriber, or the facility caring for the patient, provide a customized patient medication package. The pharmacist preparing a customized patient medication package shall abide by the guidelines set forth in the current edition of the official compendium for labeling, packaging, and recordkeeping, and state and federal law.

**Historical Note**

Former Rules 6.8410, 6.8411, 6.8412, 6.8413, 6.8414, 6.8415, 6.8416, and 6.8417. Section R4-23-704 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-705. Repealed**

**Historical Note**

Former Rules 6.8420, 6.8421, 6.8422, 6.8423, 6.8424, 6.8425, 6.8426, 6.8427, 6.8428, and 6.8429. Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 24, 1992 (Supp. 92-3). Repealed effective December 18, 1992 (Supp. 92-4).

**R4-23-706. Repealed**

**Historical Note**

Former Rules 6.8431, 6.8432, 6.8433, 6.8434, 6.8435, 6.8436, and 6.8437; Amended effective August 10, 1978 (Supp. 78-4). Amended subsections (C), (E), (F), and (G) effective April 20, 1982 (Supp. 82-2). Section R4-23-706 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**R4-23-707. Repealed**

**Historical Note**

Former Rules 6.8441, 6.8442, 6.8450, 6.8451, 6.8452, 6.8453, 6.8454, 6.8455, 6.8456, and 6.8457. Section R4-23-707 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**R4-23-708. Repealed**

**Historical Note**

Former Rules 6.8461, 6.8462, 6.8463, and 6.8464. Section R4-23-708 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**R4-23-709. Repealed**

**Historical Note**

Former Rules 6.8471, 6.8472, and 6.8473. Section R4-23-709 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

## ARTICLE 8. DRUG CLASSIFICATION

*Article 8, consisting of Sections R4-23-801 and R4-23-802, recodified from Article 5 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

**R4-23-801. Repealed**

**Historical Note**

Former Rules 7.1110, 7.1120, and 7.1130. Repealed effective November 4, 1998 (Supp. 98-4). Recodified from R4-23-501 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). Repealed by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-802. Veterinary**

Veterinary preparation: A veterinary drug manufacturer or supplier may distribute:

1. A prescription-only veterinary drug to:
   a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
   b. A full-service drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
   c. A pharmacy permitted under A.R.S. Title 32, Chapter 18, and
2. A nonprescription veterinary drug to:
   a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
   b. A nonprescription drug retailer permitted under A.R.S. Title 32, Chapter 18,
   c. A full-service or nonprescription drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
   d. A pharmacy permitted under A.R.S. Title 32, Chapter 18.

**Historical Note**

Former Rules 7.1210, 7.1220, and 7.1230. Repealed effective November 4, 1998 (Supp. 98-4). Recodified from R4-23-502 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

**R4-23-803. Repealed**

**Historical Note**

Former Rules 7.1300, 7.1400, 7.1500, and 7.1000. Repealed effective November 4, 1998 (Supp. 98-4).

**R4-23-804. Repealed**

**Historical Note**

Former Rules 7.2100, 7.2200, 7.2300, 7.2410, 7.2420, and 7.2430. Repealed effective November 4, 1998 (Supp. 98-4).

## ARTICLE 9. PENALTIES AND MISCELLANEOUS

**R4-23-901. Penalty for Violations**

Any person, firm, or corporation violating any provision of 4 A.A.C. 23 is subject to the penalties in A.R.S. § 32-1996. In addition, a license or permit issued under the provisions of A.R.S. Title 32, Chapter 18 is subject to suspension or revocation for violation of 4 A.A.C. 23.

**Historical Note**

Former Rule 9.0000. Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

**R4-23-902. Non-disciplinary Civil Penalties**

As authorized under A.R.S. § 32-1904(D), the Board may issue the following non-disciplinary civil penalties to a licensee or permittee who engages in the specified acts or omissions without posing an imminent threat to public health or safety:

1. Failing to submit a remodel application before remodeling a permitted facility: $250;
2. Failing to provide notice before a business is relocated: $500;
3. Failing to update contact information: $50/occurrence to a maximum of twice;
4. Failing to update change of employment information: $50/occurrence to a maximum of twice;
5. Failing to complete required continuing education:
   a. Registered pharmacist: $100/deficient hour of continuing education for the first occurrence, $150/deficient hour for second occurrence; and
   b. Pharmacy technician: $25/deficient hour of continuing education for the first occurrence, $37.50/deficient hour for second occurrence;
6. Failing to provide notice of a new pharmacist in charge: $100/occurrence to a maximum of twice;
7. Failing to provide notice of a new designated representative: $100/occurrence to a maximum of twice;
8. Failing to provide notice of a new criminal charge, arrest, or conviction in any jurisdiction: $250/occurrence to a maximum of twice;
9. Failing to provide notice of disciplinary action taken against the licensee or permittee by another jurisdiction: $250/occurrence to a maximum of twice;
10. Failing to renew a license timely and continuing to work with an expired license:
    a. Registered pharmacist: $100/day worked not to exceed $1,000; and
    b. Pharmacy technician: $50/day worked not to exceed $500;
11. Failing to conduct a controlled substance inventory when there is a new pharmacist in charge: $250/occurrence to a maximum of twice;
12. Failing to obtain a permit before shipping into Arizona anything for which a permit is required: $100/item shipped;
13. Failing to respond timely to a subpoena: $50;
14. Failing to provide notice before there is a change in ownership: $250; and
15. Failing to conduct required controlled substance inventories: $250.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

## ARTICLE 10. UNIFORM CONTROLLED SUBSTANCES AND DRUG OFFENSES

**R4-23-1001. Repealed**

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Section repealed by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

**R4-23-1002. Repealed**

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Repealed effective November 4, 1998 (Supp. 98-4).

**R4-23-1003. Records and Order Forms**

**A.** Records.

1. If the pharmacist-in-charge of a pharmacy is replaced by another pharmacist-in-charge, the new pharmacist-in-charge shall complete an inventory of all controlled substances in the pharmacy within 10 days of assuming the responsibility. This inventory and any other required controlled substance inventory shall:
   a. Include an exact count of all Schedule II controlled substances;

b. Include an exact count of all Schedule III through Schedule V controlled substances or an estimated count if the stock container contains fewer than 1001 units;
c. Indicate the date the inventory is taken and whether the inventory is taken before opening of business or after close of business for the pharmacy;
d. Be signed by:
i. The pharmacist-in-charge; or
ii. For other required inventories, the pharmacist who does the inventory;
e. Be kept separately from all other records; and
f. Be available in the pharmacy for inspection by the Board or its designee for not less than three years.

2. A loss of a controlled substance shall be reported:
a. Within 10 days of discovery;
b. On a DEA form 106;
c. By the pharmacist-in-charge of a pharmacy or a manufacturer;
d. By the permittee or designated representative of a full-service wholesaler; and
e. To the federal Drug Enforcement Administration (DEA), the Narcotic Division of the Department of Public Safety (DPS), and the Board of Pharmacy. A copy of the DEA form 106 shall be kept on file by the pharmacy permittee. The DEA form 106 shall state whether the police investigated the loss.

3. Every person manufacturing any controlled substance, including repackaging or relabeling, shall record and retain for not less than three years the manufacturing, repackaging, or relabeling date for each controlled substance.

4. Every person receiving, selling, delivering, or disposing of any controlled substance shall record and retain for not less than three years the following information:
a. The name, strength, dosage form, and quantity of each controlled substance received, sold, delivered, or disposed;
b. The name, address, and DEA registration number of the person from whom each controlled substance is received;
c. The name, address, and DEA registration number of the person to whom each controlled substance is sold or delivered or who disposes of each controlled substance; and
d. The date of each transaction.

5. A full-service drug wholesale permittee or the designated representative shall complete an inventory of all controlled substances in the manner prescribed in subsection (A)(1). The permittee or designated representative shall conduct this inventory:
a. On May 1 of each year or as directed by the Board; and
b. If there is a change of ownership, or discontinuance of business, or within 10 days of a change of a designated representative.

6. A drug manufacturer permittee or the pharmacist-in-charge shall complete an inventory of all controlled substances in the manner prescribed in subsection (A)(1). The permittee or pharmacist-in-charge shall conduct this inventory:
a. On May 1 of each year or as directed by the Board; and
b. If there is a change of ownership, or discontinuance of business, or within 10 days of a change of a pharmacist-in-charge.

**B.** Order form. For purposes of A.R.S. § 36-2524, "Order Form" means DEA Form 222c.

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

**R4-23-1004. Schedules of Controlled Substances**

As of the effective date of this Section and as required under A.R.S. §§ 36-2512 through 36-2516, the Board adopts the following schedules of controlled substances. The schedules adopted include no later amendments. The adopted schedules are available on the Board's website:

1. Schedule I. 21 CFR, Chapter II, Part 1308.11;
2. Schedule II. 21 CFR, Chapter II, Part 1308.12;
3. Schedule III. 21 CFR, Chapter II, Part 1308.13;
4. Schedule IV. 21 CFR, Chapter II, Part 1308.14; and
5. Schedule V. 21 CFR, Chapter II, Part 1308.15.

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Repealed effective November 4, 1998 (Supp. 98-4). New Section made by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1005. Products Excluded or Exempted from the Schedules of Controlled Substances**

The following lists of products are excluded or exempted from the schedules of controlled substances adopted in R4-23-1004. All lists are available on the Board's website and at https://www.ecfr.gov/current/title-21/chapter-II/part-1308:

1. Excluded nonnarcotic substances that may be lawfully sold over-the-counter without a prescription order. 21 CFR, Chapter II, Part 1308.22;
2. Exempted chemical preparations and mixtures. 21 CFR, Chapter II, Part 1308.24; and
3. Exempted prescription products containing a nonnarcotic controlled substance. 21 CFR, Chapter II, Part 1308.32.

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3). Amended by final rulemaking at 18 A.A.R. 2609, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1006. Substances Excepted from Drug Offenses**

The following materials, compounds, mixtures, or preparations containing any stimulant or depressant substance included in A.R.S. §§ 13-3401(6)(b) or 13-3401(6)(c) are excepted from the definition of dangerous drugs under the authority of A.R.S. § 32-1904(B)(14):

1. Over-the-counter drugs excepted in R4-23-1005(A).
2. Chemical preparations excepted in R4-23-1005(B).
3. Prescription-only drugs excepted in R4-23-1005(C).

**Historical Note**
Adopted effective August 2, 1982 (Supp. 82-4).
Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

## ARTICLE 11. PHARMACY TECHNICIANS; PHARMACY TECHNICIAN TRAINEES

*Article 11, consisting of R4-23-1101 through R4-23-1105, made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).*

### R4-23-1101. Repealed

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Repealed by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

### R4-23-1102. Pharmacy Technician Licensure

**A.** License required. A person shall not work as a pharmacy technician in Arizona unless the person possesses a license issued by the Board. A licensed pharmacy technician shall maintain the certificate of licensure, which is in good standing, at the practice site for inspection by the Board or its designee or review by the public. A license issued by the Board is not transferable.

**B.** Eligibility. An applicant for licensure as a pharmacy technician, as defined at A.R.S. § 32-1901, shall provide the Board proof the applicant is eligible under A.R.S. § 32-1923.01(A), including documentation the applicant:
1. Passed a Board-approved pharmacy technician examination;
2. Passed the Foreign Pharmacy Graduate Equivalency Examination, if applicable; or
3. Graduated from a Board-approved pharmacy school.

**C.** Application.
1. An applicant for licensure as a pharmacy technician shall:
   a. Submit a completed application electronically or manually on a form furnished by the Board, and
   b. Submit with the application form:
      i. The documents specified in the application form,
      ii. The initial licensure fee specified in R4-23-205, and
      iii. The wall license fee specified in R4-23-205.
2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.

**D.** Licensure.
1. If an applicant is found to be ineligible for pharmacy technician licensure under statute and rule, the Board office shall issue a written notice of denial to the applicant.
2. If an applicant is found to be eligible for pharmacy technician licensure under statute and rule, the Board office shall issue a certificate of licensure and a wall license. An applicant who is assigned a license number and granted "open" or "active" status on the Board's license verification site may begin practice as a pharmacy technician. An applicant shall not practice as a pharmacy technician if the Board's license verification site indicates any status other than "open" or "active."

**E.** License renewal.
1. To renew a license, a pharmacy technician shall submit a completed license renewal application electronically or manually on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1925, the pharmacy technician license is suspended and the licensee shall not practice as a pharmacy technician. The licensee shall pay a reinstatement penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.
3. Continuing education requirement. Under A.R.S. § 32-1925(H), continuing professional education is mandatory for a licensee.
   a. The Board shall accept continuing education hours awarded only by an approved provider.
   b. The Board shall not renew a pharmacy technician license unless the licensee successfully completes 20 continuing education hours during the two years since the licensee's last renewal date and attests to that on the biennial renewal form.
   c. Special continuing education requirements. If applicable, during each two-year license period, a pharmacy technician:
      i. Shall not administer a vaccine under R4-23-1104(B)(5) unless the pharmacy technician has successfully completed two continuing education hours relating to administration of vaccines; and
      ii. As described under A.R.S. § 32-1925(H), shall successfully complete two continuing education hours regarding remote dispensing site pharmacy practices.
   d. A pharmacy technician licensee is exempt from the continuing education requirement in subsection (E)(3)(b) between the time of initial licensure and first renewal.
   e. A pharmacy technician licensee shall maintain for five years continuing education records that indicate the number of hours successfully completed and the approved provider of each continuing education. The pharmacy technician licensee shall make the records available to the Board on request.
   f. The Board shall deem failure to comply with the continuing education requirements as unprofessional conduct and grounds for disciplinary action under A.R.S. § 32-1927.01.
   g. A pharmacy technician who is aggrieved by a Board decision concerning continuing education may request a hearing before the Board.

**F.** Delinquent license for five or more consecutive years. The Board shall reinstate a delinquent Arizona pharmacy technician license only if the individual furnishes satisfactory proof of fitness to be licensed as a pharmacy technician and pays all fees for the two most recent renewal periods and penalty fees. Satisfactory proof includes:
1. For an individual who is practicing as a pharmacy technician out-of-state with a pharmacy technician license issued by another jurisdiction:
   a. Proof of current, unrestricted pharmacy technician licensure in another jurisdiction; and
   b. Proof of employment as a pharmacy technician during the last 12 months; or
2. For an individual who did not practice as a pharmacy technician within the last 12 months:

a. Take and pass a Board-approved pharmacy technician examination, and
b. Complete 20 continuing education hours.

**G.** Time frames for pharmacy technician licensure and license renewal. The Board office shall follow the time frames established in R4-23-202(F).

**H.** Verification of license. A pharmacy permittee or pharmacist-in-charge shall not allow a person to practice as a pharmacy technician until the pharmacy permittee or pharmacist-in-charge verifies the person is currently licensed by the Board as a pharmacy technician.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1103. Pharmacy Technician Trainee Registration**

**A.** Registration required. As indicated under A.R.S. § 32-1923.01, a person shall not work as a pharmacy technician trainee in Arizona unless the person has registered with the Board. A registered pharmacy technician trainee shall maintain the registration certificate at the practice site for inspection by the Board or its designee or review by the public. Registration as a pharmacy technician trainee is not transferable.

**B.** Eligibility. An applicant for a 36-month, non-renewable registration as a pharmacy technician trainee shall provide the Board proof the applicant is eligible under A.R.S. § 32-1923.01(B).

**C.** Application.
1. An applicant for a 36-month, non-renewable registration as a pharmacy technician trainee shall:
   a. Submit a completed application electronically on a form available on the Board's website, and
   b. Submit with the application form:
      i. The documents specified in the application form, and
      ii. The registration fee specified in R4-23-205.
2. The Board office shall deem an application form received on the date the Board office electronically date-stamps the form.

**D.** Registration.
1. If an applicant is found to be ineligible for registration as a pharmacy technician trainee under statute and rule, the Board office shall issue a written notice of denial to the applicant.
2. If an applicant is found to be eligible for registration as a pharmacy technician trainee under statute and rule, the Board office shall issue a certificate of registration. An applicant who is assigned a registration number and granted "open" or "active" status on the Board's website may begin practice as a pharmacy technician trainee. An applicant shall not practice as a pharmacy technician trainee if the Board's website indicates any status other than "open" or "active."

**E.** Time frames for pharmacy technician trainee registration. The Board office shall follow the time frames established in R4-23-202(F).

**F.** Verification of registration. A pharmacy permittee or pharmacist-in-charge shall not allow a person to practice as a pharmacy technician trainee until the pharmacy permittee or pharmacist-in-charge verifies that the person is currently registered by the Board as a pharmacy technician trainee.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1104. Pharmacy Technicians and Pharmacy Technician Trainees**

**A.** Permissible tasks of a pharmacy technician trainee. Acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, a pharmacy technician trainee registered under R4-23-1103 may assist an intern or pharmacist with the following when applicable to the pharmacy practice site:
1. Record on the original prescription order the serial number of the prescription medication and date dispensed;
2. Initiate or accept verbal or electronic refill authorization from a medical practitioner or medical practitioner's agent and record, on the original prescription order or by an alternative method approved by the Board or its designee, the medical practitioner's name, patient name, name and quantity of prescription medication, specific refill information, and name of medical practitioner's agent, if any;
3. Record information in the refill record or patient profile;
4. Enter information for a new or refill prescription medication as required under A.R.S. § 32-1964;
5. Type and affix a label for the prescription medication. A pharmacist or intern working under the supervision of a pharmacist shall verify the accuracy of the label as described under R4-23-402(A)(11);
6. Reconstitute a prescription medication, if a pharmacist checks the ingredients and procedure before reconstitution and verifies the final product after reconstitution;
7. Retrieve, count, or pour a prescription medication, if a pharmacist verifies the contents of the prescription medication against the original prescription medication container or by an alternative drug identification method approved by the Board or its designee;
8. Prepackage drugs in accordance with R4-23-402(A); and
9. Measure, count, pour, or otherwise prepare and package a drug needed for hospital inpatient dispensing, if a pharmacist verifies the accuracy, measuring, counting, pouring, preparing, packaging, and safety of the drug before the drug is delivered to a patient care area.

**B.** Permissible tasks of a pharmacy technician. Acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, a pharmacy technician licensed under R4-23-1102 may:
1. Perform the tasks listed in subsection (A);
2. After completing a pharmacy technician drug compounding training program developed by the pharmacy permittee or pharmacist-in-charge under R4-23-1105(C), assist a pharmacist or intern in compounding prescription medi-

cations and sterile or non-sterile pharmaceuticals in accordance with written policies and procedures, if the preparation, accuracy, and safety of the final product is verified by a pharmacist before dispensing;

3. Administer a vaccine when:
   a. Administration of the vaccine is done under an order that complies with A.R.S. § 32-1974 and R4-23-411;
   b. Administration of the vaccine is delegated by and done under the supervision of a pharmacist on duty who is certified under A.R.S. § 32-1974 to administer vaccines; and
   c. There is documentation by the permittee that the pharmacy technician has completed the following:
      i. A practical training program that is approved by the Accreditation Council for Pharmacy Education and includes hands-on injection technique and recognition and treatment of emergency reactions to vaccines; and
      ii. Current certification in basic cardiopulmonary resuscitation.
4. Perform a task not related to professional judgment if the task is delegated to the pharmacy technician by the pharmacist on duty after the pharmacist on duty ensures the pharmacy technician is trained to do the task and there is documentation by the permittee of the training; and
5. A pharmacist on duty shall not delegate or attempt to delegate the following tasks to a pharmacy technician:
   a. Administering an emergency medication,
   b. Counseling a patient,
   c. Conducting a drug utilization review,
   d. Performing any task that requires the exercise of clinical judgment,
   e. Issuing a prescription order,
   f. Receiving a new prescription order for a controlled substance, or
   g. Transferring by telephone an existing prescription order for a controlled substance.

**C.** Prohibited activities. A pharmacy technician or pharmacy technician trainee shall not perform a professional practice reserved for a pharmacist or intern in accordance with R4-23-402 or R4-23-653 unless otherwise allowed by rule.

**D.** A pharmacy technician or pharmacy technician trainee shall wear a badge indicating name and title while on duty.

**E.** Before employing a pharmacy technician or pharmacy technician trainee, a pharmacy permittee or pharmacist-in-charge shall develop, implement, review, revise, and enforce, in the manner described in R4-23-653(A), policies and procedures addressing tasks to be performed by the pharmacy technician or pharmacy technician trainee that are consistent with state and federal law and the site at which the pharmacy technician or pharmacy technician trainee will be employed.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 23 A.A.R. 3257, effective January 8, 2018 (Supp. 17-4). Amended by final rulemaking at 28 A.A.R. 994 (May 13, 2022), effective July 2, 2022 (Supp. 22-2). Section made by emergency rulemaking at 29 A.A.R. 1196 (May 26, 2023), with an immediate effective date of May 4, 2023; effective for 180 days (Supp. 23-2). Amended by final rulemaking at 29 A.A.R. 2191 (September 22, 2023), with an immediate effective date of September 6, 2023 (Supp. 23-3). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1104.01 Repealed**

**Historical Note**

New Section made by final rulemaking at 23 A.A.R. 3257, effective January 8, 2018 (Supp. 17-4). Repealed by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1105. Pharmacy Technician Trainee Training Program; Pharmacy Technician Drug Compounding Training Program**

**A.** Nothing in this Section prevents additional offsite training of a pharmacy technician.

**B.** Pharmacy technician trainee training program. A pharmacy permittee or pharmacist-in-charge shall develop, implement, review, revise, and enforce, in the manner described in R4-23-653(A), a pharmacy technician trainee training program that is based on the needs of the individual pharmacy and designed to prepare the pharmacy technician trainee to pass a Board-approved national certification examination.

**C.** Pharmacy technician drug compounding training program.
1. A pharmacy permittee or pharmacist-in-charge shall develop, implement, review, revise, and enforce, in the manner described in R4-23-653(A), a pharmacy technician drug compounding training program based on the needs of the individual pharmacy.
2. A pharmacist-in-charge shall:
   a. Document the date a pharmacy technician successfully completed the pharmacy technician drug compounding training program, and
   b. Maintain the required documentation for inspection by the Board or its designee.

**D.** A pharmacy technician shall perform only those tasks, listed in R4-23-1104(B), for which training and competency has been demonstrated.

**E.** If a pharmacy technician trainee leaves a training program described under subsection (B) before successfully completing the training program, the pharmacist-in-charge shall provide the pharmacy technician trainee with written documentation of the hours of training completed and the tasks for which competence was demonstrated.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1106. Repealed**

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Section made by emergency rulemaking at 29 A.A.R. 1196 (May 26, 2023), with an

immediate effective date of May 4, 2023; effective for 180 days (Supp. 23-2). Amended by final rulemaking at 29 A.A.R. 2191 (September 22, 2023), with an immediate effective date of September 6, 2023 (Supp. 23-3). Repealed by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

## ARTICLE 12. DONATED MEDICINE PROGRAM

**R4-23-1201. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1202. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1203. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1204. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1205. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1206. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1207. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1208. Handling Fee**

**A.** The definitions at A.R.S. § 32-1909(U) apply to this Section.

**B.** As specified under A.R.S. § 32-1909(N), an authorized recipient shall not sell a medicine received from a donor.

**C.** An authorized recipient may charge a fee to an eligible patient to whom a donated medicine is dispensed. The authorized recipient shall ensure any fee charged to an eligible patient:
1. Does not exceed the reasonable cost of receiving, handling, and dispensing the donated medicine; and
2. Is consistent with the purpose of the donated medicine program. A fee consistent with the purpose of the donated medicine program includes an adjustment for the quantity and retail cost of the medicine dispensed.

**D.** An authorized recipient may charge a fee to a donor or other authorized recipient for usual and customary expenses incurred in receiving and handling donated medicine.

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1209. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1210. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1211. Repealed**

**Historical Note**
New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

## 32-1901. Definitions

In this chapter, unless the context otherwise requires:

1. "Administer" means directly applying a controlled substance, prescription-only drug, dangerous drug or narcotic drug, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by a practitioner or by the practitioner's authorized agent or the patient or research subject at the direction of the practitioner.

2. "Advertisement" means all representations that are disseminated in any manner or by any means other than by labeling for the purpose of inducing, or that are likely to induce, directly or indirectly, the purchase of drugs, devices, poisons or hazardous substances.

3. "Advisory letter" means a nondisciplinary letter to notify a licensee or permittee that either:

(a) While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee or permittee.

(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

(c) While the licensee or permittee has demonstrated substantial compliance through rehabilitation, remediation or reeducation that has mitigated the need for disciplinary action, the board believes that repeating the activities that led to the investigation may result in further board action against the licensee or permittee.

4. "Antiseptic", if a drug is represented as such on its label, means a representation that it is a germicide, except in the case of a drug purporting to be, or represented as, an antiseptic for inhibitory use as a wet dressing, ointment or dusting powder or other use that involves prolonged contact with the body.

5. "Authorized officers of the law" means legally empowered peace officers, compliance officers of the board of pharmacy and agents of the division of narcotics enforcement and criminal intelligence of the department of public safety.

6. "Automated prescription-dispensing kiosk" means a mechanical system that is operated as an extension of a pharmacy, that maintains all transaction information within the pharmacy operating system, that is separately permitted from the pharmacy and that performs operations that either:

(a) Accept a prescription or refill order, store prepackaged or repackaged medications, label and dispense patient-specific prescriptions and provide counseling on new or refilled prescriptions.

(b) Dispense or deliver a prescription or refill that has been prepared by or on behalf of the pharmacy that oversees the automated prescription-dispensing kiosk.

7. "Board" or "board of pharmacy" means the Arizona state board of pharmacy.

8. "Certificate of composition" means a list of a product's ingredients.

9. "Certificate of free sale" means a document that authenticates a product that is generally and freely sold in domestic or international channels of trade.

10. "Color additive" means a material that either:

(a) Is any dye, pigment or other substance that is made by a process of synthesis or similar artifice or that is extracted, isolated or otherwise derived, with or without intermediate or final change of identity, from any vegetable, animal, mineral or other source.

(b) If added or applied to a drug, or to the human body or any part of the human body, is capable of imparting color, except that color additive does not include any material that has been or may be exempted under the federal act. Color includes black, white and intermediate grays.

11. "Compounding" means preparing, mixing, assembling, packaging or labeling a drug by a pharmacist or an intern or pharmacy technician under the pharmacist's supervision, for the purpose of dispensing to a patient based on a valid prescription order. Compounding includes preparing drugs in anticipation of prescription orders prepared on routine, regularly observed prescribing patterns and preparing drugs as an incident to research, teaching or chemical analysis or for administration by a medical practitioner to the medical practitioner's patient and not for sale or dispensing. Compounding does not include preparing commercially available products from bulk compounds or preparing drugs for sale to pharmacies, practitioners or entities for the purpose of dispensing or distribution.

12. "Compressed medical gas distributor" means a person that holds a current permit issued by the board to distribute compressed medical gases to compressed medical gas suppliers and other entities that are registered, licensed or permitted to use, administer or distribute compressed medical gases.

13. "Compressed medical gases" means gases and liquid oxygen that a compressed medical gas distributor or manufacturer has labeled in compliance with federal law.

14. "Compressed medical gas order" means an order for compressed medical gases that is issued by a medical practitioner.

15. "Compressed medical gas supplier" means a person that holds a current permit issued by the board to supply compressed medical gases pursuant to a compressed medical gas order and only to the consumer or the patient.

16. "Controlled substance" means a drug, substance or immediate precursor that is identified, defined or listed in title 36, chapter 27, article 2 or the rules adopted pursuant to title 36, chapter 27, article 2.

17. "Corrosive" means any substance that when it comes in contact with living tissue will cause destruction of the tissue by chemical action.

18. "Counterfeit drug" means a drug that, or the container or labeling of which, without authorization, bears the trademark, trade name or other identifying mark, imprint, number or device, or any likeness of these, of a manufacturer, distributor or dispenser other than the person that in fact manufactured, distributed or dispensed that drug.

19. "Dangerous drug" has the same meaning prescribed in section 13-3401.

20. "Day" means a business day.

21. "Decree of censure" means an official action that is taken by the board and that may include a requirement for restitution of fees to a patient or consumer.

22. "Deliver" or "delivery" means the actual, constructive or attempted transfer from one person to another whether or not there is an agency relationship.

23. "Deputy director" means a pharmacist who is employed by the board and selected by the executive director to perform duties as prescribed by the executive director.

24. "Device", except as used in paragraph 18 of this section, section 32-1965, paragraph 4 and section 32-1967, subsection A, paragraph 15 and subsection C, means an instrument, apparatus or contrivance, including its components, parts and accessories, including all such items under the federal act, that is intended either:

(a) For use in diagnosing, curing, mitigating, treating or preventing disease in the human body or other animals.

(b) To affect the structure or any function of the human body or other animals.

25. "Director" means the director of the division of narcotics enforcement and criminal investigation of the department of public safety.

26. "Direct supervision of a pharmacist" means that the pharmacist is present. If relating to the sale of certain items, direct supervision of a pharmacist means that a pharmacist determines the legitimacy or advisability of a proposed purchase of those items.

27. "Dispense" means to deliver to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including prescribing, administering, packaging, labeling or compounding as necessary to prepare for that delivery.

28. "Dispenser" means a practitioner who dispenses.

29. "Distribute" means to deliver, other than by administering or dispensing.

30. "Distributor" means a person who distributes.

31. "Drug" means:

(a) Articles that are recognized, or for which standards or specifications are prescribed, in the official compendium.

(b) Articles that are intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in the human body or other animals.

(c) Articles other than food that are intended to affect the structure or any function of the human body or other animals.

(d) Articles that are intended for use as a component of any articles specified in subdivision (a), (b) or (c) of this paragraph but does not include devices or their components, parts or accessories.

32. "Drug enforcement administration" means the drug enforcement administration of the United States department of justice or its successor agency.

33. "Drug or device manufacturing" means producing, preparing, propagating or processing a drug or device, either directly or indirectly, by extraction from substances of natural origin or independently by means of chemical synthesis and includes any packaging or repackaging of substances or labeling or relabeling of its container and promoting and marketing the same. Drug or device manufacturing does not include compounding.

34. "Durable medical equipment" means technologically sophisticated medical equipment as prescribed by the board in rule that a patient or consumer may use in a home or residence and that may be a prescription-only device.

35. "Durable medical equipment distributor":

(a) Means a person that stores or distributes durable medical equipment other than to the patient or consumer.

(b) Includes a virtual durable medical equipment distributor as prescribed in rule by the board.

36. "Durable medical equipment supplier":

(a) Means a person that sells, leases or supplies durable medical equipment to the patient or consumer.

(b) Includes a virtual durable medical equipment supplier as prescribed in rule by the board.

37. "Economic poison" means any substance that alone, in chemical combination with or in formulation with one or more other substances is a pesticide within the meaning of the laws of this state or the federal insecticide, fungicide and rodenticide act and that is used in producing, storing or transporting raw agricultural commodities.

38. "Enteral feeding" means nourishment that is provided by means of a tube inserted into the stomach or intestine.

39. "Established name", with respect to a drug or ingredient of a drug, means any of the following:

(a) The applicable official name.

(b) If there is no such name and the drug or ingredient is an article recognized in an official compendium, the official title in an official compendium.

(c) If neither subdivision (a) nor (b) of this paragraph applies, the common or usual name of the drug.

40. "Executive director" means the executive director of the board of pharmacy.

41. "Federal act" means the federal laws and regulations that pertain to drugs, devices, poisons and hazardous substances and that are official at the time any drug, device, poison or hazardous substance is affected by this chapter.

42. "Full-service wholesale permittee":

(a) Means a permittee who may distribute prescription-only drugs and devices, controlled substances and over-the-counter drugs and devices to pharmacies or other legal outlets from a place devoted in whole or in part to wholesaling these items.

(b) Includes a virtual wholesaler as defined in rule by the board.

43. "Good manufacturing practice" means a system for ensuring that products are consistently produced and controlled according to quality standards and covering all aspects of design, monitoring and control of manufacturing processes and facilities to ensure that products do not pose any risk to the consumer or public.

44. "Highly toxic" means any substance that falls within any of the following categories:

(a) Produces death within fourteen days in half or more than half of a group of ten or more laboratory white rats each weighing between two hundred and three hundred grams, at a single dose of fifty milligrams or less per kilogram of body weight, when orally administered.

(b) Produces death within fourteen days in half or more than half of a group of ten or more laboratory white rats each weighing between two hundred and three hundred grams, if inhaled continuously for a period of one hour or less at an atmospheric concentration of two hundred parts per million by volume or less of gas or vapor or two milligrams per liter by volume or less of mist or dust, provided the concentration is likely to be encountered by humans if the substance is used in any reasonably foreseeable manner.

(c) Produces death within fourteen days in half or more than half of a group of ten or more rabbits tested in a dosage of two hundred milligrams or less per kilogram of body weight, if administered by continuous contact with the bare skin for twenty-four hours or less. If the board finds that available data on human experience with any substance indicate results different from those obtained on animals in the dosages or concentrations prescribed in this paragraph, the human data shall take precedence.

45. "Hospital" means any institution for the care and treatment of the sick and injured that is approved and licensed as a hospital by the department of health services.

46. "Intern" means a pharmacy intern.

47. "Internship" means the practical, experiential, hands-on training of a pharmacy intern under the supervision of a preceptor.

48. "Irritant" means any substance, other than a corrosive, that on immediate, prolonged or repeated contact with normal living tissue will induce a local inflammatory reaction.

49. "Jurisprudence examination" means a board-approved pharmacy law examination that is written and administered in cooperation with the national association of boards of pharmacy or another board-approved pharmacy law examination.

50. "Label" means a display of written, printed or graphic matter on the immediate container of any article that, unless easily legible through the outside wrapper or container, also appears on the outside wrapper or container of the article's retail package. For the purposes of this paragraph, the immediate container does not include package liners.

51. "Labeling" means all labels and other written, printed or graphic matter that either:

(a) Is on any article or any of its containers or wrappers.

(b) Accompanies that article.

52. "Letter of reprimand" means a disciplinary letter that is a public document issued by the board and that informs a licensee or permittee that the licensee's or permittee's conduct violates state or federal law and may require the board to monitor the licensee or permittee.

53. "Limited service pharmacy" means a pharmacy that is approved by the board to practice a limited segment of pharmacy as indicated by the permit issued by the board.

54. "Manufacture" or "manufacturer":

(a) Means every person who prepares, derives, produces, compounds, processes, packages or repackages or labels any drug in a place, other than a pharmacy, that is devoted to manufacturing the drug.

(b) Includes a virtual manufacturer.

55. "Marijuana" has the same meaning prescribed in section 13-3401.

56. "Medical practitioner" means any medical doctor, doctor of osteopathic medicine, dentist, podiatrist, veterinarian or other person who is licensed and authorized by law to use and prescribe drugs and devices to treat sick and injured human beings or animals or to diagnose or prevent sickness in human beings or animals in this state or any state, territory or district of the United States.

57. "Medication order" means a written or verbal order from a medical practitioner or that person's authorized agent to administer a drug or device.

58. "Narcotic drug" has the same meaning prescribed in section 13-3401.

59. "New drug" means either:

(a) Any drug of which the composition is such that the drug is not generally recognized among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs as safe and effective for use under the conditions prescribed, recommended or suggested in the labeling.

(b) Any drug of which the composition is such that the drug, as a result of investigations to determine its safety and effectiveness for use under such conditions, has become so recognized, but that has not, other than in the investigations, been used to a material extent or for a material time under those conditions.

60. "Nonprescription drug" or "over-the-counter drug" means any nonnarcotic medicine or drug that may be sold without a prescription and that is prepackaged and labeled for use by the consumer in accordance with the requirements of the laws of this state and federal law. Nonprescription drug does not include:

(a) A drug that is primarily advertised and promoted professionally to medical practitioners and pharmacists by manufacturers or primary distributors.

(b) A controlled substance.

(c) A drug that is required to bear a label that states "Rx only".

(d) A drug that is intended for human use by hypodermic injection.

61. "Nonprescription drug wholesale permittee":

(a) Means a permittee who may distribute only over-the-counter drugs and devices to pharmacies or other lawful outlets from a place devoted in whole or in part to wholesaling these items.

(b) Includes a virtual wholesaler as defined in rule by the board.

62. "Notice" means personal service or the mailing of a copy of the notice by certified mail and email addressed either to the person at the person's latest address of record in the board office or to the person and the person's attorney using the most recent information provided to the board in the board's licensing database.

63. "Nutritional supplementation" means vitamins, minerals and caloric supplementation. Nutritional supplementation does not include medication or drugs.

64. "Official compendium" means the latest revision of the United States pharmacopeia and the national formulary or any current supplement.

65. "Other jurisdiction" means one of the other forty-nine states, the District of Columbia, the Commonwealth of Puerto Rico or a territory of the United States of America.

66. "Package" means a receptacle that is defined or described in the United States pharmacopeia and the national formulary as adopted by the board.

67. "Packaging" means the act or process of placing a drug item or device in a container for the purpose or intent of dispensing or distributing the item or device to another.

68. "Parenteral nutrition" means intravenous feeding that provides an individual with fluids and essential nutrients the individual needs while the individual is unable to receive adequate fluids or feedings by mouth or by enteral feeding.

69. "Person" means an individual, partnership, corporation and association, and their duly authorized agents.

70. "Pharmaceutical care" means the provision of drug therapy and other pharmaceutical patient care services.

71. "Pharmacist" means an individual who is currently licensed by the board to practice the profession of pharmacy in this state.

72. "Pharmacist in charge" means the pharmacist who is responsible to the board for a licensed establishment's compliance with the laws and administrative rules of this state and of the federal government pertaining to the practice of pharmacy, the manufacturing of drugs and the distribution of drugs and devices.

73. "Pharmacist licensure examination" means a board-approved examination that is written and administered in cooperation with the national association of boards of pharmacy or any other board-approved pharmacist licensure examination.

74. "Pharmacy" means:

(a) Any place where drugs, devices, poisons or related hazardous substances are offered for sale at retail or where prescription orders are dispensed by a licensed pharmacist.

(b) Any place that displays on or in the place or that displays a sign on the place the words "pharmaceutical chemist", "apothecary", "druggist", "pharmacy", "drugstore", "drugs" or "drug sundries", any combination of these words, or any words of similar meaning in any language.

(c) Any place where the characteristic symbol of pharmacy or the characteristic prescription sign "Rx" is exhibited.

(d) Any building or other structure or portion of a building or other structure that is leased, used or controlled by a permittee to conduct the business authorized by the board at the address specified on the permit issued to the permittee.

(e) A remote dispensing site pharmacy.

(f) A remote hospital-site pharmacy.

(g) A satellite pharmacy.

75. "Pharmacy intern" means a person who has all of the qualifications and experience prescribed in section 32-1923.

76. "Pharmacy technician" means a person who is licensed pursuant to this chapter.

77. "Pharmacy technician trainee" means a person who is licensed pursuant to this chapter.

78. "Poison" or "hazardous substance" includes any of the following if intended and suitable for household use or use by children:

(a) Any substance that, according to standard works on medicine, pharmacology, pharmacognosy or toxicology, if applied to, introduced into or developed within the body in relatively small quantities by its inherent action uniformly produces serious bodily injury, disease or death.

(b) A toxic substance.

(c) A highly toxic substance.

(d) A corrosive substance.

(e) An irritant.

(f) A strong sensitizer.

(g) A mixture of any of the substances described in this paragraph, if the substance or mixture of substances may cause substantial personal injury or substantial illness during or as a proximate result of any customary or reasonably foreseeable handling or use, including reasonably foreseeable ingestion by children.

(h) A substance that is designated by the board to be a poison or hazardous substance. This subdivision does not apply to radioactive substances, economic poisons subject to the federal insecticide, fungicide and rodenticide act or the state pesticide act, foods, drugs and cosmetics subject to state laws or the federal act or substances intended for use as fuels when stored in containers and used in the heating, cooking or refrigeration system of a house. This subdivision applies to any substance or article that is not itself an economic poison within the meaning of the federal insecticide, fungicide and rodenticide act or the state pesticide act, but that is a poison or hazardous substance within the meaning of this paragraph by reason of bearing or containing an economic poison or hazardous substance.

79. "Practice of pharmacy":

(a) Means furnishing the following health care services as a medical professional:

(i) Interpreting, evaluating and dispensing prescription orders in the patient's best interests.

(ii) Compounding drugs pursuant to or in anticipation of a prescription order.

(iii) Labeling drugs and devices in compliance with state and federal requirements.

(iv) Participating in drug selection and drug utilization reviews, drug administration, drug or drug-related research and drug therapy monitoring or management.

(v) Providing patient counseling necessary to provide pharmaceutical care.

(vi) Properly and safely storing drugs and devices in anticipation of dispensing.

(vii) Maintaining required records of drugs and devices.

(viii) Offering or performing acts, services, operations or transactions that are necessary to conduct, operate, manage and control a pharmacy.

(ix) Providing patient care services pursuant to a collaborative practice agreement with a provider as outlined in section 32-1970.

(x) Initiating and administering immunizations or vaccines pursuant to section 32-1974.

(b) Does not include initiating a prescription order for any medication, drug or other substance used to induce or cause a medication abortion as defined in section 36-2151.

80. "Practitioner" means any physician, dentist, veterinarian, scientific investigator or other person who is licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of professional practice or research in this state, or any pharmacy, hospital or other institution that is licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of professional practice or research in this state.

81. "Preceptor" means a pharmacist who is serving as the practical instructor of an intern and who complies with section 32-1923.

82. "Precursor chemical" means a substance that is:

(a) The principal compound that is commonly used or that is produced primarily for use and that is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail or limit manufacture.

(b) Listed in section 13-3401, paragraph 26 or 27.

83. "Prescription" means either a prescription order or a prescription medication.

84. "Prescription medication" means any drug, including label and container according to context, that is dispensed pursuant to a prescription order.

85. "Prescription-only device" includes:

(a) Any device that is limited by the federal act to use under the supervision of a medical practitioner.

(b) Any device required by the federal act to bear on its label essentially the legend "Rx only".

86. "Prescription-only drug" does not include a controlled substance but does include:

(a) Any drug that because of its toxicity or other potentiality for harmful effect, the method of its use, or the collateral measures necessary to its use is not generally recognized among experts, qualified by scientific training and experience to evaluate its safety and efficacy, as safe for use except by or under the supervision of a medical practitioner.

(b) Any drug that is limited by an approved new drug application under the federal act or section 32-1962 to use under the supervision of a medical practitioner.

(c) Every potentially harmful drug, the labeling of which does not bear or contain full and adequate directions for use by the consumer.

(d) Any drug, other than a controlled substance, that is required by the federal act to bear on its label the legend "Rx only".

87. "Prescription order" means any of the following:

(a) An order to a pharmacist for drugs or devices that is issued and signed by a duly licensed medical practitioner in the authorized course of the practitioner's professional practice.

(b) An order that is transmitted to a pharmacist through word of mouth, telephone or other means of communication directed by that medical practitioner. Prescription orders received by word of mouth, telephone or other means of communication shall be maintained by the pharmacist pursuant to section 32-1964, and the record so made by the pharmacist constitutes the original prescription order to be dispensed by the pharmacist. This paragraph does not alter or affect laws of this state or any federal act requiring a written prescription order.

(c) An order that is initiated by a pharmacist pursuant to a collaborative practice agreement with a provider as outlined in section 32-1970, or immunizations or vaccines administered by a pharmacist pursuant to section 32-1974.

(d) A diet order or an order for enteral feeding, nutritional supplementation or parenteral nutrition that is initiated by a registered dietitian or other qualified nutrition professional in a hospital pursuant to section 36-416.

88. "Professionally incompetent" means:

(a) Incompetence based on a variety of factors, including a lack of sufficient pharmaceutical knowledge or skills or experience to a degree likely to endanger the health of patients.

(b) When considered with other indications of professional incompetence, a pharmacist or pharmacy intern who fails to obtain a passing score on a board-approved pharmacist licensure examination or a pharmacy technician or pharmacy technician trainee who fails to obtain a passing score on a board-approved pharmacy technician licensure examination.

89. "Radioactive substance" means a substance that emits ionizing radiation.

90. "Remote dispensing site pharmacy" means a pharmacy where a pharmacy technician or pharmacy intern prepares, compounds or dispenses prescription medications under remote supervision by a pharmacist.

91. "Remote hospital-site pharmacy" means a pharmacy located in a satellite facility that operates under the license issued by the department of health services to the hospital of which it is a satellite.

92. "Remote supervision by a pharmacist" means that a pharmacist directs and controls the actions of pharmacy technicians and pharmacy interns through the use of audio and visual technology.

93. "Revocation" or "revoke" means the official cancellation of a license, permit, registration or other approval authorized by the board for a period of two years unless otherwise specified by the board. A request or new application for reinstatement may be presented to the board for review before the conclusion of the specified revocation period upon review of the executive director.

94. "Safely engage in employment duties" means that a permittee or the permittee's employee is able to safely engage in employment duties related to the manufacture, sale, distribution or dispensing of drugs, devices, poisons, hazardous substances, controlled substances or precursor chemicals.

95. "Satellite facility" has the same meaning prescribed in section 36-422.

96. "Satellite pharmacy" means a work area located within a hospital or on a hospital campus that is not separated by other commercial property or residential property, that is under the direction of a pharmacist, that is a remote extension of a centrally licensed hospital pharmacy, that is owned by and dependent on the centrally licensed hospital pharmacy for administrative control, staffing and drug procurement and that is not required to be separately permitted.

97. "Symbol" means the characteristic symbols that have historically identified pharmacy, including show globes and mortar and pestle, and the sign "Rx".

98. "Third-party logistics provider" means an entity that provides or coordinates warehousing or other logistics services for the following items, but that does not take ownership of the items, and that distributes those items as directed by a manufacturer, wholesaler, dispenser or durable medical equipment supplier that is permitted by the board:

(a) Narcotic drugs or other controlled substances.

(b) Dangerous drugs as defined in section 13-3401.

(c) Prescription-only drugs and devices.

(d) Nonprescription drugs and devices.

(e) Precursor chemicals.

(f) Regulated chemicals as defined in section 13-3401.

99. "Toxic substance" means a substance, other than a radioactive substance, that has the capacity to produce injury or illness in humans through ingestion, inhalation or absorption through any body surface.

100. "Ultimate user" means a person who lawfully possesses a drug or controlled substance for that person's own use, for the use of a member of that person's household or for administering to an animal owned by that person or by a member of that person's household.

101. "Virtual manufacturer" means an entity that contracts for the manufacture of a drug or device, including a private label distributor as defined in 21 Code of Federal Regulations part 207.1, and that meets all of the following:

(a) Owns either:

(i) The new drug application or abbreviated new drug application number as defined by the United States food and drug administration for a drug.

(ii) The unique device identification number as defined by the United States food and drug administration for a prescription device.

(b) Is not involved in the physical manufacture of the drug or device.

(c) Contracts with a United States food and drug administration registered manufacturing entity for the physical manufacture of the drug or device.

32-1904. Powers and duties of board; immunity

A. The board shall:

1. Make bylaws and adopt rules that are necessary to protect the public and that pertain to the practice of pharmacy, the manufacturing, wholesaling or supplying of drugs, devices, poisons or hazardous substances, the use of pharmacy technicians and support personnel and the lawful performance of its duties.

2. Fix standards and requirements to register and reregister pharmacies, except as otherwise specified.

3. Investigate compliance as to the quality, label and labeling of all drugs, devices, poisons or hazardous substances and take action necessary to prevent the sale of these if they do not conform to the standards prescribed in this chapter, the official compendium or the federal act.

4. Enforce its rules. In so doing, the board or its agents have free access, during the hours reported with the board or the posted hours at the facility, to any pharmacy, manufacturer, wholesaler, third-party logistics provider, nonprescription drug permittee or other establishment in which drugs, devices, poisons or hazardous substances are manufactured, processed, packed or held, or to enter any vehicle being

used to transport or hold such drugs, devices, poisons or hazardous substances for the purpose of:

(a) Inspecting the establishment or vehicle to determine whether any provisions of this chapter or the federal act are being violated.

(b) Securing samples or specimens of any drug, device, poison or hazardous substance after paying or offering to pay for the sample.

(c) Detaining or embargoing a drug, device, poison or hazardous substance in accordance with section 32-1994.

5. Examine and license as pharmacists and pharmacy interns all qualified applicants as provided by this chapter.

6. Require each applicant for an initial license to apply for a fingerprint clearance card pursuant to section 41-1758.03. If an applicant is issued a valid fingerprint clearance card, the applicant shall submit the valid fingerprint clearance card to the board with the completed application. If an applicant applies for a fingerprint clearance card and is denied, the applicant may request that the board consider the application for licensure notwithstanding the absence of a valid fingerprint clearance card. The board, in its discretion, may approve an application for licensure despite the denial of a valid fingerprint clearance card if the board determines that the applicant's criminal history information on which the denial was based does not alone disqualify the applicant from licensure.

7. Issue duplicates of lost or destroyed permits on the payment of a fee as prescribed by the board.

8. Adopt rules to rehabilitate pharmacists and pharmacy interns as provided by this chapter.

9. At least once every three months, notify pharmacies regulated pursuant to this chapter of any modifications on prescription writing privileges of podiatrists, dentists, doctors of medicine, registered nurse practitioners, osteopathic physicians, veterinarians, physician assistants, optometrists and homeopathic physicians of which it receives notification from the state board of podiatry examiners, state board of dental examiners, Arizona medical board, Arizona state board of nursing, Arizona board of osteopathic examiners in medicine and surgery, Arizona state veterinary medical examining board, Arizona regulatory board of physician assistants, state board of optometry or board of homeopathic and integrated medicine examiners.

10. Charge a permittee a fee, as determined by the board, for an inspection if the permittee requests the inspection.

11. Issue only one active or open license per individual.

12. Allow a licensee to regress to a lower level license on written explanation and review by the board for discussion, determination and possible action.

13. Open an investigation only if the identifying information regarding a complainant is provided or the information provided is sufficient to conduct an investigation.

14. Provide notice to an applicant, licensee or permittee using only the information provided to the board through the board's licensing database.

B. The board may:

1. Employ chemists, compliance officers, clerical help and other employees subject to title 41, chapter 4, article 4 and provide laboratory facilities for the proper conduct of its business.

2. Provide, by educating and informing the licensees and the public, assistance in curtailing abuse in the use of drugs, devices, poisons and hazardous substances.

3. Approve or reject the manner of storage and security of drugs, devices, poisons and hazardous substances.

4. Accept monies and services to assist in enforcing this chapter from other than licensees:

(a) For performing inspections and other board functions.

(b) For the cost of copies of the pharmacy and controlled substances laws, the annual report of the board and other information from the board.

5. Adopt rules for professional conduct appropriate to the establishment and maintenance of a high standard of integrity and dignity in the profession of pharmacy.

6. Grant permission to deviate from a state requirement for modernization of pharmacy practice, experimentation or technological advances.

7. Adopt rules for the training and practice of pharmacy interns, pharmacy technicians and support personnel.

8. Investigate alleged violations of this chapter, conduct hearings in respect to violations, subpoena witnesses and take such action as it deems necessary to revoke or suspend a license or a permit, place a licensee or permittee on probation or warn a licensee or permittee under this chapter or to bring notice of violations to the county attorney of the county in which a violation took place or to the attorney general.

9. By rule, approve colleges or schools of pharmacy.

10. By rule, approve programs of practical experience, clinical programs, internship training programs, programs of remedial academic work and preliminary equivalency examinations as provided by this chapter.

11. Assist in the continuing education of pharmacists and pharmacy interns.

12. Issue inactive status licenses as provided by this chapter.

13. Accept monies and services from the federal government or others for educational, research or other purposes pertaining to the enforcement of this chapter.

14. By rule, except from the application of all or any part of this chapter any material, compound, mixture or preparation containing any stimulant or depressant substance included in section 13-3401, paragraph 6, subdivision (c) or (d) from the definition of dangerous drug if the material, compound, mixture or preparation contains one or more active medicinal ingredients not having a stimulant or depressant effect on the central nervous system, provided that such admixtures are included in such combinations, quantity, proportion or concentration as to vitiate the potential for abuse of the substances that do have a stimulant or depressant effect on the central nervous system.

15. Adopt rules for the revocation, suspension or reinstatement of licenses or permits or the probation of licensees or permittees as provided by this chapter.

16. Issue a certificate of free sale to any person that is licensed by the board as a manufacturer for the purpose of manufacturing or distributing food supplements or dietary supplements as defined in rule by the board and that wants to sell food supplements or dietary supplements domestically or internationally. The application shall contain all of the following:

(a) The applicant's name, address, email address, telephone and fax number.

(b) The product's full, common or usual name.

(c) A copy of the label for each product listed. If the product is to be exported in bulk and a label is not available, the applicant shall include a certificate of composition.

(d) The country of export, if applicable.

(e) The number of certificates of free sale requested.

17. Establish an inspection process to issue certificates of free sale or good manufacturing practice certifications. The board shall establish in rule:

(a) A fee to issue certificates of free sale.

(b) A fee to issue good manufacturing practice certifications.

(c) An annual inspection fee.

18. Delegate to the executive director the authority to:

(a) If the president or vice president of the board concurs after reviewing the case, enter into an interim consent agreement with a licensee or permittee if there is evidence that a restriction against the license or permit is needed to mitigate danger to the public health and safety. The board may subsequently formally adopt the interim consent agreement with any modifications the board deems necessary.

(b) Take no action or dismiss a complaint that has insufficient evidence that a violation of statute or rule governing the practice of pharmacy occurred.

(c) Request an applicant or licensee to provide court documents and police reports if the applicant or licensee has been charged with or convicted of a criminal offense. The executive director may do either of the following if the applicant or licensee fails to provide the requested documents to the board within thirty business days after the request:

(i) Close the application, deem the application fee forfeited and not consider a new application complete unless the requested documents are submitted with the application.

(ii) Notify the licensee of an opportunity for a hearing in accordance with section 41-1061 to consider suspension of the licensee.

(d) Pursuant to section 36-2604, subsection B, review prescription information collected pursuant to title 36, chapter 28, article 1.

C. At each regularly scheduled board meeting, the executive director shall provide to the board a list of the executive director's actions taken pursuant to subsection B, paragraph 18, subdivisions (a), (c) and (d) of this section since the last board meeting.

D. The board may issue nondisciplinary civil penalties or delegate to the executive director the authority to issue nondisciplinary civil penalties. The nondisciplinary civil penalties shall be prescribed by the board in rule and issued using a board-approved form. If a licensee or permittee fails to pay a nondisciplinary civil penalty that the board has imposed on it, the board shall hold a hearing on the matter. In addition to any other nondisciplinary civil penalty adopted by the board, either of the following acts or omissions that is not an imminent threat to the public health and safety is subject to a nondisciplinary civil penalty:

1. An occurrence of either of the following:

(a) Failing to submit a remodel application before remodeling a permitted facility.

(b) Failing to notify the board of the relocation of a business.

2. The occurrence of any of the following violations or any of the violations adopted by the board in rule, with three or more violations being presented to the board as a complaint:

(a) The licensee or permittee fails to update the licensee's or permittee's online profile within ten days after a change in contact information, address, telephone number or email address.

(b) The licensee fails to update the licensee's online profile within ten days after a change in employment.

(c) The licensee fails to complete the required continuing education for a license renewal.

(d) The licensee fails to update the licensee's online profile to reflect a new pharmacist in charge within fourteen days after the position change.

(e) The permittee fails to update the permittee's online profile to reflect a new designated representative within ten days after the position change.

(f) The licensee or permittee fails to notify the board of a new criminal charge, arrest or conviction against the licensee or permittee in this state or any other jurisdiction.

(g) The licensee or permittee fails to notify the board of a disciplinary action taken against the licensee or permittee by another regulating agency in this state or any other jurisdiction.

(h) A licensee or permittee fails to renew a license or permit within sixty days after the license or permit expires. If more than sixty days have lapsed after the expiration of a license or permit, the licensee or permittee shall appear before the board.

(i) A new pharmacist in charge fails to conduct a controlled substance inventory within ten days after starting the position.

(j) A person fails to obtain a permit before shipping into this state anything that requires a permit pursuant to this chapter.

(k) Any other violations of statute or rule that the board or the board's designee deems appropriate for a nondisciplinary civil penalty.

E. The board shall develop substantive policy statements pursuant to section 41-1091 for each specific licensing and regulatory authority the board delegates to the executive director.

F. The executive director and other personnel or agents of the board are not subject to civil liability for any act done or proceeding undertaken or performed in good faith and in furtherance of the purposes of this chapter.

32-1930. Types of permits; restrictions on permits; discontinuance of pharmacy permit

A. On application, the board may issue the following classes or kinds of permits:

1. If approved by the board, a pharmacy, limited service pharmacy, automated prescription-dispensing kiosk, full service wholesale drug, third-party logistics provider, nonprescription drug wholesale and drug manufacturer's permit.

2. Drug packager or drug prepackager permit to an individual or establishment that is currently listed by the United States food and drug administration and has met the requirements of that agency to purchase, repackage, relabel or otherwise alter the manufacturer's original package of an approved drug product with the intent of reselling these items to persons or businesses authorized to possess or resell the repackaged, prepackaged or relabeled drug.

3. A durable medical equipment distributor and compressed medical gas distributor permit and a durable medical equipment supplier and compressed medical gas supplier permit.

B. The board shall deny or revoke a pharmacy permit if a medical practitioner receives compensation, either directly or indirectly, from a pharmacy as a result of the practitioner's prescription orders. This does not include compensation to a medical practitioner who is the owner of a building where space is leased to a pharmacy at the prevailing rate, not resulting in a rebate to the medical practitioner.

C. If a pharmacy permanently discontinues operation, the permittee shall immediately surrender the permit to the executive director. The permittee shall remove all drug signs and symbols, either within or without the premises, and shall remove or destroy all drugs, devices, poisons and hazardous substances.

D. An automated prescription-dispensing kiosk may not contain or dispense a controlled substance as defined in section 36-2501 and the controlled substances act (P.L. 91-513; 84 Stat. 1242; 21 United States Code section 802).

## 32-1931. Permit fees; issuance; expiration; renewals; online profiles

A. The board shall assign the permit of all persons or firms issued under this chapter to one of two permit renewal groups. Except as provided in section 32-4301, a holder of a permit designated in the licensing database as even by way of verbiage or numerical value shall renew it biennially on or before November 1 of the even-numbered year, two years after the last renewal date. Except as provided in section 32-4301, a holder of a permit designated in the licensing database as odd by way of verbiage or numerical value shall renew it biennially on or before November 1 of the odd-numbered year, two years after the last renewal date. Failure to renew and pay all required fees on or before November 1 of the year in which the renewal is due suspends the permit. The board shall vacate a suspension when the permittee pays penalties of not to exceed $350 and all past due fees. The board may waive collection of a fee or penalty due after suspension under conditions established by a majority of the board.

B. Permit fees that are designated to be not more than a maximum amount shall be set by the board for the following two fiscal years beginning November 1. The board shall establish the fees approximately proportionate to the maximum fee allowed to cover the board's anticipated expenditures for the following two fiscal years. Variation in a fee is not effective except at the expiration date of the permit.

C. Applications for permits shall be accompanied by the following biennial fees as determined pursuant to subsection B of this section:

1. A drug manufacturer's permit, not more than $1,000.

2. A pharmacy permit, not more than $500.

3. A limited service pharmacy permit or an automated prescription-dispensing kiosk permit, not more than $500.

4. A full service wholesale drug permit or a third-party logistics provider permit, not more than $1,000.

5. A nonprescription drug wholesale permit, not more than $500.

6. A drug repackager's permit, not more than $1,000.

7. A durable medical equipment distributor and compressed medical gas distributor permit, not more than $200.

8. A durable medical equipment supplier and compressed medical gas supplier permit, not more than $100.

D. If an applicant is found to be satisfactory to the board, the executive director shall issue to the applicant a permit for each pharmacy, manufacturer, wholesaler or other place of business in which drugs are sold, manufactured, compounded, dispensed, stocked, exposed or offered for sale, for which application is made.

E. Permits issued under this section are not transferable.

F. If a permittee does not apply for renewal, the permit expires pursuant to subsection A of this section. A person may activate and renew an expired permit by filing the required application and fee. Renewal thirty days after the expiration date of a permit may be made only on payment of the required biennial renewal fee, all past due fees and a penalty of one-half of the amount of the applicable biennial renewal fee. The board may waive the collection of a fee or penalty due after suspension pursuant to conditions prescribed by the board.

G. A permittee shall create an online profile using the board's licensing software.

**BOARD OF PSYCHOLOGIST EXAMINERS**
Title 4, Chapter 26, Article 2

**Amend:** R4-26-407

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **BOARD OF PSYCHOLOGIST EXAMINERS**
Title 4, Chapter 26, Article 2

**Amend:** R4-26-207

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**Summary:**

This regular rulemaking from the Board of Psychologist Examiners (Board) seeks to amend one (1) rule in Title 4, Chapter 26, Article 2 regarding Licensure. Specifically, the Board is adding a continuing education requirement regarding completion of the Board's four-hour online jurisprudence education tool. The Board determined this requirement is necessary to ensure licensees practice in adherence to Arizona law and to assist licensees to avoid complaint allegations of unlawful or unethical practice and the associated consequences (e.g. legal expenses, risk management cost increases, denial of insurance credentials, cancellation of service contracts, loss of practice opportunities, etc.).

The Board indicates, the rule change does not increase the number of hours of continuing education required. Rather, it simply redirects four hours of currently required continuing education.

The vendor with which the Board has contracted to prepare and administer the online jurisprudence educational tool charges $40 to each participant. This amounts to $10 per hour of continuing education credit awarded for its completion. By comparison, a continuing education

course presenting similar content that is offered only once annually in Arizona by the Arizona Psychological Association costs $99 or $24.75 per hour of continuing education credit.

The Board indicates the Executive Director of the Arizona Board of Behavioral Health Examiners reports that a similar requirement for its licensees reduced certain types of complaints, and licensees have provided feedback that it effectively raises their compliance awareness. The Executive Director of the Missouri Board of Psychologist Examiners also reports that a similar requirement for Missouri psychologists has reduced the number of complaints received by that Board.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Board cites both general and specific statutory authority for these rules.

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Board indicates it did not review any study relevant to this rulemaking.

**4. Summary of the agency's economic impact analysis:**

The Board believes that this rule amendment's economic impact will be positive for both licensees and the Board. There are probable per-hour cost savings for licensees to utilize the four-hour online jurisprudence education tool rather than attend a similar in-person continuing education course for the same amount of time. Additionally, this rule change may help licensees and the Board avoid complaint allegations of unlawful or unethical practice, and their associated costs.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

According to the Board, because the rulemaking is neither intrusive nor costly, the Board did not consider alternative methods.

In amending this rule the Board is not requiring additional continuing education hours beyond the existing requirements of 40 hours biennially but is instead requiring that four of the 40 hours be completed through an online jurisprudence education tool that is believed to be more cost effective for a licensee than an in-person alternative. Furthermore, the Board believes that knowledge from this online course may increase the likelihood that licensees practice in a manner consistent with the statutes and rules and thus avoid complaints.

**6. What are the economic impacts on stakeholders?**

Licensees and the Board will be directly affected by, bear the costs of, and directly benefit from this rulemaking. Per the Board, there are currently 2,199 licensed psychologists in Arizona. Each is required to obtain 40 hours of continuing education biennially.

The Board determined that the online education tool that will cost $40 for four hours of continuing education credit will be less expensive for licensees than a similar in-person $99 in-person continuing education course offered annually by the Arizona Psychological Association. Licensees will also be able to avoid travel costs and time away from patient care associated with the in-person course by participating in the online education tool at any time. Beyond the $40 the licensees must pay, the Board incurred the cost of rulemaking and will incur the cost to enforce, implement, and regularly update it.

According to the Board, there were 52 complaints filed against licensees alleging unprofessional, unlawful, or unethical practice. 40 that were forwarded to the full Board for review and hearing, and eight that resulted in either disciplinary action or non-disciplinary corrective action against the licensee. The approximate average cost of a complaint to process through to final disposition or adjudication is $3,000. The Arizona jurisprudence knowledge from this online course may help licensees avoid these complaints. Avoiding complaints and the costs associated with them benefits both licensees and the Board

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Board indicates there were no changes between the Notice of Proposed Rulemaking published in the Administrative Register on January 17, 2025 and the Notice of Final Rulemaking now before the Council for consideration.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Board indicates it received no public comments related to this rulemaking.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

While the Board indicates psychologists are required to be licensed and obtain continuing education during each license period, the rule amended in this rulemaking does not require a permit. As such, the requirements in A.R.S. § 41-1037 are not applicable.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board indicates there is no corresponding federal law.

**11. Conclusion**

This regular rulemaking from the Board seeks to amend one (1) rule in Title 4, Chapter 26, Article 2 regarding Licensure. Specifically, the Board is adding a continuing education requirement regarding completion of the Board's four-hour online jurisprudence education tool. The Board indicates, the rule change does not increase the number of hours of continuing education required. Rather, it simply redirects four hours of currently required continuing education.

The Board is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A).

Council staff recommends approval of this rulemaking.

**STATE OF ARIZONA**
**BOARD OF PSYCHOLOGIST EXAMINERS**
**1740 WEST ADAMS STREET, SUITE 3403**
**PHOENIX, AZ 85007**
**PH: 602.542.8162 FX: 602.542.8279**
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KATIE HOBBS
Governor

HEIDI HERBST PAAKKONEN
Executive Director

April 29, 2025

Ms. Jessica Klein, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 305
Phoenix, AZ 85007

**Re: A.A.C. Title 4. Professions and Occupations; Chapter 26. Board of Psychologist Examiners**

Dear Ms. Klein:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

A. Close of record date: The rulemaking record was closed on February 28, 2025, following a period for public comment and an oral proceeding. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B).

B. Relation of the rulemaking to a five-year-review report: The rulemaking does not relate to a 5YRR.

C. New fee: The rulemaking does not establish a new fee.

D. Fee increase: The rulemaking does not increase an existing fee.

E. Immediate effective date: An immediate effective date is not requested.

F. Certification regarding studies: I certify that the preamble accurately discloses the Board did not review any studies in its evaluation of or justification for the rule in this rulemaking.

G. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that the rule in this rulemaking will not require a state agency to employ a new full-time employee. No notification was provided to JLBC.

H. List of documents enclosed:
   1. Cover letter signed by the Executive Director;
   2. Notice of Final Rulemaking including the preamble, table of contents, and rule text;
   3. Economic, Small Business, and Consumer Impact Statement;

Regards,

Heidi Herbst Paakkonen

Heidi Herbst Paakkonen, MPA
Executive Director

**NOTICE OF FINAL RULEMAKING**

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS**

**PREAMBLE**

**1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039(B) by the governor on:**

April 21, 2025

| **2. Article, Part, or Section Affected (as applicable)** | **Rulemaking Action** |
|---|---|
| R4-26-207 | Amend |

**3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. § 32-2063(A)(9)

Implementing statute: A.R.S. § 32-2074

**4. The effective date of the rule:**

This rule will become effective 60 days after a certified original is filed in the Office of the Secretary of State under A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

**a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable

**b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable

**5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:**

Notice of Rulemaking Docket Opening: 31 A.A.R. 278, Issue Date: January 17, 2025, Issue Number: 3, File number: R24-308

Notice of Proposed Rulemaking: 31 A.A.R. 149, Issue Date: January 17, 2025, Issue Number: 3, File number: R24-304

**6. The agency's contact person who can answer questions about the rulemaking:**

Name: Heidi Herbst Paakkonen
Title: Executive Director
Address: 1740 W. Adams Street, Suite 2430, Phoenix, AZ 85007
Telephone: (602) 542-8162
Fax: (602) 542-8279
Email: Heidi.Paakkonen@psychboard.az.us
Website: psychboard.az.gov

**7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Board is adding a continuing education requirement regarding completion of the Board's four-hour online jurisprudence education tool. The Board determined this requirement is necessary to ensure licensees practice in adherence to Arizona law and to assist licensees to avoid complaint allegations of unlawful or unethical practice and the associated consequences (e.g. legal expenses, risk management cost increases, denial of insurance credentials, cancellation of service contracts, loss of practice opportunities, etc.). The Executive Director of the Arizona Board of Behavioral Health examiners reports that a similar requirement for its licensees reduced certain types of complaints, and licensees have provided feedback that it effectively raises their compliance awareness. The Executive Director of the Missouri Board of Psychologist Examiners reports that a similar requirement for Missouri psychologists has reduced the number of complaints received by that Board.

The rule change does not increase the number of hours of continuing education required. Rather, it simply redirects four hours of currently required continuing education. The vendor with which the Board has contracted to prepare and administer the online jurisprudence educational tool charges $40 to each participant. This amounts to $10 per hour of

continuing education credit awarded for its completion. By comparison, a continuing education course presenting similar content that is offered only once annually in Arizona by the Arizona Psychological Association costs $99 or $24.75 per hour of continuing education credit. For many Arizona psychologists, travel costs are incurred to attend this annual course and all participants in the annual course must take time away from patient care to attend.

The Board's online jurisprudence education tool, which has been developed but not yet made available, will be accessed on demand and completed at the convenience of the psychologist's schedule without the need to incur travel costs or take time from patient care, and at the lowest cost identified by the Board's research. Psychologists will be encouraged to complete the online jurisprudence education tool with peers and colleagues to benefit from professional engagement opportunities that research finds enhances professional competence. There is no examination required to complete the online jurisprudence education tool.

**8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

Not applicable

**9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**10. A summary of the economic, small business, and consumer impact:**

The Board believes the economic impact of the rulemaking will be positive for licensees and the Board. Licensees will likely find the four-hour online jurisprudence education tool is less expensive than four hours of other continuing education and the online education tool is more convenient and avoids travel costs and time away from patient care. Licensees may also find that knowledge of Arizona jurisprudence helps them avoid complaint allegations of unlawful or unethical practice. Avoidance of complaint allegations is also beneficial to the Board.

**11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

Not applicable

**12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

Not applicable

**13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

Not applicable

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Psychologists are required to be licensed and obtain continuing education during each license period. However, the rule amended in this rulemaking does not require a permit.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

No federal law is directly applicable to the subject matter of this rulemaking.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

**14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Not applicable

**15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**16. The full text of the rules follows:**

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 26. BOARD OF PSYCHOLGIST EXAMINERS**
**ARTICLE 2. LICENSURE**

**Section**


**ARTICLE 2. LICENSURE**

**R4-26-207. Continuing Education**

**A.** A licensee shall complete at least 40 hours of continuing education during each license period. Unless specified otherwise, one clock hour of instruction, training, or making a presentation equals one hour of continuing education.

**B.** A licensee shall ensure the continuing education hours obtained include:
1. ~~at~~ At least four hours in professional ethics, and
2. Completion of the Board's four-hour online jurisprudence education tool.

**C.** During the license period in which an individual is initially licensed, the Board shall pro-rate the number of continuing education hours, including a pro-rated number of hours addressing ethics, that the new licensee must complete during the initial license period. To calculate the number of continuing education hours that a new licensee must obtain, the Board shall divide the 40 hours of continuing education required in a license period by 24 and multiply the quotient by the number of whole months from the date of initial licensure until the end of the license period. During the first license period, for every six months from the month of license issuance to the end of the license period, the Board shall require one hour of continuing education in ethics.

**D.** If the standards in subsection (F) are met, the Board shall accept the following for continuing education hours.
1. Post-doctoral study sponsored by a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1) and provides a graduate-level degree program;
2. A course, seminar, workshop, or home study for which a certificate of attendance or completion is provided;
3. A continuing education program offered by a national, international, regional, or state association, society, board, or continuing education provider;
4. Teaching a graduate-level course in applied psychology at a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1). A licensee who teaches a graduate-level course in applied psychology receives the same number of continuing education hours as number of classroom hours for those who take the graduate-level course;
5. Organizing and presenting a continuing education activity. A licensee who organizes and presents a continuing education activity receives the same number of continuing education hours as those who attend the continuing education activity;
6. Serving as a complaint consultant. During a license period, a licensee who serves as a Board complaint consultant to review Board complaints and provides written reports to the Board or provides expert testimony on behalf of the Board may receive continuing education hours equal to the actual number of hours served as a complaint consultant to a maximum of 20 hours. A licensee who is paid by the Board for services rendered shall not receive continuing education credit for the time or services for which payment was made;
7. The Board shall allow a maximum of 10 continuing education hours for each of the following during a license period:
   a. Attending a Board meeting or serving as a member of the Board. A licensee receives up to six continuing education hours in professional ethics for attending both morning and afternoon sessions of a Board meeting and three continuing education hours for attending either the morning or afternoon session or at least four hours of a Board meeting. A licensee shall complete documentation provided by the Board at the time the licensee attends a Board meeting;
   b. Having an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published. A licensee who has an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published receives 10 continuing education hours in the year of publication;
   c. Participating in a study group for professional growth and development as a psychologist. A licensee receives one hour of continuing education for each hour of participation to a maximum of 10 continuing education hours for participating in a study group. The Board shall allow continuing education hours for participating in a study group only if the licensee maintains the documentation required under subsection (G)(5);
   d. Presenting a symposium or paper at a state, regional, national, or international psychology meeting. A licensee who presents a symposium or paper receives the same number of continuing education hours as hours of the session, as published in the agenda of the meeting, at which the symposium or paper is presented to a maximum of 10 continuing education hours;
   e. Presenting a poster during a poster session at a state, regional, national, or international psychology meeting. A licensee who presents a poster receives an hour of continuing education for each hour the licensee is physically

present with the poster during the poster session, as published in the agenda of the meeting, to a maximum of 10 continuing education hours; and

f. Serving as an elected officer of an international, national, regional, or state psychological association or society. A licensee who serves as an elected officer may receive continuing education hours equal to the actual number of hours served to a maximum of 10 continuing education hours.

**E.** The Board shall not allow continuing education credit more than once in a license period for:

1. Teaching the same graduate-level course,
2. Organizing and presenting a continuing education activity on the same topic or content area, or
3. Presenting the same symposium or paper at a state, regional, national, or international psychology meeting.

**F.** Standards for continuing education. To be acceptable for continuing education credit, an activity identified in subsections (D)(1) through (4) shall:

1. Focus on the practice of psychology, as defined at A.R.S. § 32-2061, for at least 75 percent of the program hours; and
2. Be taught by an instructor who is readily identifiable as competent in the subject of the continuing education by having an advanced degree, teaching experience, work history, published professional articles, or previously presented continuing education on the same subject.

**G.** The Board shall accept the following documents as evidence of completion of continuing education hours:

1. A certificate of attendance or completion;
2. Statement signed by the provider verifying participation in the activity;
3. Copy of transcript of course completed under subsection (D)(1);
4. Documents indicating a licensee's participation as an elected officer or appointed member as specified in subsection (D)(7)(f); or
5. An attestation signed by all participants of a study group under subsection (D)(7)(c) that includes a description of the activity, subject covered, dates, and number of hours.

**H.** A licensee shall maintain the documents listed in subsection (G) through the license period following the license period in which the documents were obtained.

**I.** The Board may audit a licensee's compliance with continuing education requirements. The Board may deny renewal or take other disciplinary action against a licensee who fails to obtain or document required continuing education hours. The Board may discipline a licensee who commits fraud, deceit, or misrepresentation regarding continuing education hours.

**J.** A licensee who cannot meet the continuing education requirement for good cause may seek an extension of time to complete the continuing education requirement by submitting a written request to the Board with the timely submission of the renewal application required under R4-26-205.

1. Good cause includes but is not limited to illness or injury of the licensee or a close family member, death of a close family member, birth or adoption of a child, military service, relocation, natural disaster, financial hardship, or residence in a foreign country for at least 12 months of the license period.
2. The Board shall not grant an extension longer than one year.
3. A licensee who cannot complete the continuing education requirement within the extension may apply to the Board for inactive license status under A.R.S. § 32-2073 (G).

**K.** No continuing education hours may be carried over to the next licensing period.

**L.** The Board shall not accept for continuing education hours a course, workshop, seminar, or symposium designed to increase income or office efficiency.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**[1]

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS**

1. Identification of the rulemaking:

The Board is adding a continuing education requirement regarding completion of the Board's four-hour online jurisprudence education tool. The Board determined this requirement is necessary to ensure licensees practice in adherence to Arizona law and to assist licensees to avoid complaint allegations of unlawful or unethical practice and the associated consequences (e.g. legal expenses, risk management cost increases, denial of insurance credentials, cancellation of service contracts, loss of practice opportunities, etc.). The Executive Director of the Arizona Board of Behavioral Health examiners reports that a similar requirement for its licensees reduced certain types of complaints and licensees have provided feedback that it effectively raises their compliance awareness. The Executive Director of the Missouri Board of Psychologist Examiners reports a similar requirement for Missouri psychologists has reduced the number of complaints received by that Board.

The rule change does not increase the number of hours of continuing education required. Rather, it simply redirects four hours of currently required continuing education. The vendor with which the Board has contracted to prepare and administer the online jurisprudence educational tool charges $40 to each participant. This amounts to $10 per hour of continuing education credit awarded for its completion. By comparison, a continuing education course presenting similar content that is offered only once annually in Arizona by the Arizona Psychological Association costs $99 or $24.75 per hour of continuing education credit. For many Arizona psychologists, travel costs are incurred to attend this annual course and all participants in the annual course must take time away from patient care to attend.

The Board's online jurisprudence education tool, which has been developed but not yet made available, will be accessed on demand and completed at the convenience of the psychologist's schedule without the need to incur travel costs or take time from patient care, and at the lowest cost identified by the Board's research. Psychologists will be encouraged to complete the online jurisprudence education tool with peers and colleagues to benefit from professional engagement opportunities that research finds enhances professional competence. There is no examination required to complete the online jurisprudence education tool.

The conduct and its frequency of occurrence that the rule is designed to change:

Until the rulemaking is completed, the Board will not be providing an opportunity for licensees to increase knowledge of the statutes and rules governing the practice of psychology and increase the possibility of avoiding a complaint alleging unlawful or unethical practice. Although the Board's four-hour online jurisprudence education tool does not guarantee a

[1] If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms. (A.R.S. § 41-1055(C)).

licensee will always practice in a manner consistent with statutes and rules and avoid a complaint, the Board believes the tool will increase the likelihood of this result.

a. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

When a licensee practices in a manner inconsistent with statutes and rules, harm is caused to public health and safety and to the licensee who may be the subject of a complaint.

b. The estimated change in frequency of the targeted conduct expected from the rule change:

The Board believes participating in the four-hour online jurisprudence education tool will increase the likelihood that licensees practice in a manner consistent with statutes and rules.

2. A brief summary of the information included in the economic, small business, and consumer impact statement;

The Board believes the economic impact of the rulemaking will be positive for licensees and the Board. Licensees will likely find the four-hour online jurisprudence education tool is less expensive than four hours of in-person continuing education. Licensees may also find that knowledge of Arizona jurisprudence helps them avoid complaint allegations of unlawful or unethical practice. Avoidance of complaint allegations is also beneficial to the Board.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

Name: Heidi Herbst Paakkonen
Title: Executive Director
Address: 1740 W. Adams Street, Suite 2530, Phoenix, AZ 85007
Telephone: (602) 542-8162
Email: Heidi.paakkonen@pyschboard.az.us
Website: psychoboard.az.gov

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

Licensees and the Board will be directly affected by, bear the costs of, and directly benefit from this rulemaking.

There are currently 2,199 licensed psychologists in Arizona. Each is required to obtain 40 hours of continuing education biennially. In this rulemaking, the Board's four-hour online

jurisprudence education tool is required to be four of the 40 biennial hours of continuing education. The Board determined the online education tool, which will cost $40 for four hours of continuing education credit, will be less expensive for licensees than the similar $99 in-person continuing education course offered annually by the Arizona Psychological Association. Additionally, licensees will be able to participate in the online education tool at any time so they will be able to avoid the travel costs and time away from patient care associated with completing in-person continuing education.

During the last year, 52 complaints were filed against licensees alleging unprofessional, unlawful, or unethical practice. Of these complaints, 40 were forwarded by the Board's screening committee of members to the full Board for review and hearing. Eight resulted in either disciplinary action or non-disciplinary corrective action against the licensee. The Board believes that participating in the online jurisprudence education tool biennially may reduce the number of complaints against licensees and the associated consequences. Additionally, on average each complaint costs the Board approximately $3,000 to process through to final disposition or adjudication.

The Board incurred the cost of this rulemaking and will incur the cost to implement and enforce it. The Board also incurred the cost of having the four-hour online jurisprudence education tool developed and will incur the cost of ensuring the tool is updated regularly. The Board will have the benefit of assisting licensees to increase their knowledge of jurisprudence and possibly circumvent complaints. Avoiding complaints is economically beneficial to both licensees and the Board.

5. Cost-benefit analysis:
    a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:
    The Board is the only state agency directly affected by the rulemaking. Its costs and benefits are listed in item 4.
    b. Costs and benefits to political subdivisions directly affected by the rulemaking:
    No political subdivision is directly affected by the rulemaking.
    c. Costs and benefits to businesses directly affected by the rulemaking:
    Psychologists are business directly affected by the rulemaking. Their costs and benefits are listed in item 4.

6. Impact on private and public employment:

   The Board expects the rulemaking will have no impact on private or public employment.

7. Impact on small businesses[2]:

   a. Identification of the small business subject to the rulemaking:

      Some psychologists operate small businesses subject to the rulemaking.

   b. Administrative and other costs required for compliance with the rulemaking:

      Psychologists will have to redirect four of the 40 hours of continuing education required biennially. They will have to pay the $40 charge to participate in the online education tool that would otherwise be spent to complete different continuing education activities.

   c. Description of methods that may be used to reduce the impact on small businesses:

      As indicated in item 4, participating in the online jurisprudence education tool will be less expensive and easier for licensees than participating in an in-person jurisprudence continuing education course.

      i. Establish less costly or less stringent compliance or reporting requirements:

         Licensees are required to maintain records of compliance with the continuing education requirement for use at license renewal. This rulemaking does not add a compliance or reporting requirement.

      ii. Establish less costly schedules or less stringent deadlines for compliance:

         Licensees are required to obtain 40 hours of continuing education biennially. This rulemaking, which simply redirects four of the 40 hours, does not change that.

      iii. Consolidate or simplify compliance or reporting requirements:

         The compliance and reporting requirements for all continuing education remains unchanged.

      iv. Establish separate performance standards:

         There is no performance standard in this rulemaking. Indeed, there is no examination required for the four-hour online jurisprudence education tool.

      v. Exempt small businesses from any or all requirements:

         All licensees are required to obtain 40 hours of continuing education biennially. This rulemaking simply redirects four of those hours. Because most licensees are small businesses, it is not possible to exempt them from the jurisprudence requirement and accomplish the goal of the rulemaking.

[2] Small business has the meaning specified in A.R.S. § 41-1001(23).

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

   No private person or consumer is directly affected by the rulemaking.

9. Probable effects on state revenues:

   None

10. Less intrusive or less costly alternative methods considered:

    Because the rulemaking is neither intrusive nor costly, the Board did not consider alternative methods.

Former Section R4-26-120 renumbered to R4-26-305 effective July 27, 1979 (Supp. 79-4).

**R4-26-155. Renumbered**

**Historical Note**

Former Section R4-26-120 renumbered to R4-26-306 effective July 27, 1979 (Supp. 79-4).

**R4-26-156. Renumbered**

**Historical Note**

Former Section R4-26-120 renumbered to R4-26-307 effective July 27, 1979 (Supp. 79-4).

**R4-26-157. Renumbered**

**Historical Note**

Former Section R4-26-120 renumbered to R4-26-201 effective July 27, 1979 (Supp. 79-4).

## ARTICLE 2. LICENSURE

**R4-26-201. Application Deadline**

**A.** The Board shall consider a license application at the Board's next scheduled meeting if an administratively complete application packet is received by the Board office at least 18 days before the date of the meeting.

**B.** The Board shall consider a license application that is received fewer than 18 days before a scheduled meeting at a subsequent meeting.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended subsection (A) statute reference, effective June 30, 1981 (Supp. 81-3). Renumbered from R4-26-120 and amended effective July 3, 1991 (Supp. 91-3). Repealed effective March 3, 1995 (Supp. 95-1). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). New Section R4-26-201 renumbered from R4-26-108 and amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-202. Doctorate**

**A.** The Board shall apply the following criteria to determine whether a doctoral program provided by an institution of higher education met the standards in A.R.S. § 32-2071(A)(2) at the time an applicant began the degree program:

1. The program is identified and labeled as a psychology program if there were institutional catalogues and brochures that specified the intent of the institution of higher education to educate and train psychologists;
2. The program stands as a recognized, coherent organizational entity if there was an organized sequence of courses comprising a psychology curriculum; and
3. The program has clearly identified entry and exit criteria within its psychology curriculum if there were specific prerequisites for entrance into the program and delineated requirements for graduation.

**B.** The Board shall verify that an applicant completed the hours in the subject areas described in A.R.S. § 32-2071(A)(4). For this purpose, the applicant shall have the institution of higher education that the applicant attended provide directly to the Board an official transcript of all courses taken and verification of the dissertation or similar project.

1. The Board may require additional documentation from the applicant or from the institution to determine whether the applicant satisfied the requirements of A.R.S. § 32-2071(A)(4).
2. The Board shall count five quarter hours or six trimester hours as the equivalent of three semester hours, as required under A.R.S. § 32-2071(A)(4). When an academic term is other than a semester, quarter, or trimester, 15 classroom contact hours equals one semester hour.

**C.** To determine whether a comprehensive examination taken by an applicant as part of a doctoral program in psychology satisfies the requirements of A.R.S. § 32-2071(A)(4), the Board shall review documentation provided directly to the Board by the institution of higher education that granted the doctoral degree, that demonstrates how the applicant's comprehensive examination was constructed, lists criteria for passing, and provides the information used to determine that the applicant passed.

**D.** The Board shall not accept as core program hours required under A.R.S. § 32-2071(A)(4) credit:

1. For workshops, practica, undergraduate courses, life experiences, continuing education courses, or experiential or correspondence courses;
2. Transferred from institutions that are not accredited under A.R.S. § 32-2071(A)(1); or
3. For seminars, readings courses, or independent study unless the applicant proves that the course was an in-depth study devoted to a particular core program content area by submitting one or more of the following:
   a. Course description in the official catalogue of the institution of higher education,
   b. Course syllabus, or
   c. Signed statement from a dean or psychology department head affirming that the course was an in-depth study devoted to a particular core program content area.

**E.** The Board shall count a course or comprehensive examination only once to satisfy a requirement of A.R.S. § 32-2071(A)(4).

**F.** An honorary doctorate degree does not qualify an applicant for licensure as a psychologist.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended effective June 17, 1981 (Supp. 81-3). Renumbered from R4-26-121 and amended effective July 3, 1991 (Supp. 91-3). Amended effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

**R4-26-203. Application for Initial License**

**A.** An individual who wishes to be licensed as a psychologist shall submit an application packet to the Board that includes an application form approved by the Board, which is available

from the Board office and on its website, with an attestation that is signed and dated by the applicant.

**B.** Additionally, an applicant shall submit:
1. An original, un-retouched, photograph of the applicant that is no larger than 1.5 X 2 inches and taken no more than 60 days before the date of application;
2. The results of a self-query from the National Practitioner Data Bank;
3. A copy of a valid fingerprint clearance card issued by the Department of Public Safety under A.R.S. Title 41, Chapter 12, Article 3.1 or evidence of application for a valid fingerprint clearance card;
4. As required under A.R.S. § 41-1080(A), the specified documentation of citizenship or alien status indicating the applicant's presence in the U.S. is authorized under federal law;
5. The Board's Mandatory Confidential Information form;
6. Name, position, and address of at least two individuals to serve as references who:
   a. Are psychologists licensed or certified to practice psychology in a United States or Canadian regulatory jurisdiction and who are not members of the Arizona Board of Psychologist Examiners;
   b. Are familiar with the applicant's work experience in the field of psychology or in a postdoctoral program within the three years immediately before the date of application. If more than three years have elapsed since the applicant last engaged in professional activities in the field of psychology or in a postdoctoral program, the references may pertain to the most recent three-year period in which the applicant engaged in professional activities in the field of psychology or in a postdoctoral program; and
   c. Recommend the applicant for licensure;
7. The fee required under R4-26-108; and
8. Any other information authorized by statute.

**C.** In addition to the requirements in subsections (A) and (B), an applicant shall arrange to have the following directly submitted to the Board:
1. An official transcript from each university or college from which the applicant attended a graduate program or received a graduate degree that contains the date the degree was conferred;
2. An official document from the degree-granting institution indicating that the applicant completed a residency that satisfies the requirements of A.R.S. § 32-2071(K);
3. For an applicant applying supervised preinternship hours toward licensure, an attestation submitted by the doctoral program training director, faculty supervisor, or other official of the doctoral-granting institution who is knowledgeable of the applicant's preinternship experience verifying that the applicant's preinternship experience meets the requirements of A.R.S. § 32-2071(D).
4. An attestation from the applicant's supervisor, if available, or a psychologist knowledgeable of the applicant's internship training program, verifying that the applicant's internship training program meets the requirements in A.R.S. § 32-2071(F). If the supervisor or knowledgeable psychologist is not available, the Board shall accept primary source verification received from the Association of State and Provincial Psychology Boards. In this subsection, "not available" means the supervisor or knowledgeable psychologist is deceased or all reasonable efforts to locate the supervisor or knowledgeable psychologist were unsuccessful;
5. For an applicant applying supervised postdoctoral experience toward licensure, an attestation from the applicant's postdoctoral supervisor, if available, or a psychologist knowledgeable of the applicant's postdoctoral experience verifying that the applicant's postdoctoral experience meets the requirements in A.R.S. § 32-2071(G). If the supervisor or knowledgeable psychologist is not available, the Board shall accept primary source verification received from the Association of State and Provincial Psychology Boards. In this subsection, "not available" means the supervisor or knowledgeable psychologist is deceased or all reasonable efforts to locate the supervisor or knowledgeable psychologist were unsuccessful;
6. Verification of all other psychology licenses or certificates ever held in any regulatory jurisdiction; and
7. An official notification of the applicant's score on the national examination. An applicant who passed the national examination in accordance with the standard established at A.R.S. § 32-2072(A), shall have the examination score sent directly to the Board by the Association of State and Provincial Psychology Boards or by the regulatory jurisdiction in which the applicant originally passed the examination.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended effective April 25, 1980 (Supp. 80-2). Amended Introductory paragraph statute reference, effective June 30, 1981 (Supp. 81-3). Renumbered from R4-26-122 and amended effective July 3, 1991 (Supp. 91-3). Former Section R4-26-203 repealed, new Section R4-26-203 renumbered from R4-26-204 and amended effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 26 A.A.R. 1010, effective July 4, 2020 (Supp. 20-2). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-203.01. Application for Licensure by Credential**

**A.** An applicant for a psychologist license by credential under A.R.S. § 32-2071.01(D) shall submit an application packet to the Board that includes:
1. An application form approved by the Board, which is available from the Board office and on its website, with an attestation that is signed and dated by the applicant;
2. A copy of a valid fingerprint clearance card issued by the Department of Public Safety under A.R.S. Title 41, Chapter 12, Article 3.1 or evidence of application for a valid fingerprint clearance card;
3. As required under A.R.S. § 41-1080(A), the specified documentation of citizenship or alien status indicating the

applicant's presence in the U.S. is authorized under federal law;

4. Verification sent directly to the Board by the credentialing agency that the applicant:
   a. Holds a current Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards;
   b. Holds a current National Register of Health Service Providers in Psychology (NRHSPP) credential and has practiced psychology independently at the doctoral level for at least five years; or
   c. Is a diplomate or specialist of the American Board of Professional Psychology (ABPP); and
5. Verification of all other psychology licenses or certificates ever held in any jurisdiction.

**B.** An applicant for a psychologist license by credential based on a National Register of Health Service Providers in Psychology credential shall have notification that the applicant obtained a passing score on the national examination sent directly to the Board by the Association of State and Provincial Psychology Boards or by the regulatory jurisdiction in which the applicant originally passed the examination.

**C.** If the Board determines an application for licensure by credential requires clarification, the Board may require an applicant submit or cause the applicant's credentialing agency to submit directly to the Board any documentation including transcripts, course descriptions, catalogues, brochures, supervised experience verifications, examination scores, application for credential, or any other information deemed necessary by the Board.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 26 A.A.R. 1010, effective July 4, 2020 (Supp. 20-2). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-203.02. Application to Take National Examination before Completing Supervised Professional Experience Required for Licensure**

**A.** As provided under A.R.S. § 32-2072(C), an individual who has completed the education requirements specified in A.R.S. § 32-2071(A) but has not completed the supervised professional experience requirements specified in A.R.S. § 32-2071(D) may apply to the Board for approval to take the national examination.

**B.** To apply under subsection (A) for approval to take the national examination, an individual shall submit to the Board the application form and applicable documents required under R4-26-203(A) through (C) except the document required under R4-26-203(B)(3).

**C.** The Board shall administratively close an approved application to take the national examination when the Board receives the applicant's examination score. If necessary, an individual granted approval to take the national examination may request an extension under R4-26-204.

**D.** An individual whose application to take the national examination is approved may apply for an initial license under R4-26-203 after completing the supervised professional experience requirements specified in A.R.S. § 32-2071(D) as follows:

1. Within 36 months after the application to take the national examination submitted under subsection (B) was administratively closed under subsection (C), request that the Board re-open the application submitted under subsection (B); and
2. Submit the portions of the application packet required under R4-26-203 that were not submitted under subsection (B).

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-203.03. Reapplication for License; Applying Anew**

**A.** The following may reapply for a license:
1. An individual who failed the national examination required under A.R.S. § 32-2072 and R4-26-204 no more than three times, and
2. An individual whose application submitted under R4-26-203 or R4-26-203.01 was administratively closed by the Board under R4-26-208(H) less than one year before reapplication.

**B.** An individual identified in subsection (A) may ask the Board to base a licensing decision, in part, on applicable forms and documents previously submitted.

**C.** An individual eligible under subsection (B) to reapply for licensure shall:
1. Submit a reapplication form, which is available from the Board office and on its website, to the Board;
2. If previously submitted references were submitted more than 12 months before the date of reapplication, provide the names, positions, and addresses of at least two individuals to serve as references who:
   a. Are psychologists licensed or certified to practice psychology in a United States or Canadian regulatory jurisdiction and are not members of the Arizona Board of Psychologist Examiners;
   b. Are familiar with the applicant's work experience in the field of psychology or in a postdoctoral program within the three years immediately before the date of reapplication. If more than three years have elapsed since the applicant last engaged in professional activities in the field of psychology or in a postdoctoral program, the references may pertain to the most recent three-year period in which the applicant engaged in professional activities in the field of psychology or in a postdoctoral program; and
   c. Recommend the applicant for licensure;
3. List all professional employment since the date of the most recent application or reapplication including:
   a. Beginning and ending dates of employment,
   b. Number of hours worked per week,
   c. Name and address of employer,
   d. Position title,
   e. Nature of work, and
   f. Nature of supervision;
4. Submit the results of a self-query from the National Practitioner Data Bank;
5. Submit a copy of a valid fingerprint clearance card issued by the Department of Public Safety under A.R.S. Title 41, Chapter 12, Article 3.11 or evidence of application for a valid fingerprint clearance card; and
6. Pay the fee required under R4-26-108(A)(2).

**D.** The following shall apply anew for a license rather than reapplying:
1. An individual whose application submitted under R4-26-203 or R4-26-203.01 was denied by the Board,
2. An individual who was permitted by the Board to withdraw an application submitted under R4-26-203 or R4-26-203.01 before the Board acted on the application,
3. An individual whose application submitted under R4-26-203 or R4-26-203.01 was administratively closed by the Board under R4-26-208(H) more than one year before another application is submitted,
4. An individual whose license was revoked under A.R.S. § 32-2081(N)(1),
5. An individual whose license expired under A.R.S. § 32-2074,
6. An individual whose license was canceled under A.R.S. 32-2074, and
7. An individual who retired under A.R.S. § 32-2073(G).

**Historical Note**
New Section made by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-203.04. Temporary License under A.R.S. § 32-2073(B)**

**A.** To be eligible to be issued a temporary license under A.R.S. § 32-2073(B), an individual shall:
1. Have completed the educational requirements specified in A.R.S. § 32-2071(A) through (C);
2. Have completed 1,500 hours of supervised professional experience as described in A.R.S. § 32-2071(F); and
3. Be participating in a supervised postdoctoral professional experience as described in A.R.S. § 32-2071(G).

**B.** An applicant seeking a temporary license under A.R.S. § 32-2073(B), shall submit an application packet to the Board that includes:
1. The application form required under R4-26-203 and all information required under R4-26-203(B) and (C) except that specified in R4-26-203(C)(3), (5), and (7);
2. The written training plan required under A.R.S. § 32-2071(G)(7) from the entity at which the supervised postdoctoral professional experience is occurring that includes at least the following:
   a. Goal and content of each training experience,
   b. Expectations regarding the nature, quality, and quantity of work to be done by the supervisee during the supervised postdoctoral professional experience,
   c. Methods of evaluating the supervisee and the supervised postdoctoral professional experience,
   d. Total number of hours to be accrued during the supervised postdoctoral professional experience,
   e. Total number of face-to-face contact hours the supervisee is to have with clients or patients during the supervised postdoctoral professional experience,
   f. Total number of hours of supervision the supervisee is to receive during the supervised postdoctoral professional experience,
   g. Qualifications of all individuals who provide supervision during the supervised postdoctoral professional experience including documentation that each is qualified under the standards at A.R.S. § 32-2071(G),
   h. Acknowledgment that ethics training is included in the training experience; and
3. A written request for approval to take the national examination specified under A.R.S. § 32-2072, if applicable, using a form approved by the Board and available in the Board office and on its website.

**C.** An individual issued a temporary license under A.R.S. § 32-2073(B) shall practice psychology only under supervision. It is unprofessional conduct for the holder of a temporary license issued under A.R.S. § 32-2073(B) to practice psychology without supervision.

**D.** A temporary license issued under A.R.S. § 32-2073(B) is valid for 36 months and is not renewable. If the Board denies an active license under R4-26-203 to the holder of a temporary license issued under A.R.S. § 32-2073(B), the temporary license terminates at the time of license denial.

**E.** The holder of a temporary license issued under A.R.S. § 32-2073(B) shall:
1. Comply fully with all provisions of A.R.S. Title 32, Chapter 19.1, and this Chapter;
2. Not practice psychology outside the postdoctoral experience specified in the written training plan required under subsection (B)(2); and
3. Submit to the Board a proposed new training plan if the written training plan required under subsection (B)(2) is modified. The proposed new training plan shall be submitted within 10 days after the effective date of the modification.

**F.** The holder of a temporary license who was not previously approved to take the national examination may submit to the Board a written request for approval to take the national examination using a form approved by the Board and available in the Board office.

**Historical Note**
New Section made by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-204. Examinations**

**A.** General rules.
1. Under A.R.S. § 32-2072(C), an applicant who fails the national examination three times in any regulatory jurisdiction shall, before taking the national examination again, review the applicant's areas of deficiency and implement a program of study or practical experience designed to remedy the deficiencies. This remedial program may consist of any combination of course work, self-study, internship experience, and supervision.
2. An applicant required under subsection (A)(1) to implement a program of study or practical experience may apply anew for licensure. The applicant shall submit a new application packet, as described in R4-26-203, and include information about any actions proposed under subsection (A)(1).
3. The holder of a temporary license issued under A.R.S. § 32-2073(B) who:
   a. Fails the national examination three times and complies with subsection (A)(1) may submit to the Board a written request to retake the national examination using a form that is approved by the Board and available at the Board office and on its website; or

b. Fails to take the national examination within one year after the Board's authorization to do so shall submit a written request for approval to take the national examination using a form that is approved by the Board and available at the Board office and on its website.

4. Examination deadline. The Board shall administratively close the file of an applicant authorized by the Board to take an examination specified in subsection (B) or (C) who fails to take the examination within one year from the date of the Board's authorization.

5. Extension of examination deadline. An applicant or the holder of a temporary license issued under A.R.S. § 32-2073(B) may obtain an extension of the examination deadline specified in subsection (A)(3)(b) or (A)(4). To obtain an extension of the examination deadline, the applicant or temporary licensee shall submit a written request to the Board's Executive Director on or before the examination deadline. The Board shall grant the applicant or temporary licensee one extension of up to six months to take the examination. The applicant or temporary licensee may request additional extensions for good cause, which includes but is not limited to illness or injury of the licensee or a close family member, death of a close family member, birth or adoption of a child, military service, relocation, natural disaster, financial hardship, or residence in a foreign country for at least 12 months of the license period. The Board shall ensure that an extension is for no more than six months.

6. The Board shall deny or revoke a license, as applicable, if an applicant or temporary licensee commits any of the following acts with respect to a licensing examination specified under subsection (B) or (C):
   a. Violates the confidentiality of examination materials;
   b. Removes any examination materials from the examination room;
   c. Reproduces any portion of a licensing examination;
   d. Aids in the reproduction or reconstruction of any portion of a licensing examination;
   e. Pays or uses another person to take a licensing examination or to reconstruct any portion of the licensing examination;
   f. Obtains examination material, either before, during, or after an examination, for the purpose of instructing or preparing applicants for examinations;
   g. Sells, distributes, buys, receives, or has possession of any portion of a future, current, or previously administered licensing examination that is not authorized by the Board or its authorized agent for release to the public;
   h. Communicates with any other examinee during the administration of a licensing examination;
   i. Copies answers from another examinee or permits the copying of answers by another examinee;
   j. Possesses during the administration of a licensing examination any books, equipment, notes, written or printed materials, or data of any kind, other than material distributed during the examination; or
   k. Impersonates another examinee.

**B.** National examination. Under A.R.S. § 32-2072, the Board shall require that an applicant or temporary licensee take and pass the national examination. An applicant or temporary licensee authorized by the Board to take the national examination passes the examination by obtaining a score that equals or exceeds the passing score specified in A.R.S. § 32-2072(A). After the Board receives the examination results, the Board shall notify the applicant or temporary licensee in writing of the results.

**C.** Additional examination.

1. The Board shall require an applicant or temporary licensee to pass the national examination specified in subsection (B) before allowing the applicant or temporary licensee to take an additional examination.
2. Under A.R.S. § 32-2072(B), the Board may administer an additional examination to an applicant or temporary licensee to determine the adequacy of the applicant's or temporary licensee's knowledge and application of Arizona law. The additional examination may also cover the practice of psychology, ethical conduct, and psychological assessment and treatment practices.
   a. The Board shall review and approve the additional examination before administration;
   b. The additional examination may be developed and administered by the Board, a committee of the Board, consultants to the Board, or independent contractors; and
   c. Examiners and consultants to the Board shall execute a security acknowledgment form and agree to maintain examination security.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended Introductory paragraph statute reference, effective June 30, 1981 (Supp. 81-3). Renumbered from R4-26-123 and amended effective July 3, 1991 (Supp. 91-3). Former Section R4-26-204 renumbered to R4-26-203, new Section R4-26-204 renumbered from R4-26-205 and amended effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4743, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**Appendix A. Repealed**

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended subsections (A) and (B) statute references, effective June 30, 1981 (Supp. 81-3). Amended effective November 1, 1985 (Supp. 85-6). Renumbered from R4-26-124 and amended effective July 3, 1991 (Supp. 91-3). Renumbered from R4-26-205, Appendix A (Supp. 95-1). Appendix A repealed by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1).

**R4-26-205. Renewal of License**

**A.** A license issued by the Board, whether active or inactive, expires on the last day of a licensee's birth month during the licensee's renewal year.

**B.** The Board considers a license renewal application packet timely if submitted to the online renewal system on or before the last day of a licensee's birth month during the licensee's renewal year.

**C.** To renew a license, a licensee shall submit to the Board a renewal application form approved by the Board and available on its website, with an attestation that is signed and dated by the licensee.

**D.** Additionally, to renew a license, a licensee shall submit to the Board:
1. The license renewal fee required under R4-26-108;
2. A copy of a valid fingerprint clearance card issued by the Department of Public Safety under A.R.S. Title 41, Chapter 12, Article 3.1;
3. If the documentation previously submitted under R4-26-203(B)(3) was a limited form of work authorization issued by the federal government, evidence that the work authorization has not expired;
4. The following information about the continuing education completed during the previous license period:
   a. Title of the continuing education;
   b. Date completed;
   c. Sponsoring organization, publication, or educational institution;
   d. Number of hours in the continuing education; and
   e. Brief description of the continuing education; and
5. Any other information authorized by statute.

**E.** If a completed application is timely submitted under subsections (C) and (D), the licensee may continue to practice psychology under the active license until notified by the Board that the application for renewal has been approved or denied. If the Board denies license renewal, the licensee may continue to practice psychology until the last day for seeking review of the Board's decision or a later date fixed by a reviewing court.

**F.** Under A.R.S. § 32-2074 (C), the license of a licensee who fails to submit a renewal application, including the information about continuing education completed, on or before the last day of the licensee's birth month during the licensee's renewal year expires and the licensee shall immediately stop practicing psychology.

**G.** A psychologist whose license expires under subsection (F) may have the license reinstated by submitting the following to the Board within two months after the last day of the licensee's birth month during the licensee's renewal year:
1. The license renewal application required under subsection (C) and the documents required under subsections (D)(2) through (4); and
2. The license renewal and reinstatement fees required under R4-26-108.

**H.** A psychologist whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) may have the license reinstated by:
1. Complying with subsection (G) within one year after the last day of the licensee's birth month during the licensee's renewal year, and
2. Paying the fee for reinstatement of an active or inactive license as specified in R4-26-108.

**I.** A psychologist whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) or (H) may be licensed again only by complying with R4-26-203.

**J.** If the Board audits the continuing education records of a licensee and determines that some of the hours do not conform to the standards listed in R4-26-207, the Board shall disallow the non-conforming hours. If the remaining hours are less than the number required, the Board shall deem the licensee as failing to satisfy the continuing education requirements and provide notice of the disallowance to the licensee. The licensee has 90 days from the mailing date of the Board's notification of disallowance to complete the continuing education requirements for the past reporting period and shall provide the Board with an affidavit documenting completion. If the Board does not receive an affidavit within 90 days of the mailing date of notification of disallowance or the Board deems the affidavit insufficient, the Board may take disciplinary action under A.R.S. § 32-2081.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended subsections (A) and (B) statute references, effective June 30, 1981 (Supp. 81-3). Amended effective November 1, 1985 (Supp. 85-6). Renumbered from R4-26-124 and amended effective July 3, 1991 (Supp. 91-3). Former Section R4-26-205 renumbered to R4-26-204; new Section R4-26-205 renumbered from R4-26-206 and amended effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 10 A.A.R. 4743, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4). Amended by final rulemaking at 26 A.A.R. 1010, effective July 4, 2020 (Supp. 20-2). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-206. Reinstatement of License from Inactive to Active Status; Cancellation of License**

**A.** Except as provided in subsection (C), when considering reinstatement of a psychologist from inactive to active status, the Board shall presume that the psychologist has maintained and updated the psychologist's professional knowledge and capability to practice as a psychologist if the psychologist presents to the Board documentation of completion of a prorated amount of continuing education, calculated under subsection (B).

**B.** A psychologist who is on inactive status for at least two years may reinstate the license to active status by presenting to the Board:
1. A copy of a valid fingerprint clearance card issued by the Department of Public Safety under A.R.S. Title 41, Chapter 12, Article 3.1;
2. If the documentation previously submitted under R4-26-203(B)(3) was a limited form of work authorization issued by the federal government, evidence that the work authorization has not expired; and

3. Documentation of completion of at least 40 hours of continuing education that meets the standards in R4-26-207. A psychologist who is on inactive status for less than two years may reinstate the license to active status by presenting to the Board documentation of completion of a prorated amount of continuing education. To calculate the prorated amount of continuing education hours required, the Board shall multiply 1.67 by the number of months from the date of inactive status until the date the application for reinstatement is received by the Board. For every six months of inactive status, the Board shall require one hour of continuing education in ethics.

**C.** A psychologist may request that the Board cancel the psychologist's license if the psychologist is not under investigation by any regulatory jurisdiction. Fees paid to obtain a license are not refundable when the license is canceled. If an individual whose request for license cancellation is approved by the Board subsequently decides to practice psychology, the individual shall submit a new application under R4-26-203 and meet the requirements in A.R.S. § 32-2071.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended effective June 17, 1981 (Supp. 81-3). Renumbered from R4-26-125 effective July 3, 1991 (Supp. 91-3). Former Section R4-26-206 renumbered to R4-26-205; new Section R4-26-206 adopted effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 2007, effective July 2, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-207. Continuing Education**

**A.** A licensee shall complete at least 40 hours of continuing education during each license period. Unless specified otherwise, one clock hour of instruction, training, or making a presentation equals one hour of continuing education.

**B.** A licensee shall ensure the continuing education hours obtained include at least four hours in professional ethics.

**C.** During the license period in which an individual is initially licensed, the Board shall pro-rate the number of continuing education hours, including a pro-rated number of hours addressing ethics, that the new licensee must complete during the initial license period. To calculate the number of continuing education hours that a new licensee must obtain, the Board shall divide the 40 hours of continuing education required in a license period by 24 and multiply the quotient by the number of whole months from the date of initial licensure until the end of the license period. During the first license period, for every six months from the month of license issuance to the end of the license period, the Board shall require one hour of continuing education in ethics.

**D.** If the standards in subsection (F) are met, the Board shall accept the following for continuing education hours.

1. Post-doctoral study sponsored by a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1) and provides a graduate-level degree program;
2. A course, seminar, workshop, or home study for which a certificate of attendance or completion is provided;
3. A continuing education program offered by a national, international, regional, or state association, society, board, or continuing education provider;
4. Teaching a graduate-level course in applied psychology at a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1). A licensee who teaches a graduate-level course in applied psychology receives the same number of continuing education hours as number of classroom hours for those who take the graduate-level course;
5. Organizing and presenting a continuing education activity. A licensee who organizes and presents a continuing education activity receives the same number of continuing education hours as those who attend the continuing education activity;
6. Serving as a complaint consultant. During a license period, a licensee who serves as a Board complaint consultant to review Board complaints and provides written reports to the Board or provides expert testimony on behalf of the Board may receive continuing education hours equal to the actual number of hours served as a complaint consultant to a maximum of 20 hours. A licensee who is paid by the Board for services rendered shall not receive continuing education credit for the time or services for which payment was made;
7. The Board shall allow a maximum of 10 continuing education hours for each of the following during a license period:
   a. Attending a Board meeting or serving as a member of the Board. A licensee receives up to six continuing education hours in professional ethics for attending both morning and afternoon sessions of a Board meeting and three continuing education hours for attending either the morning or afternoon session or at least four hours of a Board meeting. A licensee shall complete documentation provided by the Board at the time the licensee attends a Board meeting;
   b. Having an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published. A licensee who has an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published receives 10 continuing education hours in the year of publication;
   c. Participating in a study group for professional growth and development as a psychologist. A licensee receives one hour of continuing education for each hour of participation to a maximum of 10 continuing education hours for participating in a study group. The Board shall allow continuing education hours for participating in a study group only if the licensee maintains the documentation required under subsection (G)(5);
   d. Presenting a symposium or paper at a state, regional, national, or international psychology meeting. A licensee who presents a symposium or paper

receives the same number of continuing education hours as hours of the session, as published in the agenda of the meeting, at which the symposium or paper is presented to a maximum of 10 continuing education hours;

e. Presenting a poster during a poster session at a state, regional, national, or international psychology meeting. A licensee who presents a poster receives an hour of continuing education for each hour the licensee is physically present with the poster during the poster session, as published in the agenda of the meeting, to a maximum of 10 continuing education hours; and

f. Serving as an elected officer of an international, national, regional, or state psychological association or society. A licensee who serves as an elected officer may receive continuing education hours equal to the actual number of hours served to a maximum of 10 continuing education hours.

**E.** The Board shall not allow continuing education credit more than once in a license period for:
1. Teaching the same graduate-level course,
2. Organizing and presenting a continuing education activity on the same topic or content area, or
3. Presenting the same symposium or paper at a state, regional, national, or international psychology meeting.

**F.** Standards for continuing education. To be acceptable for continuing education credit, an activity identified in subsections (D)(1) through (4) shall:
1. Focus on the practice of psychology, as defined at A.R.S. § 32-2061, for at least 75 percent of the program hours; and
2. Be taught by an instructor who is readily identifiable as competent in the subject of the continuing education by having an advanced degree, teaching experience, work history, published professional articles, or previously presented continuing education on the same subject.

**G.** The Board shall accept the following documents as evidence of completion of continuing education hours:
1. A certificate of attendance or completion;
2. Statement signed by the provider verifying participation in the activity;
3. Copy of transcript of course completed under subsection (D)(1);
4. Documents indicating a licensee's participation as an elected officer or appointed member as specified in subsection (D)(7)(f); or
5. An attestation signed by all participants of a study group under subsection (D)(7)(c) that includes a description of the activity, subject covered, dates, and number of hours.

**H.** A licensee shall maintain the documents listed in subsection (G) through the license period following the license period in which the documents were obtained.

**I.** The Board may audit a licensee's compliance with continuing education requirements. The Board may deny renewal or take other disciplinary action against a licensee who fails to obtain or document required continuing education hours. The Board may discipline a licensee who commits fraud, deceit, or misrepresentation regarding continuing education hours.

**J.** A licensee who cannot meet the continuing education requirement for good cause may seek an extension of time to complete the continuing education requirement by submitting a written request to the Board with the timely submission of the renewal application required under R4-26-205.
1. Good cause includes but is not limited to illness or injury of the licensee or a close family member, death of a close family member, birth or adoption of a child, military service, relocation, natural disaster, financial hardship, or residence in a foreign country for at least 12 months of the license period.
2. The Board shall not grant an extension longer than one year.
3. A licensee who cannot complete the continuing education requirement within the extension may apply to the Board for inactive license status under A.R.S. § 32-2073 (G).

**K.** No continuing education hours may be carried over to the next licensing period.

**L.** The Board shall not accept for continuing education hours a course, workshop, seminar, or symposium designed to increase income or office efficiency.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended effective January 23, 1981 (Supp. 81-1). Renumbered from R4-26-126 and amended effective July 3, 1991 (Supp. 91-3). Former Section R4-26-207 repealed; new Section R4-26-207 adopted effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995. Text corrected. (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4743, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4). Amended by final rulemaking at 26 A.A.R. 1010, effective July 4, 2020 (Supp. 20-2).

### R4-26-208. Time Frames for Processing Applications

**A.** For the purpose of A.R.S. § 41-1073, the Board establishes the time frames listed in Table 1. An applicant or a person requesting an approval from the Board and the Board's Executive Director may agree in writing to extend the substantive review and overall time frames by no more than 25 percent of the overall time frame.

**B.** The administrative completeness review time frame begins when the Board receives an application packet or request for approval. During the administrative completeness review time frame, the Board shall notify the applicant or person requesting approval that the application packet or request for approval is either complete or incomplete. If the application packet or request for approval is incomplete, the Board shall specify in the notice what information is missing.

**C.** If an applicant or person requesting approval receives a notice of incompleteness under subsection (B), the applicant or person requesting approval shall submit the missing information to the Board within the time to complete listed in Table 1. Both the administrative completeness review and overall time frames are suspended from the date of the Board's notice under subsection (B) until the Board receives all of the missing information.

**D.** Upon receipt of all missing information, the Board shall send a written notice of administrative completeness to the applicant

or person requesting approval. The Board shall not send a separate notice of completeness if the Board grants or denies a license or approval within the administrative completeness time frame listed in Table 1.

**E.** The substantive review time frame listed in Table 1 begins on the date of the Board's notice of administrative completeness sent under subsection (D).

**F.** If the Board determines during the substantive review that additional information is needed, the Board shall send the applicant or person requesting approval a comprehensive written request for additional information.

**G.** An applicant or person requesting approval who receives a request under subsection (F) shall submit the additional information to the Board within the time for response listed in Table 1. Both the substantive review and overall time frames are suspended from the date of the Board's request until the Board receives the additional information.

**H.** An applicant or person requesting approval may receive a 30-day extension of the time provided under subsection (C) or (G) by providing written notice to the Board before the time expires. If an applicant or person requesting approval fails to submit to the Board the missing or additional information within the time provided under Table 1 or the time as extended, the Board shall administratively close the applicant's or person's file.

**I.** At any time before the overall time frame provided in Table 1 expires, an applicant or person requesting approval may, with approval by the Board, withdraw the application or request.

**J.** Within the overall time frame listed in Table 1, the Board shall:

1. Grant a license or approval if the Board determines that the applicant or person requesting approval meets all criteria required by statute and this Chapter; or
2. Deny a license or approval if the Board determines that the applicant or person requesting approval does not meet all criteria required by statute and this Chapter.

**K.** If the Board denies a license or approval, the Board shall send the applicant or person requesting approval a written notice explaining:

1. The reason for denial, with citations to supporting statutes or rules;
2. The right to appeal the denial by filing an appeal under A.R.S. Title 41, Chapter 6, Article 10;
3. The time for appealing the denial; and
4. The right to request an informal settlement conference.

**L.** If the last day of a time frame falls on a Saturday, Sunday, or an official state holiday, the time frame ends on the next business day.

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended effective January 23, 1981 (Supp. 81-1). Amended effective July 3, 1984 (Supp. 84-4). Amended effective February 24, 1988 (Supp. 88-1). Renumbered from R4-26-127 effective July 3, 1991 (Supp. 91-3). Former Section R4-26-208 repealed; new Section R4-26-208 amended effective March 3, 1995 (Supp. 95-1). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 5 A.A.R. 737, effective February 19, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4).

**Table 1. Time Frames (in days) for Processing Applications**

| Type of Application or Request | Statutory or Rule Authority | Administrative Completeness Time Frame | Time to Respond to Notice of Deficiency | Substantive Review Time Frame | Time to Respond to Request for Additional Information | Overall Time Frame |
|---|---|---|---|---|---|---|
| Application for initial license | A.R.S. §§ 32-2071, 32-2071.01, 32-2072, and R4-26-203 | 30 | 240 | 90 | 365 | 120 |
| Application for licensure by credential | A.R.S. §§ 32-2071.01, 32-2072; and R4-26-203.01 | 30 | 240 | 90 | 240 | 120 |
| Application to Take National Examination before Completing Experience Required for Licensure | A.R.S. § 32-2072(C) and R4-26-203.02 | 30 | 240 | 90 | 240 | 120 |
| Reapplication for Licensure | A.R.S. § 32-2067 and R4-26-203.03 | 30 | 240 | 90 | 240 | 120 |
| Application for license renewal | A.R.S. § 32-2074; R4-26-205 | 60 | N/A | 90 | N/A | 150 |
| Application for reinstatement of expired license | A.R.S. § 32-2074; R4-26-206 | 60 | N/A | 90 | N/A | 150 |
| Request for extension of time to complete continuing education | A.R.S. § 32-2074; R4-26-207 | 60 | N/A | 90 | N/A | 150 |

| Type of Application or Request | Statutory or Rule Authority | Administrative Completeness Time Frame | Time to Respond to Notice of Deficiency | Substantive Review Time Frame | Time to Respond to Request for Additional Information | Overall Time Frame |
|---|---|---|---|---|---|---|
| Application for registration as an out-of-state health care provider of telehealth services | A.R.S. § 36-3606; R4-26-108 | 30 | 240 | 90 | 365 | 120 |

**Historical Note**

Table 1 adopted by final rulemaking at 5 A.A.R. 737, effective February 19, 1999 (Supp. 99-1). Amended by final rulemaking at 9 A.A.R. 778, effective April 12, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4743, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 26 A.A.R. 1010, effective July 4, 2020 (Supp. 20-2). Amended by final exempt rulemaking at 27 A.A.R. 1272, effective September 1, 2021 (Supp. 21-3).

**R4-26-209. General Supervision**

**A.** Under A.R.S. § 32-2071(D), an applicant is required to obtain 3,000 hours of supervised professional experience.

**B.** A supervising psychologist shall not supervise a member of the psychologist's immediate family or the psychologist's employer or business partner.

**C.** Payment between a supervisor and supervisee.
1. A supervising psychologist may pay a monetary stipend or fee to a supervisee if the amount paid by the supervisor is not based on the supervisee's productivity or revenue generated by the supervisee;
2. A supervising psychologist who accepts a fee for providing the supervisory service in Arizona may be subject to disciplinary action by the Board; and
3. The Board shall look to the law of the jurisdiction in which the supervision occurred to determine whether to include as part of the 3,000 hours of supervised professional experience required under A.R.S. § 32-2071(D) hours for which an applicant paid the supervisor.

**D.** A psychologist who supervises the professional experience of an unlicensed individual is professionally responsible for all work done by the individual during the supervised experience.

**E.** The Board shall include in the 3,000 hours of supervised professional experience required under A.R.S. § 32-2071(D), hours obtained through a training program only if the training program provides the supervision required under A.R.S. § 32-2071(F)(2).

**Historical Note**

Adopted effective January 23, 1981 (Supp. 81-1). Renumbered from R4-26-128 and amended effective July 3, 1991 (Supp. 91-3). Former Section R4-26-209 renumbered to R4-26-208; new Section R4-26-209 adopted effective March 3, 1995 (Supp. 95-1). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

**R4-26-210. Supervised Professional Experience**

**A.** The Board shall use the following criteria to determine whether an applicant's supervised preinternship professional experience complies with A.R.S. § 32-2071(E):
1. The supervised preinternship professional experience was part of the applicant's doctoral program from an institution of higher education that meets the standards in A.R.S. § 32-2071(A);
2. The applicant completed appropriate academic preparation before beginning the supervised preinternship professional experience. The Board shall not include any assessment or treatment conducted as part of the required academic preparation in the hours of supervised preinternship professional experience; and
3. For each supervised preinternship professional experience training site, the applicant has a written training plan with both the training site and the institution of higher education at which the applicant is pursuing a doctoral degree that includes at least the following:
   a. Training activities included and the amount of time allotted to each activity,
   b. Goals and objectives of each training activity,
   c. Methods of evaluating the supervisee and the supervised preinternship professional experiences provided,
   d. Approval of all individuals providing supervision at sites external to the training site,
   e. Total number of hours to be accrued during the supervised preinternship professional experience,
   f. Total number of hours of face-to-face contact hours with clients or patients during the supervised preinternship professional experience,
   g. Total number of hours of supervision during the supervised preinternship professional experience,
   h. Qualifications of all individuals who provide supervision during the supervised preinternship professional experience, and
   i. Acknowledgment that ethics training will be included in all activities.

**B.** The Board shall use the following criteria to determine whether an applicant's internship or training program qualifies as supervised professional experience under A.R.S. § 32-2071(F):
1. The written statement required under A.R.S. § 32-2071(F)(9):
   a. Was established no later than the time the applicant entered the internship or training program; and
   b. Corresponds to the internship or training program the applicant completed;
2. A supervisor was directly available to the applicant when decisions were made regarding emergency psychological services provided to a client or patient as required under A.R.S. § 32-2071(F)(2);

3. Course work used to satisfy the requirements of A.R.S. § 32-2071(A) or dissertation time is not credited toward the face-to-face, individual supervision time required by A.R.S. § 32-2071(F)(6);
4. The two hours a week of other learning activities required under A.R.S. § 32-2071(F)(6) include one or more of the following:
   a. Case conferences involving a case in which the applicant was actively involved,
   b. Seminars involving clinical issues,
   c. Co-therapy with a professional staff person including discussion,
   d. Group supervision, or
   e. Additional individual supervision;
5. The training program had the applicant work with other doctoral level psychology trainees and included in the written statement required under A.R.S. § 32-2071(F)(9) a description of the program policy specifying the opportunities and resources provided to the applicant for working or interacting with other doctoral level psychology trainees in the same or other sites; and
6. Time spent fulfilling academic degree requirements, such as course work applied to the doctoral degree, practicum, field laboratory, dissertation, or thesis credit, is not credited toward the 1,500 hours of supervised professional experience hours required by A.R.S. § 32-2071(F). This subsection does not restrict a student from participating in activities designed to fulfill other doctoral degree requirements. However, the Board shall not credit time spent participating in activities to fulfill academic degree requirements toward the hours required under A.R.S. § 32-2071(F).

**C.** Under A.R.S. § 32-2071(G)(5), at least 40 percent of an applicant's supervised postdoctoral experience shall involve direct client or patient contact. If an applicant's supervised postdoctoral hours applied toward licensure include less than 40 percent direct contact hours, the applicant shall work additional time to achieve the required percentage of direct contact hours. While additional direct contact hours may be obtained to meet this requirement, the Board shall count no more than 1,500 hours of total postdoctoral experience for the purpose of licensure.

**D.** An applicant shall ensure the written training plan required under A.R.S. § 32-2071(G)(7) is from the organization at which the supervised postdoctoral professional experience is occurring and includes the following:
1. Goal and content of each training experience;
2. Expectations regarding the nature, quality, and quantity of work to be done by the supervisee during the supervised postdoctoral professional experience;
3. Methods of evaluation the supervisee and the supervised postdoctoral professional experience;
4. Total number of hours to be accrued during the supervised postdoctoral professional experience;
5. Total number of face-to-face contact hours the supervisee is to have with clients or patients during the supervised postdoctoral professional experience;
6. Total number of hours of supervision the supervisee is to receive during the supervised postdoctoral professional experience;
7. Qualifications of all individuals who provide supervision during the supervised postdoctoral professional experience including documentation that each is qualified under the standards at A.R.S. § 32-2071(G); and
8. Acknowledgement that ethics training is included in the supervised postdoctoral professional experience.

**Historical Note**

Adopted effective March 3, 1995 (Supp. 95-1). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 3879 (December 23, 2022), effective January 29, 2023 (Supp. 22-4).

**R4-26-211. Foreign Graduates**

**A.** Under A.R.S. § 32-2071(B), an applicant for licensure whose application is based on graduation from an institution of higher education located outside the U.S. and its territories shall demonstrate that the applicant's formal education is equivalent to a doctoral degree in psychology from a regionally accredited educational institution as described in A.R.S. § 32-2071(A).

**B.** The Board shall find that the institution of higher education from which an applicant under subsection (A) graduated is equivalent to a regionally accredited education institution only if the institution of higher education is included in one of the following:
1. International Handbook of Universities, published for the International Association of Universities by Stockton Press, 345 Park Avenue South, 10th floor, New York, NY 10010-1708;
2. Commonwealth Universities Yearbook, published for the Association of Commonwealth Universities by John Foster House, 36 Gordon Square, London, England, WC1H OPF; or
3. Another source the Board determines provides reliable information.

**C.** The academic transcript of an applicant under subsection (A) who graduated from an institution included under subsection (B) shall be translated into English and evaluated by a member organization of the National Association of Credential Evaluation Services (NACES). The applicant is responsible for paying all expenses incurred to obtain a translation and review of the academic transcript. An applicant can find information about obtaining a professional credential review at www.naces.org.

**D.** When the credential review required under subsection (C) is completed, the NACES member organization shall submit the review report to the Board. The Board shall review the report and determine whether the applicant's education meets the standard in subsection (A).

**E.** Upon written request, the Board may waive the credential review required under subsection (C) for an applicant who graduated from a doctoral program that is accredited by the accreditation panel of the Canadian Psychological Association.

**F.** After the Board determines that the formal education of an applicant under subsection (A) is equivalent to a doctoral degree in psychology from a regionally accredited educational institution, the applicant shall provide evidence to the Board that the applicant has met all other requirements for licensure.

**Historical Note**

Adopted effective March 3, 1995 (Supp. 95-1). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 10 A.A.R. 4743, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

## ARTICLE 3. REGULATION

**R4-26-301. Rules of Professional Conduct**

**A.** The Board incorporates by reference standards 1.01 through 10.10 of the "Ethical Principles of Psychologists and Code of Conduct" adopted by the American Psychological Association, effective June 1, 2003. The incorporated materials do not include any later amendments or editions. A copy of the standards is available from the American Psychological Association Order Department, 750 First Street, NE, Washington, DC 20002-4242, www.apa.org/ethics/code, or the Board office.

**B.** A licensee shall practice psychology in accordance with the standards incorporated under subsection (A).

**Historical Note**

Adopted effective July 27, 1979 (Supp. 79-4). Amended effective June 17, 1981. Amended effective June 30, 1981 (Supp. 81-3). Renumbered from R4-26-150 and amended effective July 3, 1991 (Supp. 91-3). Repealed effective March 3, 1995 (Supp. 95-1). Corrections made to text; agency filed different versions of text in original and copies; corrections reflect the original version (Supp. 95-2). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). New Section made by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

**R4-26-302. Informal Interviews**

**A.** When a complaint is scheduled for informal interview, the Board shall send written notice of an informal interview to the licensee who is the subject of the complaint, by personal service or certified mail, return receipt requested, at least 20 days before an informal interview.

**B.** The Board shall include the following in the written notice of an informal interview:
1. The time, date, and place of the interview;
2. An explanation of the informal nature of the proceedings;
3. The licensee's right to appear at the informal interview with legal counsel licensed in Arizona or without legal counsel;
4. A statement of the allegations and issues involved;
5. The licensee's right to a formal hearing instead of the informal interview; and
6. Notice that the Board may take disciplinary action at the conclusion of the informal interview;

**C.** The procedure used during an informal interview may include the following:
1. Swearing in and taking testimony from the licensee, complainant, and witnesses, if any;
2. Optional opening and closing remarks by the licensee;
3. An opportunity for the complainant to address the Board, if requested;
4. Board questions to the licensee, complainant, and witnesses, if any; and
5. Deliberation and discussion by the Board.

**Historical Note**

Renumbered from R4-26-151 effective July 3, 1991 (Supp. 91-3). New Section made by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

**R4-26-303. Titles**

A person shall not use a title that claims a potential or future degree or qualification such as "Ph.D. (Cand)," "Ph.D. (ABD)," "License Eligible," "Candidate for Licensure," or "Board Eligible." The use of a title that claims a potential or future degree or qualification is a violation of A.R.S. § 32-2061 et seq.

**Historical Note**

Renumbered from R4-26-151 effective July 3, 1991 (Supp. 91-3). New Section adopted effective March 3, 1995 (Supp. 95-1). Pursuant to the advice of the Attorney General, the text of this Section now contains the text certified by the Attorney General and filed as a copy effective March 3, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 3297, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

**R4-26-304. Representation before the Board by Attorney Not Admitted to State Bar of Arizona**

An attorney who is not a member of the State Bar of Arizona shall not represent a party before the Board unless the attorney is admitted to practice *pro hac vice* before the Board under Rule 38(a) of the Rules of the Supreme Court of Arizona.

**Historical Note**

Renumbered from R4-26-151 effective July 3, 1991 (Supp. 91-3). New Section made by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 22 A.A.R. 3083, October 4, 2016 (Supp. 16-4).

**R4-26-305. Confidentiality of Investigative Materials**

**A.** A psychologist shall not disclose a confidential record, as defined by R4-26-101, that relates to a Board investigation to any person or entity other than the psychologist's attorney, except:
1. A redacted summary that ensures the anonymity of the client or patient;
2. Information regarding the nature of a complaint, the processes utilized by the Board, and the outcomes of a case;
3. As required by law;
4. As required by a court order compelling production; or
5. If disclosure is protected under the United States or Arizona Constitutions.

**B.** A psychologist who violates this Section commits an act of unprofessional conduct.

**Historical Note**

Renumbered from R4-26-151 effective July 3, 1991 (Supp. 91-3). New Section made by final rulemaking at 13 A.A.R. 1493, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 3444, effective January 30, 2016 (Supp. 15-4).

As of April 30, 2025

## 32-2061. Definitions

In this chapter, unless the context otherwise requires:

1. "Active license" means a valid and existing license to practice psychology.

2. "Adequate records" means records containing, at a minimum, sufficient information to identify the client or patient, the dates of service, the fee for service, the payments for service, the type of service given and copies of any reports that may have been made.

3. "Board" means the state board of psychologist examiners.

4. "Client" means a person or an entity that receives psychological services. A corporate entity, a governmental entity or any other organization may be a client if there is a professional contract to provide services or benefits primarily to an organization rather than to an individual. If an individual has a legal guardian, the legal guardian is the client for decision-making purposes, except that the individual receiving services is the client or patient for:

(a) Issues that directly affect the physical or emotional safety of the individual, such as sexual or other exploitative relationships.

(b) Issues that the guardian agrees to specifically reserve to the individual.

5. "Committee on behavior analysts" means the committee established by section 32-2091.15.

6. "Exploit" means actions by a psychologist who takes undue advantage of the professional association with a client or patient, a student or a supervisee for the advantage or profit of the psychologist.

7. "Health care institution" means a facility as defined in section 36-401.

8. "Letter of concern" means an advisory letter to notify a psychologist that while there is insufficient evidence to support disciplinary action the board believes the psychologist should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the board may result in action against the psychologist's license.

9. "Patient" means a person who receives psychological services. If an individual has a legal guardian, the legal guardian is the client or patient for decision-making purposes, except that the individual receiving services is the client or patient for:

(a) Issues that directly affect the physical or emotional safety of the individual, such as sexual or other exploitative relationships.

(b) Issues that the guardian agrees to specifically reserve to the individual.

10. "Practice of psychology" means the psychological assessment, diagnosis, treatment or correction of mental, emotional, behavioral or psychological abilities, illnesses or disorders or purporting or attempting to do this consistent with section 32-2076.

11. "Psychologically incompetent" means a person lacking in sufficient psychological knowledge or skills to a degree likely to endanger the health of clients or patients.

12. "Psychological service" means all actions of the psychologist in the practice of psychology.

13. "Psychologist" means a natural person holding a license to practice psychology pursuant to this chapter.

14. "Supervisee" means any person who functions under the extended authority of the psychologist to provide, or while in training to provide, psychological services.

15. "Telepractice" means providing psychological services through interactive audio, video or electronic communication that occurs between the psychologist and the patient or client, including any electronic communication for diagnostic, treatment or consultation purposes in a secure platform, and that meets the requirements of telehealth pursuant to section 36-3602. Telepractice includes supervision.

16. "Unprofessional conduct" includes the following activities whether occurring in this state or elsewhere:

(a) Obtaining a fee by fraud or misrepresentation.

(b) Betraying professional confidences.

(c) Making or using statements of a character tending to deceive or mislead.

(d) Aiding or abetting a person who is not licensed pursuant to this chapter in representing that person as a psychologist.

(e) Gross negligence in the practice of a psychologist.

(f) Sexual intimacies or sexual intercourse with a current client or patient or a supervisee or with a former client or patient within two years after the cessation or termination of treatment. For the purposes of this subdivision, "sexual intercourse" has the same meaning prescribed in section 13-1401.

(g) Engaging or offering to engage as a psychologist in activities that are not congruent with the psychologist's professional education, training and experience.

(h) Failing or refusing to maintain and retain adequate business, financial or professional records pertaining to the psychological services provided to a client or patient.

(i) Commission of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

(j) Making a fraudulent or untrue statement to the board or its investigators, staff or consultants.

(k) Violating any federal or state laws or rules that relate to the practice of psychology or to obtaining a license to practice psychology.

(l) Practicing psychology while impaired or incapacitated to the extent and in a manner that jeopardizes the welfare of the client or patient or renders the psychological services provided ineffective.

(m) Using fraud, misrepresentation or deception to obtain or attempt to obtain a psychology license or to pass or attempt to pass a psychology licensing examination or in assisting another person to do so.

(n) Unprofessional conduct in another jurisdiction that resulted in censure, probation or a civil penalty or in the denial, suspension, restriction or revocation of a certificate or license to practice as a psychologist.

(o) Providing services that are unnecessary or unsafe or otherwise engaging in activities as a psychologist that are unprofessional by current standards of practice.

(p) Falsely or fraudulently claiming to have performed a professional service, charging for a service or representing a service as the licensee's own when the licensee has not rendered the service or assumed supervisory responsibility for the service.

(q) Representing activities or services as being performed under the licensee's supervision if the psychologist has not assumed responsibility for them and has not exercised control, oversight and review.

(r) Failing to obtain a client's or patient's informed and written consent to release personal or otherwise confidential information to another party unless the release is otherwise authorized by law.

(s) Failing to make client or patient records in the psychologist's possession promptly available to another psychologist who is licensed pursuant to this chapter on receipt of proper authorization to do so from the client or patient, a minor client's or patient's parent, the client's or patient's legal guardian or the client's or patient's authorized representative or failing to comply with title 12, chapter 13, article 7.1.

(t) Failing to take reasonable steps to inform or protect a client's or patient's intended victim and inform the proper law enforcement officials in circumstances in which the psychologist becomes aware during the course of providing or supervising psychological services that a client or patient intends or plans to inflict serious bodily harm on another person.

(u) Failing to take reasonable steps to protect a client or patient in circumstances in which the psychologist becomes aware during the course of providing or supervising psychological services that a client or patient intends or plans to inflict serious bodily harm on self.

(v) Abandoning or neglecting a client or patient in need of immediate care without making suitable arrangements for continuation of the care.

(w) Engaging in direct or indirect personal solicitation of clients or patients through the use of coercion, duress, undue influence, compulsion or intimidation practices.

(x) Engaging in false, deceptive or misleading advertising.

(y) Exploiting a client or patient, a student or a supervisee.

(z) Failing to report information to the board regarding a possible act of unprofessional conduct committed by another psychologist who is licensed pursuant to this chapter unless this reporting violates the psychologist's confidential relationship with the client or patient pursuant to section 32-2085. Any psychologist who reports or provides information to the board in good faith is not subject to an action for civil damages. For the purposes of this subdivision, it is not an act of unprofessional conduct if a licensee addresses an ethical conflict in a manner that is consistent with the ethical standards contained in the document entitled "ethical principles of psychologists and code of conduct" as adopted by the American psychological association and in effect at the time the licensee makes the report.

(aa) Violating a formal board order, consent agreement, term of probation or stipulated agreement issued under this chapter.

(bb) Failing to furnish information in a timely manner to the board or its investigators or representatives if requested or subpoenaed by the board as prescribed by this chapter.

(cc) Failing to make available to a client or patient or to the client's or patient's designated representative, on written request, a copy of the client's or patient's record, including raw test data, psychometric testing materials and other information as provided by law.

(dd) Violating an ethical standard adopted by the board.

32-2062. Board; qualifications; appointments; terms; compensation; immunity

A. The state board of psychologist examiners is established consisting of ten members appointed by the governor pursuant to section 38-211.

B. Each member of the board shall be a citizen of the United States and a resident of this state at the time of appointment. Seven members shall be licensed pursuant to this chapter, and three shall be public members who are not eligible for licensure. The board shall have at all times, except for the period when a vacancy exists, at least two members who are licensed as psychologists and who are full-time faculty members from universities in this state with a doctoral program in psychology that meets the requirements of section 32-2071, at least three members who are psychologists in professional practice and at least two members who are behavior analysts in professional practice and who are members of the committee on behavior analysts. The public members shall not have a substantial financial interest in the health care industry and shall not have a household member who is eligible for licensure under this chapter.

C. Each member shall serve for a term of five years beginning and ending on the third Monday in January.

D. A vacancy on the board occurring other than by the expiration of term shall be filled by appointment by the governor for the unexpired term as provided in subsection C of this section. The governor, after a hearing, may remove any member of the board for misconduct, incompetency or neglect of duty.

E. Board members shall receive compensation in the amount of one hundred dollars for each cumulative eight hours of actual service in the business of the board and reimbursement of all expenses pursuant to title 38, chapter 4, article 2.

F. Members of the board and its employees, consultants and test examiners are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this chapter.

32-2063. Powers and duties

A. The board shall:

1. Administer and enforce this chapter and board rules.

2. Regulate disciplinary actions, the granting, denial, revocation, renewal and suspension of licenses and the rehabilitation of licensees pursuant to this chapter and board rules.

3. Prescribe the forms, content and manner of application for licensure and renewal of licensure and set deadlines for the receipt of materials required by the board.

4. Keep a record of all licensees, board actions taken on all applicants and licensees and the receipt and disbursal of monies.

5. Adopt an official seal for attesting licenses and other official papers and documents.

6. Investigate charges of violations of this chapter and board rules and orders.

7. Subject to title 41, chapter 4, article 4, employ an executive director who serves at the pleasure of the board.

8. Annually elect from among its membership a chairman, a vice chairman and a secretary, who serve at the pleasure of the board.

9. Adopt rules pursuant to title 41, chapter 6 to carry out this chapter and to define unprofessional conduct.

10. Engage in a full exchange of information with other regulatory boards and psychological associations, national psychology organizations and the Arizona psychological association and its components.

11. By rule, adopt a code of ethics relating to the practice of psychology. The board shall base this code on the code of ethics adopted and published by the American psychological association. The board shall

apply the code to all board enforcement policies and disciplinary case evaluations and development of licensing examinations.

12. Adopt rules regarding the use of telepractice.

13. Before the board takes action, receive and consider recommendations from the committee on behavior analysts on all matters relating to licensing and regulating behavior analysts, as well as regulatory changes pertaining to the practice of behavior analysis, except in the case of a summary suspension of a license pursuant to section 32-2091.09, subsection E.

14. Beginning January 1, 2022, require each applicant for an initial or temporary license or a license renewal pursuant to this chapter to have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1. If an applicant is issued a valid fingerprint clearance card, the applicant shall submit the valid fingerprint clearance card to the board with the completed application. If an applicant applies for a fingerprint clearance card and is denied, the applicant may request that the board consider the application for licensure notwithstanding the absence of a valid fingerprint clearance card. The board, in its discretion, may approve an application for licensure despite the denial of a valid fingerprint clearance card if the board determines that the applicant's criminal history information on which the denial is based does not alone disqualify the applicant from licensure.

B. Subject to title 41, chapter 4, article 4, the board may employ personnel it deems necessary to carry out this chapter. The board, in investigating violations of this chapter, may employ investigators who may be psychologists. The board or its executive director may take and hear evidence, administer oaths and affirmations and compel by subpoena the attendance of witnesses and the production of books, papers, records, documents and other information relating to the investigation or hearing.

C. Subject to section 35-149, the board may accept, expend and account for gifts, grants, devises and other contributions, monies or property from any public or private source, including the federal government. The board shall deposit, pursuant to sections 35-146 and 35-147, monies received pursuant to this subsection in special funds for the purpose specified, and monies in these funds are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

D. Compensation for all personnel shall be determined pursuant to section 38-611.

32-2064. Meetings; committees; quorum

A. The board shall hold regular quarterly meetings at a time and place determined by the chairman. The board shall hold special meetings the chairman determines necessary to carry out the functions of the board.

B. The chairman may establish committees from the board membership necessary to carry out the functions of the board. The board may establish committees of licensed psychologists to act as consultants to the board. Members of consultant committees are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2.

C. A majority of board members constitutes a quorum and a majority vote of a quorum present is necessary for the board to take any action.

32-2065. Board of psychologist examiners fund; separate behavior analyst account

(L24, Ch. 222, sec. 31. Eff. until 7/1/28)

A. The board of psychologist examiners fund is established.

B. Except as provided in section 32-2081 and section 32-2091.09, subsection I, pursuant to sections 35-146 and 35-147, the board shall deposit fifteen percent of all monies collected pursuant to this chapter in the state general fund and deposit the remaining eighty-five percent in the board of psychologist examiners fund.

C. All monies deposited in the board of psychologist examiners fund are subject to section 35-143.01.

D. All monies deposited in the board of psychologist examiners fund pursuant to section 32-2067 and any monies received pursuant to section 32-2063, subsection C for psychologist licensing and regulation must be used only for licensing and regulating psychologists pursuant to this article and articles 2 and 3 of this chapter and may not be used for licensing and regulating behavior analysts pursuant to article 4 of this chapter.

E. All monies deposited in the board of psychologist examiners fund pursuant to article 4 of this chapter and any monies received pursuant to section 32-2063, subsection C for behavior analyst licensing and regulation must be used only for licensing and regulating behavior analysts pursuant to article 4 of this chapter and may not be used for licensing and regulating psychologists pursuant to this article and articles 2 and 3 of this chapter.

F. The board shall establish a separate account in the fund for monies transferred to the fund pursuant to article 4 of this chapter, and any monies received pursuant to section 32-2063, subsection C for behavior analyst licensing and regulation.

32-2065. Board of psychologist examiners fund; separate behavior analyst account

(L24, Ch. 222, sec. 32. Eff. 7/1/28)

A. The board of psychologist examiners fund is established.

B. Except as provided in section 32-2081 and section 32-2091.09, subsection I, pursuant to sections 35-146 and 35-147, the board shall deposit ten percent of all monies collected pursuant to this chapter in the state general fund and deposit the remaining ninety percent in the board of psychologist examiners fund.

C. All monies deposited in the board of psychologist examiners fund are subject to section 35-143.01.

D. All monies deposited in the board of psychologist examiners fund pursuant to section 32-2067 and any monies received pursuant to section 32-2063, subsection C for psychologist licensing and regulation must be used only for licensing and regulating psychologists pursuant to this article and articles 2 and 3 of this chapter and may not be used for licensing and regulating behavior analysts pursuant to article 4 of this chapter.

E. All monies deposited in the board of psychologist examiners fund pursuant to article 4 of this chapter and any monies received pursuant to section 32-2063, subsection C for behavior analyst licensing and regulation must be used only for licensing and regulating behavior analysts pursuant to article 4 of this

chapter and may not be used for licensing and regulating psychologists pursuant to this article and articles 2 and 3 of this chapter.

F. The board shall establish a separate account in the fund for monies transferred to the fund pursuant to article 4 of this chapter, and any monies received pursuant to section 32-2063, subsection C for behavior analyst licensing and regulation.

32-2066. Directory; change of address; costs; civil penalty

A. The board shall compile and publish on its web site a directory containing:

1. The names and addresses of the officers and members of the board.

2. The names and addresses of all licensees.

3. The current board rules.

4. A copy of this chapter.

5. Additional information the board deems of interest and importance to licensees.

B. A licensee shall inform the board in writing of the licensee's current residence address, office address and telephone number within thirty days of each change in this information. The board may assess the costs incurred by the board in locating a licensee and may assess a civil penalty of not more than one hundred dollars against a licensee who fails to notify the board within thirty days from the date of any change of information required to be reported under this subsection.

32-2067. Fees; alternative payment methods

A. The board, by a formal vote at its annual fall meeting, may establish fees and penalties that do not exceed:

1. Four hundred dollars for an application for an active license to practice psychology.

2. Two hundred dollars for an application for a temporary license to practice psychology.

3. Two hundred fifty dollars for reapplication for an active license.

4. Five hundred dollars for issuing an initial license. The board shall prorate this fee pursuant to subsection D of this section.

5. Fifty dollars for a duplicate license.

6. Five hundred dollars for biennial renewal of an active license.

7. Eighty-five dollars for biennial renewal of an inactive license.

8. Three hundred dollars for the reinstatement of an active or inactive license.

9. Three hundred fifty dollars for any additional examination.

10. Two hundred fifty dollars for delinquent compliance with continuing education requirements.

11. Five dollars for the sale of a duplicate renewal receipt.

12. Five dollars for the sale of a copy of the board's statutes and rules.

13. Two dollars for verification of a license.

14. Ten dollars for the sale of each audiotape of board meetings.

15. Five cents per name for the sale of computerized discs that contain the name of each licensee.

16. Twenty-five cents per name for the sale of computerized discs that contain the name and address of each licensee.

17. Thirty-five cents per name for the sale of customized computerized discs that contain additional licensee information that is not required by law to remain confidential.

18. Twenty-five cents per page for copying records, documents, letters, minutes, applications, files and policy statements. This fee includes postage.

B. The board may charge additional fees for services the board deems necessary and appropriate to carry out this chapter. These fees shall not exceed the actual cost of providing the service.

C. The board shall not refund fees except as provided in section 32-2073, subsection G. On special request and for good cause the board may return the license renewal fee.

D. The board shall prorate the fee for issuing an initial license by dividing the biennial renewal fee by twenty-four and multiplying that amount by the number of months that remain until the next biennial renewal date.

E. Subject to the requirements of section 41-2544, the executive director may enter into agreements to allow licensees to pay fees by alternative methods, including credit cards, charge cards, debit cards and electronic funds transfers.

32-2071. Qualifications of applicants; education; training

A. An applicant for licensure shall have a doctoral degree from an institution of higher education in clinical or counseling psychology, school or educational psychology or any other subject area in applied psychology acceptable to the board and shall have completed a doctoral program in psychology from an educational institution that has:

1. Been accredited by one of the following regional accrediting agencies at the time of the applicant's graduation:

(a) The New England association of schools and colleges.

(b) The middle states association of colleges and schools.

(c) The north central association of colleges and schools.

(d) The northwest association of schools and colleges.

(e) The southern association of colleges and schools.

(f) The western association of schools and colleges.

2. A program that is identified and labeled as a psychology program and that stands as a recognized, coherent organizational entity within the institution with clearly identified entry and exit criteria for graduate students in the program.

3. An identifiable psychology faculty in the area of health service delivery and a psychologist responsible for the program.

4. A core program that requires each student to demonstrate competence by passing suitable comprehensive examinations or by successfully completing at least three or more graduate semester hours, five or more quarter hours or six or more trimester hours or by other suitable means in the following content areas:

(a) Scientific and professional ethics and standards in psychology.

(b) Research, which may include design, methodology, statistics and psychometrics.

(c) The biological basis of behavior, which may include physiological psychology, comparative psychology, neuropsychology, sensation and perception and psychopharmacology.

(d) The cognitive-affective basis of behavior, which may include learning, thinking, motivation and emotion.

(e) The social basis of behavior, which may include social psychology, group processes, cultural diversity and organizational and systems theory.

(f) Individual differences, which may include personality theory, human development and abnormal psychology.

(g) Assessment, which includes instruction in interviewing and administering, scoring and interpreting psychological test batteries to diagnose cognitive abilities and personality functioning.

(h) Treatment modalities, which include instruction in the theory and application of a diverse range of psychological interventions to treat mental, emotional, psychological and behavioral disorders.

5. A psychology program that leads to a doctoral degree requiring at least the equivalent of three full-time academic years of graduate study, two years of which are at the institution from which the doctoral degree is granted.

6. A requirement that the student must successfully defend a dissertation, the content of which is primarily psychological, or an equivalent project acceptable to the board.

7. Official transcripts that have been prepared solely by the institution and not by the student and, except for manifest clerical errors or grade changes, have not been altered by the institution after the student's graduation.

8. Given the student credit only for coursework that is listed on its official transcripts and that is obtained only at regionally accredited educational institutions as listed in paragraph 1 of this subsection and does not give credit for continuing education experiences or courses.

B. If the institution is located outside the United States, the applicant shall demonstrate that the program meets the requirements of subsection A, paragraphs 2 through 7 and subsections C through M of this section.

C. The applicant shall complete relevant didactic courses of the program required under subsection A, paragraph 4 of this section before starting the supervised professional experiences as described pursuant to subsection F of this section.

D. Each applicant for licensure shall obtain three thousand hours of supervised professional work experiences. The applicant shall demonstrate clearly how the applicant met this requirement. The applicant shall obtain a minimum of one thousand five hundred hours through an internship as described in subsection F of this section. The applicant shall obtain the remaining one thousand five hundred hours through any combination of the following:

1. Supervised preinternship professional experiences as described in subsection E of this section.

2. Additional internship hours as described in subsection F of this section.

3. Supervised postdoctoral experiences as described in subsection G of this section.

E. If the applicant chooses to include up to one thousand five hundred hours of supervised preinternship professional experience to satisfy a portion of the three thousand hours of supervised professional experience, the following requirements must be met:

1. The applicant's supervised preinternship professional experiences shall reflect a faculty directed, organized, sequential series of supervised experiences of increasing complexity that follows appropriate academic coursework and that prepares the applicant for an internship.

2. The applicant's supervised preinternship professional experiences shall follow appropriate academic preparation. There must be a written training plan between the student and the graduate training program. The training plan for each supervised preinternship professional experience training site must designate an allotment of time for each training activity and must ensure the quality, breadth and depth of training experience by specifying goals and objectives of the supervised preinternship professional experience, the methods of evaluation of the student and supervisory experiences. If supervision is to be completed by qualified site supervisors at external sites, their approval must be included in the plan.

3. More than one part-time supervised preinternship professional experience placement of appropriate scope and complexity over the course of the graduate training may be combined to satisfy the one thousand five hundred hours of supervised preinternship professional experiences.

4. Every twenty hours of supervised preinternship professional experience must include the following:

(a) At least fifty percent of the supervised preinternship professional experiences must be in psychological service-related activities. Psychological service-related activities may include treatment, assessment, interviews, report writing, case presentations, seminars on applied issues providing cotherapy, group supervision and consultations.

(b) At least twenty-five percent of the supervised preinternship professional experiences must be devoted to face-to-face patient-client contact.

(c) At least one hour per week of regularly scheduled contemporaneous in-person individual supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student.

(d) At least two hours of regularly scheduled contemporaneous supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student. At least fifty percent of the supervision during the total supervised preinternship professional experience shall be provided through contemporaneous in-person individual supervision. Not more than fifty percent shall be through in-person group supervision. At least seventy-five percent of the supervision shall be by a psychologist who is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada and who is designated by the academic program. Not more than twenty-five percent of the supervision shall be by a licensed mental health professional who is licensed or certified by a licensing jurisdiction of the United States or Canada, a psychology intern currently under the supervision of a licensed psychologist or an individual completing a postdoctoral supervised experience currently under the supervision of a licensed psychologist.

5. The applicant must provide to the board the written training plan developed by the applicant's program and documentation of the total hours accrued by the applicant during the supervised preinternship professional experience, including the number of face-to-face patient-client contact hours and the amount of supervision and qualifications of the supervisors for the entire supervised preinternship professional experiences. Documentation must include an acknowledgement that ethics training was included throughout the supervised preinternship professional experience.

6. Supervised professional preinternship experiences must be completed within seventy-two months.

F. The applicant shall have one thousand five hundred hours of supervised professional experience, which shall be either an internship that is approved by the American psychological association committee on accreditation, an internship that is a member of the association of psychology postdoctoral and internship centers or an organized training program that is designed to provide the trainee with a planned, programmed sequence of training experience, the focus and purpose of which are to ensure breadth and quality of training, and that meets the following requirements:

1. The training program has a clearly designated staff psychologist who is responsible for the integrity and quality of the training and who is licensed or certified to practice psychology at the independent level by any licensing jurisdiction of the United States or Canada in which the program exists.

2. The training program provides at least two psychologists on staff as supervisors, at least one of whom is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada in which the program exists and at least one of whom is directly available to the trainee in case of emergency.

3. Supervision is provided by the person who carries clinical responsibility for the cases being supervised. At least half of the training supervision shall be provided by one or more psychologists.

4. Training includes a range of assessment, consultation and treatment activities conducted directly with clients or patients.

5. A minimum of twenty-five percent of a trainee's supervised professional experience hours is in direct client or patient contact.

6. Training includes regular in-person, individual supervision conducted on a contemporaneous basis, with a minimum of one hour of in-person, individual supervision for each twenty hours of experience and with the specific intent of dealing with psychological services rendered directly by the trainee and at least two additional hours per week in other learning activities. The supervisor shall ensure that the telepractice supervision is conducted using secure, confidential real-time visual telecommunication.

7. The training program includes interaction with other psychology trainees.

8. Trainees have a title that designates their trainee status.

9. The applicant provides from the training organization a written statement that describes the goals and content of the training program and documents that clear expectations existed for the breadth, depth and quality and quantity of a trainee's work at the time of the supervised professional experience.

10. The supervised professional experience is completed within twenty-four consecutive months.

G. Not more than one thousand five hundred hours of supervised professional experience shall be postdoctoral and may start on written certification by the applicant's education program that the applicant has satisfied all requirements for the doctoral degree and on written certification that the applicant has completed an appropriate supervised professional experience as required in subsection F of this section. The applicant may complete more than one thousand five hundred hours of a supervised postdoctoral experience, but not more than one thousand five hundred hours may count towards the requirements of this subsection. The one thousand five hundred hours of supervised professional experience shall meet the following requirements:

1. Supervision is conducted by a psychologist who is licensed or certified to practice psychology at the independent level in any licensing jurisdiction of the United States or Canada in which the supervision occurs or by a psychologist who is on full-time active duty in the United States armed services and who is licensed or certified by a board of psychologist examiners in a United States jurisdiction, who has been

licensed or certified for at least two years and who is competent in the areas of professional practice in which the supervisee is receiving supervised professional experience.

2. The supervisor takes full legal responsibility for the welfare of the client or patient as well as the diagnosis, intervention and outcome of the intervention and takes reasonable steps to ensure that clients or patients are informed of the supervisee's training and status and that clients or patients may meet with the supervisor at the client's or patient's request.

3. The supervisor or the appropriate custodian of records is responsible for ensuring that adequate records of client or patient contacts are maintained and that the client or patient is informed that the source of access to this information in the future is the supervisor.

4. The supervisor is fully available for consultation in the event of an emergency and provides emergency consultation coverage for the supervisee.

5. Regular in-person, individual supervision is conducted on a contemporaneous basis, with a minimum of one hour of in-person, individual supervision for each twenty hours of supervised professional experience. At least forty percent of the supervisee's time shall be in direct contact with clients or patients. The supervisor shall ensure that the telepractice supervision is conducted using secure, confidential real-time visual telecommunication technology.

6. The supervised professional experience as described in this subsection is completed within thirty-six consecutive months.

7. The applicant provides from the training organization a written training plan that describes the goals and content of the training experience and documents that clear expectations existed for the breadth, depth and quality and quantity of a trainee's work at the time of the supervised professional experience.

H. In meeting the supervised preinternship professional experience as described in subsection E of this section and the supervised professional experience as described in subsections F and G of this section, an applicant shall not receive credit for more than forty hours of experience per week.

I. An applicant who does not satisfy the supervised professional experience requirements of subsection F of this section may qualify on demonstration of twenty years' licensed or certified practice as a psychologist in a jurisdiction of the United States or Canada.

J. An applicant who does not satisfy the supervised preinternship professional experience requirements of subsection E of this section or the supervised professional experience requirements of subsection G of this section, or a combination of subsections E and G of this section, may qualify on demonstration of ten years' licensed or certified practice as a psychologist in a jurisdiction of the United States or Canada.

K. The applicant shall complete a residency at the institution that awarded the applicant's doctoral degree. The residency shall require the following:

1. The student's active participation and involvement in learning.

2. Direct regular contact with faculty and other matriculated doctoral students.

3. Eighteen semester hours or thirty quarter hours or thirty-six trimester hours completed within a twelve-month consecutive period at the institution or a minimum of three hundred hours of student-faculty contact that involves face-to-face educational meetings conducted by the institution's psychology faculty and fully documented by the institution and the student. These meetings shall include interaction between the student and faculty and the student and other students and shall relate to the program content areas specified in subsection A, paragraph 4 of this section. These meetings shall be in addition to the supervised preinternship professional experience, clerkship or externship supervision hours

or dissertation hours. On request by the board, the applicant shall obtain documentation from the institution showing how the applicant's performance was assessed and documented.

L. To determine whether an applicant satisfies the requirements of subsection A of this section relating to subject areas in applied psychology, the board may require the applicant to complete a respecialization program in a program or professional school of psychology that has either an established American psychological association accredited doctoral program in clinical or counseling psychology or school or educational psychology or an established doctoral program that meets board rules. The applicant must also:

1. Meet all of the requirements of the new respecialization area. The board shall give the applicant credit for coursework that the applicant has previously successfully completed and that meets the requirements of subsection A, paragraph 4 of this section.

2. Complete one thousand five hundred hours of supervised professional experience as prescribed in subsection F of this section.

3. Present a certificate or letter from the department head, training director or dean that verifies that the applicant completed the program and that identifies the specialty area of applied psychology the applicant completed.

M. For the purposes of subsection A, paragraph 4 of this section, "other suitable means" means that an applicant demonstrates competence by being a diplomate of the American board of professional psychology or, if an applicant fails to demonstrate completion of coursework in two content areas prescribed in subsection A, paragraph 4 of this section, the applicant has fulfilled the two deficient requirements by successfully passing a graduate course in each deficient content area as a nonmatriculated student in a doctoral level psychology program at a university that is accredited pursuant to subsection A, paragraph 1 of this section.

32-2071.01. Requirements for licensure; remediation; credentials

A. An applicant for licensure shall demonstrate to the board's satisfaction that the applicant:

1. Has met the education and training qualifications for licensure prescribed in section 32-2071 or subsection D of this section.

2. Has passed any examination or examinations required by section 32-2072.

3. Has a professional record that indicates that the applicant has not committed any act or engaged in any conduct that constitutes grounds for disciplinary action against a licensee pursuant to this chapter.

4. Has not had a license or a certificate to practice psychology refused, revoked, suspended or restricted by a state, territory, district or country for reasons that relate to unprofessional conduct.

5. Has not voluntarily surrendered a license in another regulatory jurisdiction in the United States or Canada while under investigation for conduct that relates to unprofessional conduct.

6. Does not have a complaint, allegation or investigation pending before another regulatory jurisdiction in the United States or Canada that relates to unprofessional conduct.

7. Beginning January 1, 2022, has applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

B. If the board finds that an applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action in this state, or if the board or any jurisdiction has taken disciplinary action against an applicant, the board may issue a license if the board first determines to its satisfaction that the

act or conduct has been corrected, monitored or resolved. If the act or conduct has not been resolved before issuing a license, the board must determine to its satisfaction that mitigating circumstances exist that prevent its resolution.

C. An applicant for licensure meets the requirements of section 32-2071, subsection A, paragraphs 1, 2, 3, 4, 5, 6 and 8 if the applicant earned a doctoral degree from a program that was accredited by the American psychological association, office of program consultation and accreditation, or the psychological clinical science accreditation system at the time of graduation.

D. An applicant for licensure who is licensed to practice psychology at the independent level in another licensing jurisdiction of the United States or Canada meets the requirements of subsection A, paragraph 1 of this section if the applicant meets any of the following requirements:

1. Holds a certificate of professional qualification in psychology in good standing issued by the association of state and provincial psychology boards or its successor.

2. Is currently credentialed by the national register of health service providers in psychology or its successor and submits evidence of having practiced psychology independently at the doctoral level for a minimum of five years.

3. Is a diplomate of the American board of professional psychology.

32-2072. Examinations; exemptions

A. An applicant for licensure must pass the examination for professional practice in psychology, which is the national examination established by the association of state and provincial psychology boards. An applicant is considered to have passed the national examination if the applicant's score equals or exceeds either:

1. Seventy per cent on the written examination.

2. A scaled score of five hundred on the computer-based examination.

B. The board may implement an additional examination for all applicants to cover areas of professional ethics and practice consistent with the applicant's education and experience, state law relating to the practice of psychology or other areas the board determines are suitable.

C. An applicant may not take an examination administered for or by the board until the applicant completes the education requirements of this article. The board may approve an applicant who has obtained a doctoral degree in psychology as required under section 32-2071 to take the national examination before completing the experience requirements of this article. Except as provided in subsection D of this section, an applicant may not take an additional board examination until the applicant passes the national examination. An applicant who fails the national examination administered for or by any jurisdiction three times is not eligible to take that examination again until the applicant meets additional requirements prescribed by the board.

D. An applicant is exempt from taking the national examination administered pursuant to this section if the applicant either:

1. Is a diplomate of the American board of professional psychology.

2. Holds a certificate of professional qualification in psychology in good standing issued by the association of state and provincial psychology boards or its successor.

32-2073. Temporary licenses; inactive status; reinstatement to active status

A. If the board requires an additional examination, it may issue a temporary license to a psychologist licensed or certified under the laws of another jurisdiction, if the psychologist applies to the board for licensure and meets the educational, experience and first examination requirements of this article.

B. The board may issue a temporary license to an individual who submits an application for temporary licensure, who is working under supervision for postdoctoral experience and who meets the requirements of section 32-2071, subsections A, B, C and D, as applicable. The individual's postdoctoral experience must meet the requirements of section 32-2071, subsection G. The applicant shall submit the written training plan for the supervised professional experience required in section 32-2071, subsection G, paragraph 7 as part of the application for the temporary license.

C. A temporary license issued pursuant to subsection A of this section is effective from the date that the application is approved until the last day of the month in which the applicant receives the results of the additional examination as provided in section 32-2072.

D. A temporary license issued pursuant to subsection A of this section shall not be extended, renewed, reissued or allowed to continue in effect beyond the period authorized by this section.

E. A temporary license issued pursuant to subsection B of this section is effective for thirty-six months after the date the application is approved and is subject to an initial license fee pursuant to section 32-2067, subsection A, paragraph 4. A temporary license is not subject to renewal.

F. Denial of an application for licensure terminates a temporary license.

G. The board may place on inactive status and waive the license renewal fee requirements for a person who is temporarily or permanently unable to practice as a psychologist due to physical or mental incapacity or disability. An initial request for the waiver of renewal fees shall be accompanied by the renewal fee for an active license, which the board shall return if the waiver is granted. The board shall judge each request for the waiver of renewal fees on its own merits and may seek the verification it deems necessary to substantiate the facts of the situation. A psychologist who is retired is exempt from paying the renewal fee. A psychologist may request voluntary inactive status by submitting to the board an application on a form prescribed by the board and an affirmation that the psychologist shall not practice as a psychologist in this state for the duration of the voluntary inactive status and paying the required fee.

H. A psychologist who is on any form of inactive status shall renew the inactive status every two years by submitting a renewal form provided by the board and paying any applicable fee. A notice to renew is fully effective by mailing the renewal application to the licensee's last known address of record in the board's file. Notice is complete at the time of its deposit in the mail. A psychologist on inactive status due to physical or mental incapacity or disability or retirement shall use the term "inactive" to describe the person's status and shall not practice as a psychologist.

I. A psychologist on inactive status may request reinstatement of the license to active status by applying to the board. The board shall determine whether the person has been or is in violation of any provisions of this chapter and whether the person has maintained and updated the person's professional knowledge and capability to practice as a psychologist. The board may require the person to take or retake the licensure examinations and may require other knowledge or skill training experiences. If approved for active status, the person shall pay a renewal fee that equals the renewal fee for the license to be reinstated.

J. Beginning January 1, 2022, an applicant for a temporary license pursuant to this section shall have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

32-2074. Active license; issuance; renewal; expiration; continuing education; cancellation of active license

A. If the applicant satisfies all of the requirements for licensure pursuant to this chapter, the board shall issue an active license and shall prorate the fee for issuing that license for the period remaining until the last day of the birth month of the applicant of the next odd-numbered year or even-numbered year pursuant to subsection B, paragraph 1 or 2 of this section.

B. Except as provided in section 32-4301, a person holding an active or an inactive license shall apply to renew the license on or before the last day of the birth month of the licensee every other year as follows:

1. In each odd-numbered year, if the licensee holds an odd-numbered license.

2. In each even-numbered year, if the licensee holds an even-numbered license.

C. The application shall include any applicable renewal fee. Except as provided in section 32-4301 or 41-1092.11, a license expires if the licensee fails to renew the license on or before the last day of the licensee's birth month of the licensee's renewal year pursuant to subsection B of this section. A licensee may reinstate an expired license by paying a reinstatement fee within two months after the last day of the licensee's birth month in that year. Beginning two months after the last day of the licensee's birth month during the licensee's renewal year until the last day of the licensee's birth month the following year, a licensee may reinstate the license by paying a reinstatement fee and providing proof of competency and qualifications to the board. This proof may include continuing education, an oral examination, a written examination or an interview with the board. A licensee whose license is not reinstated within a year after the last day of the licensee's birth month of the licensee's renewal year may reapply for licensure as prescribed by this chapter. A notice to renew is fully effective by mailing or electronically providing the notice to the licensee's last known address of record or last known email address of record in the board's file. Notice is complete at the time of deposit in the mail or when the email is sent.

D. A person renewing a license shall attach to the completed renewal form a report of disciplinary actions or restrictions placed against the license by another state licensing or disciplinary board or disciplinary actions or sanctions imposed by a state or national psychology ethics committee or health care institution. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action.

E. A person who renews an active license to practice psychology in this state shall satisfy a continuing education requirement designed to provide the necessary understanding of current developments, skills, procedures or treatment related to the practice of psychology in the amount and during the period the board prescribes. The board shall prescribe documentation requirements.

F. On request of an active licensee, the board may cancel the license if the licensee is not presently under investigation by the board and the board has not initiated any disciplinary proceeding against the licensee.

G. A person who applies for an initial renewal of a license pursuant to this section on or after January 1, 2022 shall possess or have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

32-2075. Exemptions from licensure

A. This chapter does not limit the activities, services and use of a title by the following:

1. A school psychologist who is employed by or contracted to provide services in a common school, high school, charter school or other educational institution setting that serves pupils in prekindergarten or kindergarten programs or any of grades one through twelve and who is certified to use that title by the department of education if the services or activities are a part of the duties of that person's employment or contract with the common school, high school, charter school or other educational institution setting.

2. An employee of a government agency in a subdoctorate position who uses the word "assistant" or "associate" after the title and who is supervised by a doctorate position employee who is licensed as a psychologist, including a temporary licensee.

3. A student of psychology who is pursuing an official course of graduate study at an educational institution accredited as provided in section 32-2071, if after the title the word "trainee", "intern" or "extern" appears and the student uses the title only in conjunction with activities and services that are a part of the supervised program.

4. A person who resides outside of this state and who is currently licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada if the activities and services conducted in this state are within the psychologist's customary area of practice, do not exceed twenty days per year and are not otherwise in violation of this chapter and the client or patient, the public or the consumer is informed of the limited nature of these activities and services and that the psychologist is not licensed in this state. A person may exceed the twenty-day limit of this paragraph to assist in public service that is related to a disaster as acknowledged by the board.

5. A person who is employed by Arizona state university, northern Arizona university, the university of Arizona or another regionally accredited university in this state or who is in other institutional services if the services are a part of the faculty duties of that person's salaried position, with the exception of faculty providing direct services or faculty providing supervision of students providing direct services, and the person has received a doctoral degree as provided in section 32-2071.

6. A supervisee who is pursuing a supervised professional experience pursuant to section 32-2071, subsection G if the services or activities are provided under the direct supervision of a licensed psychologist who has been licensed or certified for at least two years and who is competent in the areas of professional practice in which the supervisee is receiving supervised professional experience, if clients or patients are informed of the training nature of the services provided and if the supervisee has a title that designates that person's training status.

B. This chapter does not prevent a member of other recognized professions that are licensed, certified or regulated under the laws of this state from rendering services within that person's scope of practice and code of ethics if that person does not claim to be a psychologist.

32-2076. Unauthorized practice of medicine

This chapter does not authorize a person to engage in any manner in the practice of medicine pursuant to chapter 13, 17 or 29 of this title, except that a person licensed as provided in this chapter may diagnose, treat and correct human conditions ordinarily within the scope of the practice of a psychologist.

32-2081. Grounds for disciplinary action; duty to report; immunity; proceedings; board action; notice requirements; civil penalty

A. The board, on its own motion, may investigate evidence that appears to show that a psychologist is psychologically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of psychology. A health care institution shall, and any other person may, report to the board information that appears to show that a psychologist is psychologically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of psychology.

B. The board shall not consider a complaint against a psychologist arising out of a judicially ordered evaluation, treatment or psychoeducation of a person charged with violating any provision of title 13, chapter 14 to present a charge of unprofessional conduct unless the court ordering the evaluation has found a substantial basis to refer the complaint for consideration by the board.

C. A claim of unprofessional conduct brought on or after July 3, 2015 against a psychologist arising out of court-ordered services shall be independently reviewed by three members of the board, including a public member. Each of the three board members who are reviewing the claim shall independently provide the board's executive director a recommendation indicating whether the member believes there is merit to open an investigation. If one or more of the board members who are reviewing the claim determine that there is merit to open an investigation as a complaint, an investigation shall be opened and shall follow the complaint process pursuant to this article.

D. The board may not consider a complaint for administrative action if the complaint is filed against a person who is a licensed psychologist and who is a member of the board or a staff member of the board or who is acting as an agent of or consultant to the board if the complaint relates to the person's performance of board duties.

E. The board shall notify the psychologist about whom information has been received as to the content of the information within one hundred twenty days after receiving the information. A person who reports or provides information to the board in good faith is not subject to an action for civil damages. The board, if requested, shall not disclose the name of the person providing information unless this information is essential to proceedings conducted pursuant to this section. The board shall report a health care institution that fails to report as required by this section to the institution's licensing agency.

F. A health care institution shall inform the board if the privileges of a psychologist to practice in that institution are denied, revoked, suspended or limited because of actions by the psychologist that appear to show that that person is psychologically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of psychology, along with a general statement of the reasons that led the health care institution to take this action. A health care institution shall inform the board if a psychologist under investigation resigns the psychologist's privileges or if a psychologist resigns in lieu of disciplinary action by the health care institution. Notification shall include a general statement of the reasons for the resignation.

G. The board may require the licensee to undergo any combination of mental, physical or psychological competence examinations at the licensee's expense and shall conduct investigations necessary to determine the competence and conduct of the licensee.

H. The chairperson of the board shall appoint a complaint screening committee of not less than three members of the board, including a public member. The complaint screening committee is subject to open meeting requirements pursuant to title 38, chapter 3, article 3.1. Except as provided in subsection I of this section, the complaint screening committee shall review all complaints and, based on the information provided pursuant to subsection A or F of this section, may take either of the following actions:

1. Dismiss the complaint if the committee determines that there is no evidence of a violation of law or community standards of practice. Complaints dismissed by the complaint screening committee shall not be disclosed in response to a telephone inquiry or placed on the board's website.

2. Refer the complaint to the full board for further review and action.

I. If the board finds, based on the information it receives under subsection A or F of this section, that the public health, safety or welfare requires emergency action, the board may order a summary suspension of a license pending proceedings for revocation or other action. If the board issues this order, it shall serve the licensee with a written notice of complaint and formal hearing pursuant to title 41, chapter 6, article 10, setting forth the charges made against the licensee and the licensee's right to a formal hearing before the board or an administrative law judge within sixty days.

J. If the board finds that the information provided pursuant to subsection A or F of this section is not of sufficient seriousness to merit direct action against the licensee, it may take any of the following actions:

1. Dismiss if the board believes there is no evidence of a violation of law or community standards of practice.

2. File a letter of concern.

3. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

K. If the board believes the information provided pursuant to subsection A or F of this section is or may be true, the board may request an informal interview with the psychologist. If the licensee refuses to be interviewed or if pursuant to an interview the board determines that cause may exist to revoke or suspend the license, the board shall issue a formal complaint and hold a hearing pursuant to title 41, chapter 6, article 10. If as a result of an informal interview or a hearing the board determines that the facts do not warrant revocation or suspension of the license, the board may take any of the following actions:

1. Dismiss if the board believes there is no evidence of a violation of law or community standards of practice.

2. File a letter of concern.

3. Issue a decree of censure.

4. Fix a period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the psychologist. Probation may include temporary suspension for a period of not more than twelve months, restriction of the license or restitution of fees to a client or patient resulting from violations of this chapter. If a licensee fails to comply with a term of probation, the board may file a complaint and notice of hearing pursuant to title 41, chapter 6, article 10 and take further disciplinary action.

5. Enter into an agreement with the licensee to restrict or limit the licensee's practice or activities in order to rehabilitate the psychologist, protect the public and ensure the psychologist's ability to safely engage in the practice of psychology.

6. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

L. If the board finds that the information provided pursuant to subsection A or F of this section warrants suspension or revocation of a license, the board shall hold a hearing pursuant to title 41, chapter 6, article 10. Notice of a complaint and hearing is fully effective by mailing a true copy to the licensee's last known address of record in the board's files. Notice is complete at the time of its deposit in the mail.

M. The board may impose a civil penalty of at least $300 but not more than $3,000 for each violation of this chapter or a rule adopted under this chapter. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it collects from civil penalties pursuant to this subsection in the state general fund.

N. If the board determines after a hearing that a licensee has committed an act of unprofessional conduct, is mentally or physically unable to safely engage in the practice of psychology or is psychologically incompetent, it may do any of the following in any combination and for any period of time it determines necessary:

1. Suspend or revoke the license.

2. Censure the licensee.

3. Place the licensee on probation.

O. A licensee may submit a written response to the board within thirty days after receiving a letter of concern. The response is a public document and shall be placed in the licensee's file.

P. A letter of concern is a public document and may be used in future disciplinary actions against a psychologist. A decree of censure is an official action against the psychologist's license and may include a requirement that the licensee return fees to a client or patient.

Q. Except as provided in section 41-1092.08, subsection H or for a decision made pursuant to subsection C of this section, a person may appeal a final decision made pursuant to this section to the superior court pursuant to title 12, chapter 7, article 6.

R. If during the course of an investigation the board determines that a criminal violation may have occurred involving the delivery of psychological services, it shall inform the appropriate criminal justice agency.

S. If the board finds that it can take rehabilitative or disciplinary action at any time during the investigative or disciplinary process, the board may enter into a consent agreement with the psychologist to limit or restrict the psychologist's practice or to rehabilitate the psychologist in order to protect the public and ensure the psychologist's ability to safely engage in the practice of psychology. The board may also require the psychologist to successfully complete a board-approved rehabilitative, retraining or assessment program at the psychologist's expense.

T. A psychologist who conducts an independent psychological examination pursuant to section 23-1026 is not subject to a complaint of unprofessional conduct unless the complaint alleges unprofessional conduct based on an act other than a disagreement with the findings and opinions expressed by the psychologist as a result of the examination.

32-2082. Right to examine and copy evidence; subpoenas; right to counsel; appeal

A. In connection with an investigation conducted pursuant to this chapter, at all reasonable times the board and its authorized agents may examine and copy documents, reports, records and other physical evidence wherever located relating to the licensee's professional competence, unprofessional conduct or mental or physical ability to safely practice psychology.

B. The board and its authorized agents may issue subpoenas to compel the attendance and testimony of witnesses and the production of documents and other physical evidence as prescribed in subsection A of this section. The board may petition the superior court to enforce a subpoena.

C. Within five days of receiving a subpoena, a person may petition the board to revoke, limit or modify the subpoena. The board shall take this action if it determines that the evidence demanded is not relevant to the investigation. The person may petition the superior court for this relief without first petitioning the board.

D. A person appearing before the board or its authorized agents may be represented by an attorney.

E. Documents associated with an investigation are not open to the public and shall remain confidential. No documents may be released without a court order compelling their production.

F. Nothing in this section or any other provision of law making communications between a psychologist and client or patient privileged applies to an investigation conducted pursuant to this chapter. The board, its employees and its agents shall keep in confidence the names of clients or patients whose records are reviewed during an investigation.

32-2083. Injunction

A. The board may petition the superior court for an order to enjoin the following:

1. A person not licensed pursuant to this chapter from practicing psychology.

2. The activities of a licensee that are an immediate threat to the public.

3. Criminal activities.

B. If the board seeks an injunction to stop the unlicensed practice of psychology, it is sufficient to charge that the respondent on a certain day in a specific county engaged in the practice of psychology without a license and without being exempt from the licensure requirements of this chapter. It is not necessary to show specific damages or injury.

C. The issuance of an injunction does not limit the board's authority to take other action against a licensee pursuant to this chapter.

32-2084. Violations; classification

A. It is a class 2 misdemeanor for a person not licensed pursuant to this chapter to engage in the practice of psychology.

B. It is a class 2 misdemeanor for any person to:

1. Secure a license to practice psychology pursuant to this chapter by fraud or deceit.

2. Impersonate a member of the board in order to issue a license to practice psychology.

C. It is a class 2 misdemeanor for a person not licensed pursuant to this chapter to:

1. Use the designation "psychology", "psychological" or "psychologist".

2. Use any combination of words, initials and symbols that leads the public to believe the person is licensed to practice psychology in this state.

D. It is a class 2 misdemeanor for a person not licensed or not exempt from licensure pursuant to this chapter to use the designation "psychotherapist" or other derivation of the root word "psycho".

32-2085. Confidential communications

A. The confidential relations and communication between a client or patient and a psychologist licensed pursuant to this chapter, including temporary licensees, are placed on the same basis as those provided by law between an attorney and client. Unless the client or patient waives the psychologist-client privilege in writing or in court testimony, a psychologist shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the psychologist's practice. The psychologist shall divulge to the board information it requires in connection with any investigation, public hearing or other proceeding. The psychologist-client privilege does not extend to cases in which the psychologist has a duty to report information as required by law.

B. The psychologist shall ensure that client or patient records and communications are treated by clerical and paraprofessional staff at the same level of confidentiality and privilege required of the psychologist.

32-2086. Treatment and rehabilitation program

A. The board may establish a confidential program for the treatment and rehabilitation of psychologists who are impaired. The treatment and rehabilitation may include education, intervention, therapeutic treatment and posttreatment monitoring and support. The licensee is responsible for the costs associated with the treatment and rehabilitation, including monitoring.

B. The board may contract with other organizations to operate the program established pursuant to subsection A of this section. A contract with a private organization shall include the following requirements:

1. Periodic reports to the board regarding treatment program activity.

2. Release to the board on demand of all treatment records.

3. Quarterly reports to the board regarding each psychologist's diagnosis, prognosis and recommendations for continuing care, treatment and supervision.

4. Immediate reporting to the board of the name of an impaired psychologist whom the treating organization believes to be a danger to the public or to the psychologist.

5. Reports to the board, as soon as possible, of the name of a psychologist who refuses to submit to treatment or whose impairment is not substantially alleviated through treatment.

C. The board may allocate an amount of not more than twenty dollars from each fee it collects from the biennial renewal of active licenses pursuant to section 32-2067 for the operation of the program established by this section.

D. A psychologist who is impaired and who does not agree to enter into a stipulated order with the board shall be placed on probation or shall be subject to other action as provided by law.

E. In order to determine that a psychologist who has been placed on a probation order or who has entered into a stipulation order pursuant to this section is not impaired by alcohol or illegal substances after that order is no longer in effect, the board or its designee may require the psychologist to submit to bodily fluid examinations and other examinations known to detect the presence of alcohol or illegal substances at any time within the five consecutive years following termination of the probationary or stipulated order.

F. A psychologist who is impaired by alcohol or illegal substances and who was under a board stipulation or probationary order that is no longer in effect must ask the board to place the psychologist's license on inactive status with cause. If the psychologist fails to do this, the board shall summarily suspend the license pursuant to section 32-2081. In order to reactivate the license the psychologist must successfully complete a board approved long-term care residential treatment program, an inpatient hospital treatment program or an intensive outpatient treatment program and shall meet the requirements of section 32-2074. After the psychologist completes treatment the board shall determine if it should reactivate the license without restrictions or refer the matter to a formal hearing for the purpose of suspending or revoking the license or to place the psychologist on probation with restrictions necessary to ensure the public's safety.

G. The board may revoke the license of a psychologist if that psychologist is impaired by alcohol or illegal substances and was previously placed on probation pursuant to subsection F of this section. If the licensee is no longer on probation, the board may accept the surrender of the license if the psychologist admits in writing to being impaired by alcohol or illegal substances.

H. An evaluator, treatment provider, teacher, supervisor or volunteer in the board's substance abuse treatment and rehabilitation program who acts in good faith within the scope of that program is not subject to civil liability, including malpractice liability, for the actions of a psychologist who is attending the program pursuant to board action.

32-2087. Psychology interjurisdictional compact

ARTICLE I

PURPOSE

Whereas, states license psychologists in order to protect the public through verification of education, training and experience and to ensure accountability for professional practice; and

Whereas, this compact is intended to regulate the day-to-day practice of telepsychology, which is the provision of psychological services using telecommunication technologies, by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for thirty days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority;

Whereas, this compact is intended to authorize state psychology regulatory authorities to afford legal recognition, in a manner consistent with the terms of the compact, to psychologists licensed in another state;

Whereas, this compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety;

Whereas, this compact does not apply when a psychologist is licensed in both the home and receiving states; and

Whereas, this compact does not apply to permanent in-person, face-to-face practice, but it does allow for authorization of temporary psychological practice.

Consistent with these principles, this compact is designed to achieve the following purposes and objectives:

1. Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state where the psychologist is not licensed to practice psychology;

2. Enhance the states' ability to protect the public's health and safety, especially client/patient safety;

3. Encourage the cooperation of compact states in the areas of psychology licensure and regulation;

4. Facilitate the exchange of information between compact states regarding psychologist licensure, adverse actions and disciplinary history;

5. Promote compliance with the laws governing psychological practice in each compact state; and

6. Invest all compact states with the authority to hold licensed psychologists accountable through the mutual recognition of compact state licenses.

ARTICLE II

DEFINITIONS

As used in this compact:

A. "Adverse action" means any action that is taken by a state psychology regulatory authority that finds a violation of a statute or regulation, that is identified by the state psychology regulatory authority as discipline and that is a matter of public record.

B. "Association of state and provincial psychology boards" or "ASPPB" means the recognized membership organization composed of state and provincial psychology regulatory authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

C. "Authority to practice interjurisdictional telepsychology" means a licensed psychologist's authority to practice telepsychology, within the limits authorized under this compact, in another compact state.

D. "Bylaws" means those bylaws established by the psychology interjurisdictional compact commission pursuant to article X of this compact for its governance or for directing and controlling its actions and conduct.

E. "Client/patient" means the recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision or consulting services.

F. "Commissioner" means the voting representative appointed by each state psychology regulatory authority pursuant to article X of this compact.

G. "Compact state" means a state, the District of Columbia, or a United States territory that has enacted this compact legislation and that has not withdrawn pursuant to article XIII, subsection C or been terminated pursuant to article XII, subsection B.

H. "Confidentiality" means the principle that data or information is not made available or disclosed to unauthorized persons or processes.

I. "Coordinated licensure information system" or "coordinated database" means an integrated process for collecting, storing and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws that is administered by the recognized membership organization composed of state and provincial psychology regulatory authorities.

J. "Day" means any part of a day in which psychological work is performed.

K. "Distant state" means the compact state where a psychologist is physically present, not through the use of telecommunications technologies, to provide temporary in-person, face-to-face psychological services.

L. "E.Passport" means a certificate issued by the association of state and provincial psychology boards that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

M. "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

N. "Home state" means a compact state where a psychologist is licensed to practice psychology. if the psychologist is licensed in more than one compact state and is practicing under the authorization to practice interjurisdictional telepsychology, the home state is the compact state where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one compact state and is practicing under the temporary authorization to practice, the home state is any compact state where the psychologist is licensed.

O. "Identity history summary" means a summary of information retained by the federal bureau of investigation or another designee with similar authority in connection with arrests and in some instances, federal employment, naturalization or military service.

P. "In-person, face-to-face" means interactions in which the psychologist and the client/patient are in the same physical space and does not include interactions that may occur through the use of telecommunication technologies.

Q. "Interjurisdictional practice certificate" or "IPC" means a certificate issued by the association of state and provincial psychology boards that grants temporary authority to practice based on notification to the state psychology regulatory authority of intention to practice temporarily, and verification of one's qualifications for such practice.

R. "License" means authorization by a state psychology regulatory authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

S. "Non-compact state" means any state that is not at the time a compact state.

T. "Psychologist" means an individual who is licensed for the independent practice of psychology.

U. "Psychology interjurisdictional compact commission" or "commission" means the national administration of which all compact states are members.

V. "Receiving state" means a compact state where the client/patient is physically located when the telepsychological services are delivered.

W. "Rule" means a written statement by the psychology interjurisdictional compact commission promulgated pursuant to article XI of this compact that is of general applicability, that implements, interprets or prescribes a policy or provision of the compact or an organizational, procedural or practice requirement of the commission and that has the force and effect of statutory law in a compact state, and includes the amendment, repeal or suspension of an existing rule.

X. "Significant investigatory information" means either of the following:

1. Investigative information that a state psychology regulatory authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than a minor infraction.

2. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified or had an opportunity to respond.

Y. "State" means a state, commonwealth, territory or possession of the United States or the District of Columbia.

Z. "State psychology regulatory authority" means the board, office or other agency with the legislative mandate to license and regulate the practice of psychology.

AA. "Telepsychology" means the provision of psychological services using telecommunication technologies.

BB. "Temporary authorization to practice" means a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this compact, in another compact state.

CC. "Temporary in-person, face-to-face practice" means that a psychologist is physically present, not through the use of telecommunications technologies, in the distant state to provide for the practice of psychology for thirty days within a calendar year, based on notification to the distant state.

ARTICLE III

HOME STATE LICENSURE

A. The home state shall be a compact state where a psychologist is licensed to practice psychology.

B. A psychologist may hold one or more compact state licenses at a time. If the psychologist is licensed in more than one compact state, the home state is the compact state where the psychologist is physically present when the services are delivered as authorized by the authority to practice interjurisdictional telepsychology under the terms of this compact.

C. Any compact state may require a psychologist who has not been previously licensed in a compact state to obtain and retain a license to be authorized to practice in the compact state under circumstances not authorized by the authority to practice interjurisdictional telepsychology under the terms of this compact.

D. Any compact state may require a psychologist to obtain and retain a license to be authorized to practice in a compact state under circumstances not authorized by temporary authorization to practice under the terms of this compact.

E. A home state's license authorizes a psychologist to practice in a receiving state under the authority to practice interjurisdictional telepsychology only if the compact state:

1. Currently requires the psychologist to hold an active E.Passport;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the commission, in compliance with the terms in this compact, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an identity history summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the federal bureau of investigation or another designee with similar authority, no later than ten years after activation of the compact; and

5. Complies with the bylaws and rules of the commission.

F. A home state's license grants temporary authorization to practice to a psychologist in a distant state only if the compact state:

1. Currently requires the psychologist to hold an active IPC;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the commission, in compliance with the terms in this compact, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an identity history summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the federal bureau of investigation or another designee with similar authority, no later than ten years after activation of the compact; and

5. Complies with the bylaws and rules of the commission.

ARTICLE IV

COMPACT PRIVILEGE TO PRACTICE TELEPSYCHOLOGY

A. Compact states shall recognize the right of a psychologist who is licensed in a compact state in conformance with article III of this compact to practice telepsychology in other compact states, or receiving states, in which the psychologist is not licensed, under the authority to practice interjurisdictional telepsychology as provided in this compact.

B. To exercise the authority to practice interjurisdictional telepsychology under the terms and provisions of this compact, a psychologist licensed to practice in a compact state must meet all of the following:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

(a) Regionally accredited by an accrediting body recognized by the United States department of education to grant graduate degrees or authorized by provincial statute or royal charter to grant doctoral degrees; or

(b) A foreign college or university deemed to be equivalent to subdivision (a) of this paragraph by a foreign credential evaluation service that is a member of the national association of credential evaluation services or by a recognized foreign credential evaluation service; and

2. Hold a graduate degree in psychology that meets the following criteria:

(a) The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

(b) The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

(c) There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

(d) The program must consist of an integrated, organized sequence of study;

(e) There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

(f) The designated director of the program must be a psychologist and a member of the core faculty;

(g) The program must have an identifiable body of students who are matriculated in that program for a degree;

(h) The program must include supervised practicum, internship or field training appropriate to the practice of psychology;

(i) The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

(j) The program includes an acceptable residency as defined by the rules of the commission.

3. Possess a current, full and unrestricted license to practice psychology in a home state that is a compact state;

4. Have no history of adverse action that violates the rules of the commission;

5. Have no criminal record history reported on an identity history summary that violates the rules of the commission;

6. Possess a current, active E.Passport;

7. Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the commission; and

8. Meet other criteria as defined by the rules of the commission.

C. The home state maintains authority over the license of the psychologist practicing into a receiving state under the authority to practice telepsychology.

D. A psychologist practicing into a receiving state under the authority to practice interjurisdictional telepsychology will be subject to the receiving state's scope of practice. A receiving state may, in accordance with that state's due process law, limit or revoke a psychologist's authority to practice interjurisdictional telepsychology in the receiving state and may take any other necessary actions under the receiving state's applicable law to protect the health and safety of the receiving state's citizens. If a receiving state takes action, the state shall promptly notify the home state and the commission.

E. If a psychologist's license in any home state or another compact state, or any authority to practice interjurisdictional telepsychology in any receiving state, is restricted, suspended or otherwise limited, the E.Passport shall be revoked and the psychologist is not eligible to practice telepsychology in a compact state under the authority to practice interjurisdictional telepsychology.

ARTICLE V

COMPACT TEMPORARY AUTHORIZATION TO PRACTICE

A. Compact states shall also recognize the right of a psychologist who is licensed in a compact state in conformance with article III of this compact to practice temporarily in other compact states, or distant states, in which the psychologist is not licensed, as provided in this compact.

B. To exercise the temporary authorization to practice under the terms and provisions of this compact, a psychologist licensed to practice in a compact state must meet all of the following:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

(a) Regionally accredited by an accrediting body recognized by the United States department of education to grant graduate degrees, or authorized by provincial statute or royal charter to grant doctoral degrees; or

(b) A foreign college or university deemed to be equivalent to subdivision (a) of this paragraph by a foreign credential evaluation service that is a member of the national association of credential evaluation services or by a recognized foreign credential evaluation service; and

2. Hold a graduate degree in psychology that meets the following criteria:

(a) The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

(b) The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

(c) There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

(d) The program must consist of an integrated, organized sequence of study;

(e) There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

(f) The designated director of the program must be a psychologist and a member of the core faculty;

(g) The program must have an identifiable body of students who are matriculated in that program for a degree;

(h) The program must include supervised practicum, internship or field training appropriate to the practice of psychology;

(i) The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

(j) The program includes an acceptable residency as defined by the rules of the commission.

3. Possess a current, full and unrestricted license to practice psychology in a home state that is a compact state;

4. Have no history of adverse action that violates the rules of the commission;

5. Have no criminal record history that violates the rules of the commission;

6. Possess a current, active IPC;

7. Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the rules of the commission.

C. A psychologist practicing into a distant state under the temporary authorization to practice shall practice within the scope of practice authorized by the distant state.

D. A psychologist practicing into a distant state under the temporary authorization to practice will be subject to the distant state's authority and law. A distant state may, in accordance with that state's due process law, limit or revoke a psychologist's temporary authorization to practice in the distant state and may take any other necessary actions under the distant state's applicable law to protect the health and safety of the distant state's citizens. If a distant state takes action, the state shall promptly notify the home state and the commission.

E. If a psychologist's license in any home state or another compact state, or any temporary authorization to practice in any distant state, is restricted, suspended or otherwise limited, the IPC shall be revoked and the psychologist is not eligible to practice in a compact state under the temporary authorization to practice.

ARTICLE VI

CONDITIONS OF TELEPSYCHOLOGY PRACTICE

IN A RECEIVING STATE

A psychologist may practice in a receiving state under the authority to practice interjurisdictional telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate state psychology regulatory authority, as defined in the rules of the commission, and under the following circumstances:

1. The psychologist initiates a client/patient contact in a home state via telecommunications technologies with a client/patient in a receiving state;

2. Other conditions regarding telepsychology as determined by rules promulgated by the commission.

ARTICLE VII

ADVERSE ACTIONS

A. A home state shall have the power to impose adverse action against a psychologist's license issued by the home state. A distant state shall have the power to take adverse action on a psychologist's temporary authorization to practice within that distant state.

B. A receiving state may take adverse action on a psychologist's authority to practice interjurisdictional telepsychology within that receiving state. A home state may take adverse action against a psychologist based on an adverse action taken by a distant state regarding temporary in-person, face-to-face practice.

C. If a home state takes adverse action against a psychologist's license, that psychologist's authority to practice interjurisdictional telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's temporary authorization to practice is terminated and the IPC is revoked as follows:

1. All home state disciplinary orders that impose adverse action shall be reported to the commission in accordance with the rules promulgated by the commission. A compact state shall report adverse actions in accordance with the rules of the commission.

2. In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the rules of the commission.

3. Other actions may be imposed as determined by the rules of the commission.

D. A home state's psychology regulatory authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee that occurred in a receiving state as it would if such conduct had occurred by a licensee within the home state. In such cases, the home state's law shall control in determining any adverse action against a psychologist's license.

E. A distant state's psychology regulatory authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under temporary authorization practice which occurred in that distant state as it would if such conduct had occurred by a licensee within the home state. In such cases, the distant state's law shall control in determining any adverse action against a psychologist's temporary authorization to practice.

F. Nothing in this compact shall override a compact state's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the compact state's law. Compact states must require psychologists who enter any alternative programs to not provide telepsychology services under the authority to practice interjurisdictional telepsychology or provide temporary psychological services under the temporary authorization to practice in any other compact state during the term of the alternative program.

G. No other judicial or administrative remedies shall be available to a psychologist in the event a compact state imposes an adverse action pursuant to subsection C of this article.

ARTICLE VIII

ADDITIONAL AUTHORITIES INVESTED IN A COMPACT

STATE'S PSYCHOLOGY REGULATORY AUTHORITY

A. In addition to any other powers granted under state law, a compact state's psychology regulatory authority shall have the authority under this compact to:

1. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a compact state's psychology regulatory authority for the attendance and testimony of witnesses or the production of evidence from another compact state shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state psychology regulatory authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses or evidence are located; and

2. Issue cease and desist or injunctive relief orders to revoke a psychologist's authority to practice interjurisdictional telepsychology and/or temporary authorization to practice.

B. During the course of any investigation, a psychologist may not change the psychologist's home state licensure. A home state psychology regulatory authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The home state psychology regulatory authority shall promptly report the conclusions of such investigations to the commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change the psychologist's home state licensure. The commission shall promptly notify the new home state of any such decisions as provided in the rules of the commission. All information provided to the commission or distributed by compact states pursuant to the psychologist shall be confidential, filed under seal and used for investigatory or disciplinary matters. The commission may create additional rules for mandated or discretionary sharing of information by compact states.

ARTICLE IX

COORDINATED LICENSURE INFORMATION SYSTEM

A. The commission shall provide for the development and maintenance of a coordinated database and reporting system containing licensure and disciplinary action information on all psychologists or individuals to whom this compact is applicable in all compact states as defined by the rules of the commission.

B. Notwithstanding any other provision of state law to the contrary, a compact state shall submit a uniform data set to the coordinated database on all licensees as required by the rules of the commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against a psychologist's license;

5. An indicator that a psychologist's authority to practice interjurisdictional telepsychology and/or temporary authorization to practice is revoked;

6. Nonconfidential information related to alternative program participation information;

7. Any denial of application for licensure and the reasons for such denial; and

8. Other information that may facilitate the administration of this compact, as determined by the rules of the commission.

C. The coordinated database administrator shall promptly notify all compact states of any adverse action taken against, or significant investigative information on, any licensee in a compact state.

D. Compact States reporting information to the coordinated database may designate information that may not be shared with the public without the express permission of the compact state reporting the information.

E. Any information submitted to the coordinated database that is subsequently required to be expunged by the law of the compact state reporting the information shall be removed from the coordinated database.

ARTICLE X

ESTABLISHMENT OF THE PSYCHOLOGY INTERJURISDICTIONAL

COMPACT COMMISSION

A. The compact states hereby create and establish a joint public agency known as the psychology interjurisdictional compact commission as follows:

1. The commission is a body politic and an instrumentality of the compact states.

2. Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting and Meetings are as follows:

1. The commission shall consist of one voting representative appointed by each compact state who shall serve as that state's commissioner. The state psychology regulatory authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the compact state. This delegate shall be limited to:

(a) The executive director or executive secretary or a similar executive;

(b) A current member of the state psychology regulatory authority of a compact state; or

(c) A designee empowered with the appropriate delegate authority to act on behalf of the compact state.

2. Any commissioner may be removed or suspended from office as provided by the law of the state from which the commissioner is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compact state in which the vacancy exists.

3. Each commissioner shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. A commissioner shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for commissioners' participation in meetings by telephone or other means of communication.

4. The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

5. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in article XI of this compact.

6. The commission may convene in a closed, nonpublic meeting if the commission must discuss:

(a) Noncompliance of a compact state with its obligations under the compact;

(b) The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures;

(c) Current, threatened or reasonably anticipated litigation against the commission;

(d) The negotiation of contracts for the purchase or sale of goods, services or real estate;

(e) An accusation against any person of a crime or formally censuring any person;

(f) The disclosure of trade secrets or commercial or financial information that is privileged or confidential;

(g) The disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(h) The disclosure of investigatory records compiled for law enforcement purposes;

(i) The disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the commission or another committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact; or

(j) Matters specifically exempted from disclosure by federal and state statute.

7. If a meeting, or portion of a meeting, is closed pursuant to this provision, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

C. The commission shall, by a majority vote of the commissioners, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including:

1. Establishing the fiscal year of the commission;

2. Providing reasonable standards and procedures:

(a) For the establishment and meetings of other committees; and

(b) Governing any general or specific delegation of any authority or function of the commission;

3. Providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings and proprietary information, including trade secrets. The commission may meet in closed session only after a majority of the commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting revealing the vote of each commissioner with no proxy votes allowed;

4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar law of any compact state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

6. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees;

7. Providing a mechanism for concluding the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact and after the payment and/or reserving of all of its debts and obligations;

8. The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compact states;

9. The commission shall maintain its financial records in accordance with the bylaws; and

10. The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

D. The commission shall have the following powers:

1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this compact. The rule shall have the force and effect of law and shall be binding in all compact states;

2. To bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state psychology regulatory authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including employees of a compact state;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same, provided that at all times the commission shall strive to avoid any appearance of impropriety or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed, provided that at all times the commission shall strive to avoid any appearance of impropriety;

8. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this compact and the bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

E. The elected officers shall serve as the executive board, which shall have the power to act on behalf of the commission according to the terms of this compact as follows:

1. The executive board shall be composed of the following six members:

(a) Five voting members who are elected from the current membership of the commission by the commission;

(b) One ex officio, nonvoting member from the recognized membership organization composed of state and provincial psychology regulatory authorities.

2. The ex officio member must have served as staff with or a member on a state psychology regulatory authority and will be selected by its respective organization.

3. The commission may remove any member of the executive board as provided in bylaws.

4. The Executive Board shall meet at least annually.

5. The executive board shall have the following duties and responsibilities:

(a) Recommend to the entire commission changes to the rules or bylaws, changes to this compact, fees paid by compact states such as annual dues, and any other applicable fees;

(b) Ensure compact administration services are appropriately provided, contractual or otherwise;

(c) Prepare and recommend the budget;

(d) Maintain financial records on behalf of the commission;

(e) Monitor compact compliance of member states and provide compliance reports to the commission;

(f) Establish additional committees as necessary; and

(g) Other duties as provided in rules or bylaws.

F. The financing of the commission shall be as follows:

1. The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

2. The commission may accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services.

3. The commission may levy on and collect an annual assessment from each compact state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based on a formula to be determined by the commission, which shall promulgate a rule binding on all compact states.

4. The commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the commission pledge the credit of any of the compact states, except by and with the authority of the compact state.

5. The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the commission.

G. Qualified immunity, defense and indemnification provisions are as follows:

1. The members, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to

or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, except that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or wilful or wanton misconduct of that person.

2. The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, except that nothing in this paragraph shall be construed to prohibit that person from retaining his or her own counsel, and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or wilful or wanton misconduct.

3. The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, if the actual or alleged act, error or omission did not result from the intentional or wilful or wanton misconduct of that person.

ARTICLE XI

RULEMAKING

A. The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted under this article. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the compact states reject a rule, by enactment of a statute or resolution in the same manner used to adopt the compact, that rule shall have no further force and effect in any compact state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

D. Prior to promulgation and adoption of a final rule or rules by the commission, and at least sixty days in advance of the meeting at which the rule will be considered and voted on, the commission shall file a notice of proposed rulemaking:

1. On the website of the commission; and

2. On the website of each compact state's psychology regulatory authority or the publication in which each state would otherwise publish proposed rules.

E. The notice of proposed rulemaking shall include:

1. The proposed time, date and location of the meeting in which the rule will be considered and voted on;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five persons who submit comments independently of each other;

2. A governmental subdivision or agency; or

3. A duly appointed person in an association that has at least twenty-five members.

H. If a hearing is held on the proposed rule or amendment, the commission shall publish the place, time and date of the scheduled public hearing. The following apply to a hearing:

1. All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This paragraph does not preclude the commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this subsection shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this subsection.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

J. The commission, by majority vote of all members, shall take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with promulgation of the proposed rule without a public hearing.

L. On a determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in the compact and in this section shall be retroactively applied to the rule as soon as reasonably practicable but not later than ninety days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety or welfare;

2. Prevent a loss of commission or compact state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE XII

OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

A. Oversight of the commission is as follows:

1. The executive, legislative and judicial branches of state government in each compact state shall enforce this compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a compact state pertaining to the subject matter of this compact that may affect the powers, responsibilities or actions of the commission.

3. The commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission shall render a judgment or order void as to the commission, this compact or promulgated rules.

B. Default, technical assistance and termination provisions are as follows:

1. If the commission determines that a compact state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the commission shall:

(a) Provide written notice to the defaulting state and other compact states of the nature of the default, the proposed means of remedying the default or any other action to be taken by the commission; and

(b) Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to remedy the default, the defaulting state may be terminated from the compact on an affirmative vote of a majority of the compact states, and all rights, privileges and benefits conferred by this compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the commission to the Governor, the majority and minority leaders of the defaulting state's legislature and each of the compact states.

4. A compact state that has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

5. The commission shall not bear any costs incurred by the state that is found to be in default or that has been terminated from the compact, unless agreed on in writing between the commission and the defaulting state.

6. The defaulting state may appeal the action of the commission by petitioning the United States district court for the state of Georgia or the federal district where the compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute resolution provisions are as follows:

1. On request by a compact state, the commission shall attempt to resolve disputes related to the compact which arise among compact states and between compact and non-compact states.

2. The commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the commission.

D. Enforcement provisions are as follows:

1. The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

2. By majority vote, the commission may initiate legal action in the United States district court for the state of Georgia or the federal district where the compact has its principal offices against a compact state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

3. The remedies in this subsection are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XIII

DATE OF IMPLEMENTATION OF THE PSYCHOLOGY

INTERJURISDICTIONAL COMPACT COMMISSION and

ASSOCIATED RULES, WITHDRAWAL AND AMENDMENTS

A. The compact shall take effect on the date on which the compact is enacted into law in the seventh compact state. The provisions that become effective at that time shall be limited to the powers granted to the commission relating to assembly and the promulgation of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to the implementation and administration of this compact.

B. Any state that joins the compact subsequent to the commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the commission shall have the full force and effect of law on the day the compact becomes law in that state.

C. Any compact state may withdraw from this compact by enacting a statute repealing the same, subject to the following:

1. A compact state's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's psychology regulatory authority to comply with the investigative and adverse action reporting requirements of this compact before the effective date of withdrawal.

D. Nothing in this compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a compact state and a non-compact state that does not conflict with the provisions of this compact.

E. This compact may be amended by the compact states. No amendment to this compact shall become effective and binding on any compact state until it is enacted into the law of all compact states.

ARTICLE XIV

CONSTRUCTION AND SEVERABILITY

This compact shall be liberally construed so as to effectuate the purposes thereof. If this compact is held contrary to the constitution of any state member thereto, the compact remains in full force and effect as to the remaining compact states.

32-2087.01. Participation in compact as condition of employment; prohibition

An employer may not require a psychologist to seek licensure through the psychology interjurisdictional compact enacted by section 32-2087 as a condition of initial or continued employment as a psychologist in this state. An employer may require that a psychologist obtain and maintain a license to practice psychology in multiple states, if the psychologist is free to obtain and maintain the licenses by any means authorized by the laws of the respective states.

32-2087.02. Open meeting requirements

If a meeting, or a portion of a meeting, of the psychology interjurisdictional compact commission is closed pursuant to section 32-2087, article X, subsection B, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision consistent with title 38, chapter 3, article 3.1.

32-2087.03. State board of psychologist examiners; notice of commission actions

The state board of psychologist examiners, within thirty days after a psychology interjurisdictional compact commission action, shall post on the board's public website notice of any commission action that may affect a psychologist's license.

32-2091. Definitions

In this article, unless the context otherwise requires:

1. "Active license" means a current license issued by the board to a person licensed pursuant to this article.

2. "Adequate records" means records that contain, at a minimum, sufficient information to identify the client, the dates of service, the fee for service, the payments for service and the type of service given and copies of any reports that may have been made.

3. "Behavior analysis" means the design, implementation and evaluation of systematic environmental modifications by a behavior analyst to produce socially significant improvements in human behavior based on the principles of behavior identified through the experimental analysis of behavior. Behavior analysis does not include cognitive therapies or psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities.

4. "Behavior analysis services" means the use of behavior analysis to assist a person to learn new behavior, increase existing behavior, reduce existing behavior and emit behavior under precise environmental conditions. Behavior analysis includes behavioral programming and behavioral programs.

5. "Behavior analyst" means a person who is licensed pursuant to this article to practice behavior analysis.

6. "Client" means:

(a) A person or entity that receives behavior analysis services.

(b) A corporate entity, a governmental entity or any other organization that has a professional contract to provide services or benefits primarily to an organization rather than to an individual.

(c) An individual's legal guardian for decision making purposes, except that the individual is the client for issues that directly affect the individual's physical or emotional safety and issues that the legal guardian agrees to specifically reserve to the individual.

7. "Exploit" means an action by a behavior analyst who takes undue advantage of the professional association with a client, student or supervisee for the advantage or profit of the behavior analyst.

8. "Health care institution" means a facility that is licensed pursuant to title 36, chapter 4, article 1.

9. "Incompetent as a behavior analyst" means that a person who is licensed pursuant to article 4 of this chapter lacks the knowledge or skills of a behavior analyst to a degree that is likely to endanger the health of a client.

10. "Letter of concern" means an advisory letter to notify a licensee that while there is insufficient evidence to support disciplinary action the board believes the licensee should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the board may result in action against the license.

11. "Supervisee" means a person who acts under the extended authority of a behavior analyst to provide behavioral services and includes a person who is in training to provide these services.

12. "Unprofessional conduct" includes the following activities, whether occurring in this state or elsewhere:

(a) Obtaining a fee by fraud or misrepresentation.

(b) Betraying professional confidences.

(c) Making or using statements of a character tending to deceive or mislead.

(d) Aiding or abetting a person who is not licensed pursuant to this article in representing that person as a behavior analyst.

(e) Gross negligence in the practice of a behavior analyst.

(f) Sexual intimacies or sexual intercourse with a current client or a supervisee or with a former client within two years after the cessation or termination of treatment. For the purposes of this subdivision, "sexual intercourse" has the same meaning prescribed in section 13-1401.

(g) Engaging or offering to engage as a behavior analyst in activities that are not congruent with the behavior analyst's professional education, training and experience.

(h) Failing or refusing to maintain and retain adequate business, financial or professional records pertaining to the behavior analysis services provided to a client.

(i) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

(j) Making a fraudulent or untrue statement to the board or its investigators, staff or consultants.

(k) Violating any federal or state law that relates to the practice of behavior analysis or to obtain a license to practice behavior analysis.

(l) Practicing behavior analysis while impaired or incapacitated to the extent and in a manner that jeopardizes the welfare of a client or renders the services provided ineffective.

(m) Using fraud, misrepresentation or deception to obtain or attempt to obtain a behavior analysis license or to pass or attempt to pass a behavior analysis licensing examination or in assisting another person to do so.

(n) Unprofessional conduct in another jurisdiction that resulted in censure, probation or a civil penalty or in the denial, suspension, restriction or revocation of a certificate or license to practice as a behavior analyst.

(o) Providing services that are unnecessary or unsafe or otherwise engaging in activities as a behavior analyst that are unprofessional by current standards of practice.

(p) Falsely or fraudulently claiming to have performed a professional service, charging for a service or representing a service as the licensee's own if the licensee has not rendered the service or assumed supervisory responsibility for the service.

(q) Representing activities or services as being performed under the licensee's supervision if the behavior analyst has not assumed responsibility for them and has not exercised control, oversight and review.

(r) Failing to obtain a client's informed and written consent to release personal or otherwise confidential information to another party unless the release is otherwise authorized by law.

(s) Failing to make client records in the behavior analyst's possession promptly available to another behavior analyst on receipt of proper authorization to do so from the client, a minor client's parent, the client's legal guardian or the client's authorized representative or failing to comply with title 12, chapter 13, article 7.1.

(t) Failing to take reasonable steps to inform or protect a client's intended victim and inform the proper law enforcement officials if the behavior analyst becomes aware during the course of providing or supervising behavior analysis services that a client intends or plans to inflict serious bodily harm on another person.

(u) Failing to take reasonable steps to protect a client if the behavior analyst becomes aware during the course of providing or supervising behavior analysis services that a client intends or plans to inflict serious bodily harm on self.

(v) Abandoning or neglecting a client in need of immediate care without making suitable arrangements for continuation of the care.

(w) Engaging in direct or indirect personal solicitation of clients through the use of coercion, duress, undue influence, compulsion or intimidation practices.

(x) Engaging in false, deceptive or misleading advertising.

(y) Exploiting a client, student or supervisee.

(z) Failing to report information to the board regarding a possible act of unprofessional conduct committed by another behavior analyst who is licensed pursuant to this article unless this reporting violates the behavior analyst's confidential relationship with a client pursuant to this article. A behavior

analyst who reports or provides information to the board in good faith is not subject to an action for civil damages.

(aa) Violating a formal board order, consent agreement, term of probation or stipulated agreement issued under this article.

(bb) Failing to furnish information in a timely manner to the board or its investigators or representatives if requested or subpoenaed by the board as prescribed by this article.

(cc) Failing to make available to a client or to the client's designated representative, on written request, a copy of the client's record, excluding raw test data, psychometric testing materials and other information as provided by law.

(dd) Violating an ethical standard adopted by the board.

(ee) Representing oneself as a psychologist or permitting others to do so if the behavior analyst is not also licensed as a psychologist pursuant to this chapter.

32-2091.01. Fees

A. The board, by a formal vote, shall establish fees for the following relating to the licensure of behavior analysts:

1. An application for an active license.

2. An application for a temporary license.

3. Renewal of an active license.

4. Issuance of an initial license.

B. The board may charge additional fees for services it deems necessary and appropriate to carry out this article. These fees shall not exceed the actual cost of providing the service.

C. The board shall not refund fees except as otherwise provided in this article. On special request and for good cause, the board may return the license renewal fee.

32-2091.02. Qualifications of applicant

A person who wishes to practice as a behavior analyst must be licensed pursuant to this article. An applicant for licensure must meet all of the following requirements:

1. Submit an application as prescribed by the board.

2. Be at least twenty-one years of age.

3. Pay all applicable fees prescribed by the board.

4. Have the physical and mental capability to safely and competently engage in the practice of behavior analysis.

5. Not have committed any act or engaged in any conduct that would constitute grounds for disciplinary action against a licensee pursuant to this article.

6. Not have had a professional license or certificate refused, revoked, suspended or restricted in any regulatory jurisdiction in the United States or in another country for reasons that relate to unprofessional conduct. If the board finds that the applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action in this state, the board shall determine to its satisfaction that the

conduct has been corrected, monitored and resolved. If the matter has not been resolved, the board shall determine to its satisfaction that mitigating circumstances exist that prevent its resolution.

7. Not have voluntarily surrendered a license or certificate in another regulatory jurisdiction in the United States or in another country while under investigation for reasons that relate to unprofessional conduct. If another jurisdiction has taken disciplinary action against an applicant, the board shall determine to its satisfaction that the cause for the action was corrected and the matter resolved. If the matter has not been resolved by that jurisdiction, the board shall determine to its satisfaction that mitigating circumstances exist that prevent its resolution.

8. Not have a complaint, allegation or investigation pending before another regulatory jurisdiction in the United States or another country that relates to unprofessional conduct. If an applicant has any such complaints, allegations or investigations pending, the board shall suspend the application process and may not issue or deny a license to the applicant until the complaint, allegation or investigation is resolved.

9. Beginning January 1, 2022, have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

32-2091.03. Educational and training standards for licensure

A. An applicant for licensure as a behavior analyst must meet standards adopted by the state board of psychologist examiners, including meeting graduate-level education and supervised experience requirements and passing a national examination. The state board of psychologist examiners shall adopt standards consistent with the standards set by a nationally recognized behavior analyst certification board, except that:

1. The number of hours required for supervised experience must be at least one thousand five hundred hours of supervised work experience.

2. If the experience was obtained in a state that licensed behavior analysts at the time of the supervised work experience, the supervisor must be licensed in the state where the behavior analysis trainee services were provided.

B. The standards adopted for supervised experience must also be consistent with the standards set by a nationally recognized behavior analyst certification board. If the state board of psychologist examiners does not agree with a standard set by a nationally recognized behavior analyst certification board, the state board may adopt an alternate standard.

32-2091.04. Reciprocity

The board may issue a license to a person as a behavior analyst if the person is licensed or certified by a regulatory agency of another state that imposes requirements that are substantially equivalent to those imposed by this article at an equivalent or higher practice level as determined by the board, pays the fee prescribed by the board and meets all of the following requirements:

1. Submits a written application prescribed by the board.

2. Documents to the board's satisfaction proof of initial licensure or certification at an equivalent designation for which the applicant is seeking licensure in this state and proof that the license or certificate is current and in good standing.

3. Documents to the board's satisfaction proof that any other license or certificate issued to the applicant by another state has not been suspended or revoked. If a licensee or certificate holder has been subjected to any other disciplinary action, the board may assess the magnitude of that action and make a decision regarding reciprocity based on this assessment.

4. Meets any other requirements prescribed by the board by rule.

32-2091.06. Temporary licenses; inactive status; reinstatement to active status

A. If the board requires an additional examination, it may issue a temporary license to a behavior analyst who is licensed or certified under the laws of another jurisdiction if the behavior analyst applies to the board for licensure and meets the educational, experience and first examination requirements of this article.

B. A temporary license issued pursuant to this section is effective from the date the application is approved until the last day of the month in which the applicant receives the results of the additional examination.

C. The board shall not extend, renew or reissue a temporary license or allow it to continue in effect beyond the period authorized by this section.

D. The board's denial of an application for licensure terminates a temporary license.

E. The board may place on inactive status and waive the license renewal fee requirements for a person who is temporarily or permanently unable to practice as a behavior analyst due to physical or mental incapacity or disability. An initial request for the waiver of renewal fees shall be accompanied by the renewal fee for an active license, which the board shall return if the waiver is granted. The board shall judge each request for the waiver of renewal fees on its own merits and may seek the verification it deems necessary to substantiate the facts of the situation. A behavior analyst who is retired is exempt from paying the renewal fee. A behavior analyst may request voluntary inactive status by submitting to the board an application on a form prescribed by the board and an affirmation that the behavior analyst will not practice as a behavior analyst in this state for the duration of the voluntary inactive status and by paying the required fee as prescribed by the board by rule.

F. A behavior analyst who is on any form of inactive status shall renew the inactive status every two years by submitting a renewal form provided by the board and paying any applicable fee as prescribed by the board by rule. A notice to renew is fully effective by mailing the renewal application to the licensee's last known address of record in the board's file. Notice is complete at the time of its deposit in the mail. A behavior analyst who is on inactive status due to physical or mental incapacity or disability or retirement shall use the term "inactive" to describe the person's status and shall not practice as a behavior analyst.

G. A behavior analyst on inactive status may request reinstatement of the license to active status by applying to the board. The board shall determine whether the person has been or is in violation of any provisions of this article and whether the person has maintained and updated the person's professional knowledge and capability to practice as a behavior analyst. The board may require the person to take or retake the licensure examinations and may require other knowledge or skill training experiences. If approved for active status, the person shall pay a renewal fee that equals the renewal fee for the license to be reinstated.

H. Beginning January 1, 2022, an applicant for a temporary license pursuant to this section shall have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

32-2091.07. Active license; issuance; renewal; expiration; continuing education

A. If the applicant satisfies all of the requirements for licensure pursuant to this article, the board shall issue an active license and shall prorate the fee for issuing that license for the period remaining until the last day of the birth month of the applicant of the next odd-numbered year or even-numbered year pursuant to subsection B, paragraph 1 or 2 of this section.

B. A person holding an active or inactive license shall apply to renew the license on or before the last day of the birth month of the licensee every other year as follows:

1. In each odd-numbered year, if the licensee holds an odd-numbered license.

2. In each even-numbered year, if the licensee holds an even-numbered license.

C. The application shall include any applicable renewal fee as prescribed by the board by rule. Except as provided in section 32-4301 or 41-1092.11, a license expires if the licensee fails to renew the license on or before the last day of the licensee's birth month of the licensee's renewal year pursuant to subsection B of this section. A licensee may reinstate an expired license by paying a reinstatement fee as prescribed by the board by rule within two months after the last day of the licensee's birth month of that year. Beginning two months after the last day of the licensee's birth month during the licensee's renewal year until the last day of the licensee's birth month the following year, a licensee may reinstate the license by paying a reinstatement fee as prescribed by the board by rule and providing proof of competency and qualifications to the board. This proof may include continuing education, an oral examination, a written examination or an interview with the board. A licensee whose license is not reinstated within a year after the last day of the licensee's birth month of the licensee's renewal year may reapply for licensure as prescribed by this article. A notice to renew is fully effective by mailing or electronically providing the notice to the licensee's last known address of record or last known email address of record in the board's file. Notice is complete at the time of deposit in the mail or when the email is sent.

D. A person renewing a license shall attach to the completed renewal form a report of disciplinary actions or restrictions placed against the license by another state licensing or disciplinary board or disciplinary actions or sanctions imposed by a state or national behavior analysis ethics committee or health care institution. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action.

E. A person who renews an active license to practice behavior analysis in this state shall satisfy a continuing education requirement designed to provide the necessary understanding of current developments, skills, procedures or treatment related to the practice of behavior analysis in the amount and during the period the board prescribes. The board shall prescribe documentation requirements.

F. A person who applies for an initial renewal of a license pursuant to this section on or after January 1, 2022 shall possess or have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1.

32-2091.08. Exemptions from licensure

A. This article does not limit the activities, services and use of a title by the following:

1. A behavior analyst who is employed in a common school, high school or charter school setting and who is certified to use that title by the department of education if the services or activities are a part of the duties of that person's common school, high school or charter school employment.

2. An employee of a government agency in a subdoctorate position who uses the word "assistant" or "associate" after the title and who is supervised by a doctorate position employee who is licensed as a behavior analyst, including a temporary licensee.

3. A matriculated graduate student, or a trainee whose activities are part of a defined behavior analysis program of study, practicum, intensive practicum or supervised independent fieldwork. The practice under this paragraph requires direct supervision consistent with the standards set by a nationally recognized behavior analyst certification board, as determined by the state board of psychologist examiners. A student or trainee may not claim to be a behavior analyst and must use a title that clearly indicates the person's training status, such as "behavior analysis student" or "behavior analysis trainee".

4. A person who resides outside of this state and who is currently licensed or certified as a behavior analyst in that state if the activities and services conducted in this state are within the behavior analyst's customary area of practice, do not exceed twenty days per year and are not otherwise in violation of this article and the client, public or consumer is informed of the limited nature of these activities and services and that the behavior analyst is not licensed in this state.

5. A person in the employ of Arizona state university, northern Arizona university, the university of Arizona or another regionally accredited university in this state if the services are a part of the faculty duties of that person's salaried position and the person is participating in a graduate program.

6. A noncredentialed individual who delivers applied behavior analysis services under the extended authority and direction of a licensed behavior analyst. The individual may not claim to be a professional behavior analyst and must use a title indicating the person's nonprofessional status, such as "ABA technician", "behavior technician" or "tutor".

B. This article does not prevent a member of other recognized professions who is licensed, certified or regulated under the laws of this state from rendering services within that person's scope of practice and code of ethics if that person does not claim to be a behavior analyst.

32-2091.09. Grounds for disciplinary action; duty to report; immunity; proceedings; board action; notice requirements; civil penalty

A. The board on its own motion may investigate evidence that appears to show that a behavior analyst is incompetent as a behavior analyst, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of behavior analysis. A health care institution shall, and any other person may, report to the board information that appears to show that a behavior analyst is incompetent as a behavior analyst, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of behavior analysis. The board shall notify the licensee about whom information has been received as to the content of the information within one hundred twenty days after receiving the information. A person who reports or provides information to the board in good faith is not subject to an action for civil damages. The board, if requested, shall not disclose the name of the person providing information unless this information is essential to proceedings conducted pursuant to this section. The board shall report a health care institution that fails to report as required by this section to the institution's licensing agency.

B. A health care institution shall inform the board if the privileges of a licensee to practice in that institution are denied, revoked, suspended or limited because of actions by the licensee that appear to show that the person is incompetent as a behavior analyst, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of behavior analysis, along with a general statement of the reasons that led the health care institution to take this action. A health care institution shall inform the board if a licensee under investigation resigns the licensee's privileges or if a licensee resigns in lieu of disciplinary action by the health care institution. Notification must include a general statement of the reasons for the resignation.

C. The board may require the licensee to undergo any combination of mental, physical or psychological competence examinations at the licensee's expense and shall conduct investigations necessary to determine the competence and conduct of the licensee.

D. Except as provided in subsection E of this section, the committee on behavior analysts shall review all complaints against behavior analysts and, based on the information provided pursuant to subsection A or B of this section, shall submit its recommendations to the full board.

E. If the board finds, based on the information it receives under subsection A or B of this section, that the public health, safety or welfare requires emergency action, the board may order a summary suspension of

a license pending proceedings for revocation or other action. If the board issues this order, the board shall serve the licensee with a written notice of complaint and formal hearing pursuant to title 41, chapter 6, article 10, setting forth the charges made against the licensee and the licensee's right to a formal hearing before the board or an administrative law judge within sixty days. The board shall notify the committee on behavior analysts of any action taken pursuant to this subsection.

F. If the board finds that the information provided pursuant to subsection A or B of this section is not of sufficient seriousness to merit direct action against the licensee, the board may take any of the following actions:

1. Dismiss if the board believes the information is without merit.

2. File a letter of concern.

3. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

G. If the board believes the information provided pursuant to subsection A or B of this section is or may be true, the board may request an informal interview with the licensee. If the licensee refuses to be interviewed or if pursuant to an interview the board determines that cause may exist to revoke or suspend the license, the board shall issue a formal complaint and hold a hearing pursuant to title 41, chapter 6, article 10. If as a result of an informal interview or a hearing the board determines that the facts do not warrant revocation or suspension of the license, the board may take any of the following actions:

1. Dismiss if the board believes the information is without merit.

2. File a letter of concern.

3. Issue a decree of censure.

4. Fix a period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the licensee. Probation may include temporary suspension for not more than twelve months, restriction of the license or restitution of fees to a client resulting from violations of this article. If a licensee fails to comply with a term of probation, the board may file a complaint and notice of hearing pursuant to title 41, chapter 6, article 10 and take further disciplinary action.

5. Enter into an agreement with the licensee to restrict or limit the licensee's practice or activities in order to rehabilitate the licensee, protect the public and ensure the licensee's ability to safely engage in the practice of behavior analysis.

6. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

H. If the board finds that the information provided pursuant to subsection A or B of this section warrants suspension or revocation of a license, the board shall hold a hearing pursuant to title 41, chapter 6, article 10. Notice of a complaint and hearing is fully effective by mailing a true copy to the licensee's last known address of record in the board's files. Notice is complete at the time of its deposit in the mail.

I. The board may impose a civil penalty of at least $300 but not more than $3,000 for each violation of this article or a rule adopted under this article. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it collects from civil penalties pursuant to this subsection in the state general fund.

J. If the board determines after a hearing that a licensee has committed an act of unprofessional conduct, is mentally or physically unable to safely engage in the practice of behavior analysis or is incompetent as

a behavior analyst, the board may do any of the following in any combination and for any period of time it determines necessary:

1. Suspend or revoke the license.

2. Censure the licensee.

3. Place the licensee on probation.

K. A licensee may submit a written response to the board within thirty days after receiving a letter of concern. The response is a public document and shall be placed in the licensee's file.

L. A letter of concern is a public document and may be used in future disciplinary actions against a licensee. A decree of censure is an official action against the behavior analyst's license and may include a requirement that the licensee return fees to a client.

M. Except as provided in section 41-1092.08, subsection H, a person may appeal a final decision made pursuant to this section to the superior court pursuant to title 12, chapter 7, article 6.

N. If during the course of an investigation the board determines that a criminal violation may have occurred involving the delivery of behavior analysis services, it shall inform the appropriate criminal justice agency.

32-2091.10. Right to examine and copy evidence; subpoenas; right to counsel; confidentiality

A. In connection with an investigation conducted pursuant to this article, at all reasonable times the board and its authorized agents may examine and copy documents, reports, records and other physical evidence wherever located relating to the licensee's professional competence, unprofessional conduct or mental or physical ability to safely practice behavior analysis.

B. The board and its authorized agents may issue subpoenas to compel the attendance and testimony of witnesses and the production of documents and other physical evidence as prescribed in subsection A. The board may petition the superior court to enforce a subpoena.

C. Within five days of receiving a subpoena, a person may petition the board to revoke, limit or modify the subpoena. The board shall take this action if it determines that the evidence demanded is not relevant to the investigation. The person may petition the superior court for this relief without first petitioning the board.

D. A person appearing before the board or its authorized agents may be represented by an attorney.

E. Documents associated with an investigation are not open to the public and shall remain confidential. Documents may not be released without a court order compelling their production.

F. This section or any other provision of law making communications between a behavior analyst and client privileged does not apply to an investigation conducted pursuant to this article. The board, its employees and its agents shall keep in confidence the names of clients whose records are reviewed during an investigation.

32-2091.11. Injunction

A. The board may petition the superior court for an order to enjoin the following:

1. A person who is not licensed pursuant to this article from practicing behavior analysis.

2. The activities of a licensee that are an immediate threat to the public.

3. Criminal activities.

B. If the board seeks an injunction to stop the unlicensed practice of behavior analysis, it is sufficient to charge that the respondent on a certain day in a specific county engaged in the practice of behavior analysis without a license and without being exempt from the licensure requirements of this article. It is not necessary to show specific damages or injury.

C. The issuance of an injunction does not limit the board's authority to take other action against a licensee pursuant to this article.

32-2091.12. Violations; classification

A. It is a class 2 misdemeanor for a person who is not licensed pursuant to this article to engage in the practice of behavior analysis.

B. It is a class 2 misdemeanor for any person to:

1. Secure a license to practice pursuant to this article by fraud or deceit.

2. Impersonate a member of the board in order to issue a license to practice pursuant to this article.

C. It is a class 2 misdemeanor for a person who is not licensed pursuant to this article to use any combination of words, initials and symbols that leads the public to believe the person is licensed to practice behavior analysis in this state.

32-2091.13. Confidential communications

A. The confidential relations and communications between a client and a person who is licensed pursuant to this article, including temporary licensees, are placed on the same basis as those provided by law between an attorney and client. Unless the client waives the behavior analyst-client privilege in writing or in court testimony, a behavior analyst shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the behavior analyst's practice. The behavior analyst shall divulge to the board information it requires in connection with any investigation, public hearing or other proceeding. The behavior analyst-client privilege does not extend to cases in which the behavior analyst has a duty to report information as required by law.

B. The behavior analyst shall ensure that client records and communications are treated by clerical and paraprofessional staff at the same level of confidentiality and privilege required of the behavior analyst.

32-2091.14. Status as behavioral health professional

Notwithstanding any law to the contrary, the Arizona health care cost containment system administration shall recognize a behavior analyst who is licensed pursuant to this article as a behavioral health professional who is eligible for reimbursement of services.

32-2091.15. Committee on behavior analysts; membership; duties; board responsibilities

A. The committee on behavior analysts is established within the state board of psychologist examiners consisting of five members who are appointed by the governor and who serve at the pleasure of the governor. Each member shall serve for a term of five years beginning and ending on the third Monday in January. A committee member may not serve more than two full consecutive terms.

B. All members of the committee shall be licensed behavior analysts in professional practice, two of whom shall be members of the board. The committee shall annually elect a chairperson from among its membership.

C. Within one year after their initial appointment to the committee, members shall receive at least five hours of training prescribed by the board that includes instruction in ethics and open meeting requirements.

D. Committee members shall receive reimbursement of all expenses pursuant to title 38, chapter 4, article 2.

E. The committee shall make recommendations to the board on all matters relating to the licensing and regulation of behavior analysts. The committee may recommend regulatory changes to the board that are not specific to an individual licensee, but the committee shall obtain public input from behavior analyst licensees or their designated representatives before making any final recommendation to the board.

**D-3.**

**BOARD OF PHYSICAL THERAPY**
Title 4, Chapter 24, Articles 1-4

**Amend:** R4-24-101; R4-24-104; R4-24-107; R4-24-201; R4-24-202; R4-24-203; R4-24-204; R4-24-205; R4-24-207; R4-24-208; R4-24-209; Table 1; R4-24-210; R4-24-211; R4-24-302; R4-24-303; R4-24-304; R4-24-305; R4-24-306; R4-24-308; R4-24-309; R4-24-310; R4-24-311; R4-24-312; R4-24-313; R4-24-401; R4-24-402; R4-24-403

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **BOARD OF PHYSICAL THERAPY**
Title 4, Chapter 24, Articles 1-4

**Amend:** R4-24-101; R4-24-104; R4-24-107; R4-24-201; R4-24-202; R4-24-203; R4-24-204; R4-24-205; R4-24-207; R4-24-208; R4-24-209; Table 1; R4-24-210; R4-24-211; R4-24-302; R4-24-303; R4-24-304; R4-24-305; R4-24-306; R4-24-308; R4-24-309; R4-24-310; R4-24-311; R4-24-312; R4-24-313; R4-24-401; R4-24-402; R4-24-403

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**Summary:**

This regular rulemaking from the Board of Physical Therapy (Board) seeks to amend twenty-seven (27) rules and one (1) table in Title 4, Chapter 24, Articles 1 through 4 regarding General Provisions, Licensing Provision, Practice of Physical Therapy, and Continuing Competence, respectively. Specifically, the Board is seeking to address the issues identified in a Five-Year Review Report approved by the Council on April 1, 2025. In particular, the Board is updating the ethics materials incorporated by reference in R4-24-101.

Additionally, relying on the authority provided under A.R.S. §§ 32-2022(B)(7) and 32-2025(D), the Board is removing clinical performance instruments from materials incorporated by reference and will approve available instruments on a case-by-case basis. The Board concluded this flexibility is necessary because multiple entities have expressed the intent to

develop clinical performance instruments and because some current instruments are available only online.

Finally, under Laws 2024, Chapter 236, the Legislature changed certification of physical therapist assistants to licensure. This change ricochets throughout existing rules. Additional changes are made to be consistent with statute and agency practice.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Board cites both general and specific statutory authority for these rules.

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Board indicates it did not review any study relevant to this rulemaking.

**4. Summary of the agency's economic impact analysis:**

The Board is completing a rulemaking that addresses the issues identified in a 5YRR approved by the Council on December 3, 2019; brings rules in compliance with changes under Laws 2024, Chapter 236; and updates rules to be consistent with industry and agency practice. The Board believes the rulemaking has minimal economic impact since, according to the Board, the updated materials incorporated by reference or approved by the Board simply make the rules consistent with current industry standards. In its reasoning, the Board also states that other changes make the rules consistent with Board practice or legislative change.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Board determined that the rules are neither intrusive nor costly and therefore did not consider alternatives. The Board states it is the only state agency affected by the rulemaking and that it incurred the cost of completing the rulemaking and will incur the cost of implementing and enforcing the rule changes. The Board believes these rule amendments will benefit the agency, business entities, and licensees, and that these benefits will outweigh the costs, which are, according to the Board, largely administrative and minimal.

**6. What are the economic impacts on stakeholders?**

The Board indicates that there is minimal economic impact on small businesses and licensees. The Board believes that, besides paying minimal administrative costs to be compliant

with the rulemaking, small businesses will benefit from no longer paying the duplicate license registration fee, and from having a clearer understanding that complaints can be made against business entities. The Board believes that licensees will also benefit from saving the duplicate license registration cost and from the ease to move from one state to another given rules that are consistent with industry practice. Specifically for the duplicate registration savings, the Board estimates that repealing the charge for a duplicate license or registration would have saved licensees and registrants $1,600 during the last year if it had been in effect.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Board indicates there were no changes between the Notice of Proposed Rulemaking published in the Administrative Register on November 29, 2024 and the Notice of Final Rulemaking now before the Council for consideration.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Board indicates it received no public comments related to this rulemaking.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Pursuant to A.R.S. § 41-1037(A), if an agency proposes an amendment to an existing rule that requires the issuance of a regulatory permit, license, or agency authorization, the agency shall use a general permit, as defined by A.R.S. § 41-1001(12), if the facilities, activities or practices in the class are substantially similar in nature unless certain exceptions apply.

A.R.S. § 41-1001(12) defines "general permit" to mean "a regulatory permit, license or agency authorization that is for facilities, activities or practices in a class that are substantially similar in nature and that is issued or granted by an agency to a qualified applicant to conduct identified operations or activities if the applicant meets the applicable requirements of the general permit, that requires less information than an individual or traditional permit, license or authorization and that does not require a public hearing."

The Board indicates it does not issue general permits. Rather, the Board states it issues individual licenses as required by the Board's statutes to each person that is qualified by statute (*See* A.R.S. § 32-2022) and rule. As such, the issuance of an alternative type of permit, license or authorization is specifically authorized by state statute. *See* A.R.S. § 41-1037(A)(2). Council staff believes the Board is in compliance with A.R.S. § 41-1037.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board indicates there is no corresponding federal law.

## 11. Conclusion

This regular rulemaking from the Board seeks to amend twenty-seven (27) rules and one (1) table in Title 4, Chapter 24, Articles 1 through 4 regarding General Provisions, Licensing Provision, Practice of Physical Therapy, and Continuing Competence, respectively. Specifically, the Board is seeking to address the issues identified in a Five-Year Review Report approved by the Council on April 1, 2025 by updating the ethics materials incorporated by reference in R4-24-101. Additionally, the Board is removing clinical performance instruments from materials incorporated by reference and will approve available instruments on a case-by-case basis. Finally, under Laws 2024, Chapter 236, the Legislature changed certification of physical therapist assistants to licensure. This change ricochets throughout existing rules. Additional changes are made to be consistent with statute and agency practice.

The Board is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A).

Council staff recommends approval of this rulemaking.

ARIZONA
BOARD OF
PHYSICAL THERAPY

KATIE HOBBS
Governor

1740 W. Adams Street, Suite 2450
Phoenix, AZ 85007
(602) 274 – 0236
ptboard.az.gov

JUDY CHEPEUS
Executive Director

April 28, 2025

Ms. Jessica Klein, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 305
Phoenix, AZ 85007

**Re: A.A.C. Title 4. Professions and Occupations**
**Chapter 24. Board of Physical Therapy**

Dear Ms. Klein:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

A. Close of record date: The rulemaking record was closed on January 10, 2025, following a period for public comment and an oral proceeding. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B).

B. Relation of the rulemaking to a five-year-review report: The rulemaking relates to a 5YRR approved by the Council on April 1, 2025.

C. New fee: The rulemaking does not establish a new fee.

D. Fee increase: The rulemaking does not increase an existing fee.

E. Immediate effective date: An immediate effective date is not requested.

F. Certification regarding studies: I certify that the preamble accurately discloses the Board did not review any studies in its evaluation of or justification for the rule in this rulemaking.

G. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that the rule in this rulemaking will not require a state agency to employ a new full-time employee. No notification was provided to JLBC.

H. List of documents enclosed:
1. Cover letter signed by the Executive Director;
2. Notice of Final Rulemaking including the preamble, table of contents, and rule text;
3. Economic, Small Business, and Consumer Impact Statement;

Sincerely,

Judy Chepeus

Judy Chepeus
Executive Director

**NOTICE OF FINAL RULEMAKING**

**TITLE 4. PROFESSIONS AND OCCUPATIONS**
**CHAPTER 24. BOARD OF PHYSICAL THERAPY**
**PREAMBLE**

**1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039(B) by the governor on:**

April 21, 2025

| **2. Article, Part, or Section Affected (as applicable)** | **Rulemaking Action** |
|---|---|
| R4-24-101 | Amend |
| R4-24-104 | Amend |
| R4-24-107 | Amend |
| R4-24-201 | Amend |
| R4-24-202 | Amend |
| R4-24-203 | Amend |
| R4-24-204 | Amend |
| R4-24-205 | Amend |
| R4-24-207 | Amend |
| R4-24-208 | Amend |
| R4-24-209 | Amend |
| Table 1 | Amend |
| R4-24-210 | Amend |
| R4-24-211 | Amend |
| R4-24-302 | Amend |
| R4-24-303 | Amend |
| R4-24-304 | Amend |
| R4-24-305 | Amend |
| R4-24-306 | Amend |
| R4-24-308 | Amend |
| R4-24-309 | Amend |
| R4-24-310 | Amend |
| R4-24-311 | Amend |
| R4-24-312 | Amend |
| R4-24-313 | Amend |
| R4-24-401 | Amend |
| R4-24-402 | Amend |
| R4-24-403 | Amend |

**3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. § 32-2003(A)(5)
Implementing statute: A.R.S. § 32-2003(A)(1), 32-2022(B)(7) and (D), and 32-2025

**4. The effective date of the rule:**

This rule will be effective 60 days after a certified original and preamble are filed in the Office of the Secretary of State under A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

**a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable

**b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable

**5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:**

Notice of Rulemaking Docket Opening: 30 A.A.R. 3685, Issue Date: November 29, 2024, Issue Number: 48, File number: R24-260

Notice of Proposed Rulemaking: 30 A.A.R. 3568, Issue Date: November 29, 2024, Issue Number: 48, File number: R24-255

**6. The agency's contact person who can answer questions about the rulemaking:**


Name: Judy Chepeus
Title: Executive Director
Address: 1740 West Adams Street, Suite 2450, Phoenix, AZ 85007
Telephone: (602) 271-7365
Email: judy.chepeus@ptboard.az.gov
Website: ptboard.az.gov


**7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Board is completing a rulemaking that addresses the issues identified in a 5YRR approved by the Council on April 1, 2025. In particular, the Board is updating the ethics materials incorporated by reference in R4-24-101. Additionally, relying on the authority provided under A.R.S. §§ 32-2022(B)(7) and 32-2025(D), the Board is removing clinical performance instruments from materials incorporated by reference and will approve available instruments on a case-by-case basis. The Board concluded this flexibility is necessary because multiple entities have expressed the intent to develop clinical performance instruments and because some current instruments are available only online.

Under Laws 2024, Chapter 236, the legislature changed certification of physical therapist assistants to licensure. This change ricochets throughout existing rules. Additional changes are made to be consistent with statute and agency practice.

**8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

Not applicable

**9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**10. A summary of the economic, small business, and consumer impact:**

The Board determined the rulemaking has minimal economic impact. The updated materials incorporated by reference or approved by the Board simply make the rules consistent with current industry standards. Other changes make the rules consistent with Board practice or legislative change.

**11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

Not applicable

**12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

Not applicable

**13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

Not applicable

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

The Board does not issue general permits. Rather, the Board issues individual licenses as require by the Board's statutes to each person that is qualified by statute (See A.R.S. § 32-2022) and rule.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

There are numerous federal laws that impact the provision of health care services such as physical therapy. However, no federal law is directly applicable to any rule in this rulemaking.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

**14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

The following materials are incorporated by reference in R4-24-101:

- *The Code of Ethics for the Physical Therapist* (amended August 12, 2020) and the accompanying *Guide for Professional Conduct* (amended March 2019).
- *The Standards of Ethical Conduct for the PTA* (amended August 12, 2020)

**15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**16. The full text of the rules follows:**

**TITLE 4. PROFESSIONS AND OCCUPATIONS**
**CHAPTER 24. BOARD OF PHYSICAL THERAPY**
**ARTICLE 1. GENERAL PROVISIONS**

Section
R4-24-101. Definitions
R4-24-104. Confidential Information and Records
R4-24-107. Fees

**ARTICLE 2. LICENSING PROVISIONS**

Section
R4-24-201. Application for a Physical Therapist License
R4-24-202. Reinstatement of License ~~or Certificate~~; Reapplication
R4-24-203. Foreign-educated Applicant Requirements
R4-24-204. Supervised Clinical Practice
R4-24-205. Examination Scores
R4-24-207. Application for a Physical Therapist Assistant ~~Certificate~~ License
R4-24-208. License ~~or Certificate~~ Renewal; ~~Address~~ Change in Contact Information
R4-24-209. ~~Time-frames~~ Time Frames for Board Approvals
Table 1. Time Frames (in days)
R4-24-210. Business Entity Registration; Display of Registration Certificate
R4-24-211. Renewal of Business Entity Registration

**ARTICLE 3. PRACTICE OF PHYSICAL THERAPY**

Section
R4-24-302. Use of Titles
R4-24-304. Adequate Patient Records
R4-24-303. Patient Care Management
R4-24-305. Complaints and Investigations
R4-24-306. Hearings
R4-24-308. Rehearing or Review of Board Decisions
R4-24-309. Disciplinary Actions
R4-24-310. Substance Abuse Recovery Program
R4-24-311. Display of License; Disclosure
R4-24-312. Mandatory Reporting Requirement
R4-24-313. Professional Standards of Care and Training and Education Qualifications for Delivery of Dry Needling Skilled Intervention

**ARTICLE 4. CONTINUING COMPETENCE**

Section
R4-24-401. Continuing Competence Requirements for Renewal
R4-24-402. Continuing Competence Activities
R4-24-403. Activities Not Eligible for Continuing Competence Credit

**ARTICLE 1. GENERAL PROVISIONS**

**R4-24-101. Definitions**

In addition to the definitions in A.R.S. §§ 32-2001 and 32-2053, in this Chapter:

1. "Accredited" means accredited by a nationally recognized accreditation organization.
2. "Accredited educational program" means a physical therapist or physical therapist assistant educational program that is accredited by:
   a. The Commission on Accreditation of Physical Therapy Education, or
   b. An agency recognized as qualified to accredit physical therapist or physical therapist assistant programs by either the U.S. Department of Education or the Council on Higher Education Accreditation at the time of the applicant's graduation.
3. "Administratively suspend," as used in A.R.S. § 32-2027, means a non-disciplinary action in which the Board places a license ~~or certificate~~ issued under A.R.S. Title 32, Chapter 19 and this Chapter on suspended status because the license ~~or certificate~~ was not renewed timely.
4. "Applicant" means an individual or business entity seeking an initial or renewal license, ~~initial or renewal certificate,~~ initial or renewal registration, interim permit, or reinstatement from the Board.
5. "Applicant packet" means the forms and additional information the Board requires to be submitted by an applicant or on the applicant's behalf.
6. "Campus" means a facility and immediately adjacent buildings.
7. "Clinical performance instrument" means a tool used to assess an individual's knowledge, skills, and attitudes for readiness to work as a physical therapist or physical therapist assistant, as applicable, that is accepted by the Board and listed on its website.

~~7.~~8. "College Board" means an association composed of schools, colleges, universities, and other educational organizations across the United States that is responsible for the development of assessment tests that are used to provide college credit or for college placement.

~~8.~~9. "College level examination program" means services offered by the College Board for an individual to demonstrate college-level achievement by taking an examination approved by the College Board.

~~9.~~10. "Compliance period" means ~~a~~ the two-year license renewal cycle that ends August 31 of even-numbered years.

~~10.~~11. "Continuing competence" means maintaining the professional skill, knowledge, and ability of a physical therapist or physical therapist assistant by successfully completing scholarly and professional activities related to physical therapy.

~~11.~~12. "Course" means an organized subject matter in which instruction is offered within a specified period of time.

~~12.~~13. "Course evaluation tool" means the Coursework Evaluation Tool for Foreign Educated Physical Therapists who Graduated after June 30, 2009, Fifth Edition, 2004 (effective July 1, 2009), published by the Federation of State Boards of Physical Therapy, 124 West Street, South Alexandria, VA, 22314, incorporated by reference and on file with the Board. This incorporation by reference contains no future editions or amendments.

~~13.~~14. "Credential evaluation" means a written assessment of a foreign-educated applicant's general and professional educational course work.

~~14.~~15. "Credential evaluation agency" means an organization that evaluates a foreign-educated applicant's education and provides recommendations to the Board about whether the applicant's education is substantially equivalent to physical therapy education provided in an accredited educational program.

~~15.~~16. "Days" means calendar days.

~~16.~~17. "Endorsement" means a procedure for granting an Arizona license ~~or certificate~~ to an applicant already licensed as a physical therapist or ~~certified as a~~ physical therapist assistant in another jurisdiction of the United States.

~~17.~~18. "ETS" means Educational Testing Service, an organization that provides educational learning and assessment services, including the Test of English as a Foreign Language Program.

~~18.~~19. "Facility" means a building where:
   a. A physical therapist is engaged in the practice of physical therapy;
   b. An applicant~~,~~ or licensee~~, or certificate holder~~ is engaged in a supervised clinical practice; or
   c. A physical therapist assistant performs physical therapy-related tasks delegated by an onsite supervisor.

~~19.~~20. "Foreign-educated applicant" means an individual who graduated from a physical therapist educational program outside the United States, Puerto Rico, District of Columbia, or a U.S. territory.

~~20.~~21. "Functional limitation" means restriction of the ability to perform a physical action, activity, or task in an efficient, typically expected, or competent manner.

~~21. "Good moral character" means the applicant has not taken any action that is grounds for disciplinary action against a licensee or certificate holder under A.R.S. § 32-2044.~~

22. "Hour" means 60 minutes.
23. "iBT" means internet-based TOEFL.
24. "National disciplinary database" means the disciplinary database of the U.S. Department of Health and Human Services' Health Integrity and Protection Data Base, which contains previous or current disciplinary actions taken

against a ~~licensed~~ physical therapist or ~~certified~~ physical therapist assistant by state licensing agencies.

25. "National examination" means an examination produced by the Federation of State Boards of Physical Therapy or an examination produced by the American Physical Therapy Association.
26. "On call," as used in the definition of "general supervision" prescribed under A.R.S. § 32-2001, means a supervising physical therapist is able to go to the location at which and on the same day that a physical therapist assistant provides a selected treatment intervention if the physical therapist, after consultation with the physical therapist assistant, determines that going to the location is in the best interest of the patient.
27. "Onsite supervisor" means a physical therapist who provides onsite supervision as defined in A.R.S. § 32-2001.
~~28. "Physical Therapist Assistant Clinical Performance Instrument" means the document used to assess an individual's knowledge, skills, and attitudes to determine the individual's readiness to work as a physical therapist assistant that is published by the American Physical Therapy Association, Division of Education, March 1998, 1111 North Fairfax Street, Alexandria, VA 22314-1488 and incorporated by reference and on file with the Board. This incorporation by reference contains no future editions or amendments.~~
~~29. "Physical Therapist Clinical Performance Instrument" means the document used to assess an individual's knowledge, skills, and attitudes to determine the individual's readiness to practice physical therapy that is published by the American Physical Therapy Association, Division of Education, December 1997, 1111 North Fairfax Street, Alexandria, VA 22314-1488 and incorporated by reference and on file with the Board. This incorporation by reference contains no future editions or amendments.~~
~~30.~~28. "Physical therapy services" means any of the actions stated in the definition of practice of physical therapy in A.R.S. § 32-2001.
~~31.~~29. "Qualified translator" means an individual, other than an applicant, who is:
    a. An officer or employee of an official translation bureau or government agency,
    b. A professor or instructor who teaches a translated language in an accredited college or university in the United States,
    c. An American consul in the country where the translated document is issued or another individual designated by the American consul in the country where the translated document is issued, or
    d. A consul general or diplomatic representative of the United States or individual designated by the consul general or diplomatic representative.
~~32.~~30. "Readily available," as used in the definition of "general supervision" prescribed under A.R.S. § 32-2001, means a supervising physical therapist is able to respond within 15 minutes to a communication from a physical therapist assistant providing a selected treatment intervention under general supervision.
~~33.~~31. "Recognized standards of ethics" means the *Code of Ethics for the Physical Therapist* (amended ~~June 2000~~ August 12, 2020) and the accompanying *Guide for Professional Conduct* (amended ~~January 2004~~ March 2019 and the *Standards of Ethical Conduct for the PTA* (amended August 12, 2020) of the American Physical Therapy Association, ~~1111 North Fairfax Street~~ 3030 Potomac Avenue, Suite 100, Alexandria, VA ~~22314-1488~~ 22305-3085, which ~~is~~ are incorporated by reference and on file with the Board. This incorporation includes no later editions or amendments.
~~34.~~32. "Supervised clinical practice" means ~~the period of time~~ a physical therapist is engaged in the practice of physical therapy or a physical therapist assistant is engaged in work as a physical therapist assistant after being issued an interim permit by the Board.
~~35.~~33. "Supervising physical therapist" means ~~an individual~~ a physical therapist licensed under this Chapter who provides onsite or general supervision to ~~assistive personnel~~ licensed physical therapist assistants or onsite supervision to other assistive personnel, interim permit holders, student physical therapists, and student physical therapist assistants.
~~36.~~34. "Suspend" means a disciplinary action in which the Board places a license~~, certificate, permit,~~ or registration in a status that restricts the holder of the license~~, certificate, permit,~~ or registration from practicing as a physical therapist, working as a physical therapist assistant, or offering physical therapy services.
~~37.~~35. "TOEFL" means test of English as a foreign language.
~~38.~~36. "Week" means the period beginning on Sunday at 12:00 a.m. and ending the following Saturday at 11:59 p.m.

**R4-24-104. Confidential Information and Records**

The following information or a record containing this information is confidential and is not provided to the public by the Board:

1. An applicant's~~,~~ or licensee's~~, or certificate holder's~~:
    a. Social Security number;
    b. Home address or home telephone number unless the applicant or licensee designates the ~~address or telephone number, is the only address or telephone number of record~~ information for disclosure under A.R.S. § 32-3226;
    c. Credential evaluation report, education transcript, grades, or examination scores;
    d. National physical therapist or physical therapist assistant examination score;

e. Diagnosis and treatment records; and

2. According to A.R.S. § 32-2045, information or a document related to investigations by the Board until the information or document becomes a public record or as required by law.

**R4-24-107. Fees**

**A.** Under the authority provided by A.R.S. §§ 32-2029, ~~and~~ 32-2030, 32-2032, and 32-2053 the Board establishes and shall collect the following fees:

1. For a physical therapist:
   a. Application for an original license if the applicant applies on or after September 1 in an even-numbered year and no later than August 31 in an odd-numbered year, $260;
   b. Application for an original license if the applicant applies on or after September 1 in an odd-numbered year and no later than August 31 in an even-numbered year, $190;
   c. Renewal of an active license, $160;
   d. Renewal of an inactive license, $80; and
   e. Reinstatement of an administratively suspended license, $100 plus the renewal fee~~; and~~
   ~~f. Duplicate license, $10~~.
2. For a physical therapist assistant:
   a. Application for an original ~~certificate~~ license if the applicant applies on or after September 1 in an even-numbered year and no later than August 31 in an odd-numbered year, $160;
   b. Application for an original ~~certificate~~ license if the applicant applies on or after September 1 in an odd-numbered year and no later than August 31 in an even-numbered year, $120;
   c. Renewal of an active ~~certificate~~ license, $55;
   d. Renewal of an inactive ~~certificate~~ license, $27.50; and
   e. Reinstatement of an administratively suspended ~~certificate~~ license, $50 plus the renewal fee~~; and~~
   ~~f. Duplicate certificate, $10~~.
3. For a business entity:
   a. Application for an original registration, $50;
   b. Renewal, $50; and
   c. Late fee, $25~~; and~~
   ~~d. Duplicate registration, $10~~.

**B.** Under the authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect a registration fee from an out-of-state health care provider of telehealth services: $100.

**C.** The fees specified in subsections (A) and (B) are nonrefundable unless A.R.S. § 41-1077 applies.

## ARTICLE 2. LICENSING PROVISIONS

**R4-24-201. Application for a Physical Therapist License**

**A.** An applicant for ~~a~~ an original physical therapist license shall submit to the Board an application packet that includes:

1. An electronic application form, ~~provided by~~ which is available on the ~~Board that is signed, dated, and verified by the applicant and contains:~~ Board's website;
   ~~a. The applicant's name, business, residential, and e-mail addresses, business and residential telephone numbers, birth date, and Social Security number;~~
   ~~b. The name and address of each university or college attended by the applicant, the dates of attendance, and the date of graduation and degree received, if applicable;~~
   ~~c. The name and address of the university or college where the applicant completed an accredited educational program and dates of attendance;~~
   ~~d. A statement of whether the applicant has ever been licensed as a physical therapist in any other jurisdiction of the United States or foreign country;~~
   ~~e. Professional employment history for the past five years, including the name, address, and telephone number for each place of employment, job title, description of the work completed, and explanation of any breaks in employment, if applicable;~~
   ~~f. A statement of whether the applicant has ever been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country and if so, an explanation;~~
   ~~g. A statement of whether the applicant has ever had an application for a professional or occupational license, certificate, or registration, other than a driver's license, denied, rejected, suspended, or revoked by any jurisdiction~~

~~of the United States or foreign country and if so, an explanation;~~

~~h. A statement of whether the applicant is currently or ever has been under investigation, suspension, or restriction by a professional licensing board in any jurisdiction of the United States or foreign country for any act that occurred in that jurisdiction that would be the subject of discipline under this Chapter and if so, an explanation;~~

~~i. A statement of whether the applicant has ever been the subject of disciplinary action by a professional association or postsecondary educational institution;~~

~~j. A statement of whether the applicant has committed any of the actions referenced in the definition of good moral character in R4-24-101;~~

~~k. A statement of whether the applicant has ever had a malpractice judgment, has a lawsuit currently pending for malpractice, or entered into a settlement from a malpractice suit and if so, an explanation;~~

~~l. A statement of whether the applicant is currently more than 30 days in arrears for payment required by a judgment and order for child support in Arizona or any other jurisdiction;~~

~~m. A statement of whether the applicant has any impairment to the applicant's cognitive, communicative, or physical ability to engage in the practice of physical therapy with skill and safety and if so, an explanation;~~

~~n. A statement of whether the applicant has, within the past 10 years, used alcohol, any illegal chemical substance, or prescription medications, that in any way has impaired or limited the applicant's ability to practice physical therapy with skill and safety and if so, an explanation;~~

~~o. A statement of whether the applicant has, within the past 10 years, been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited the applicant's ability to practice physical therapy with skill and safety and if so, an explanation;~~

~~p. A statement of whether the applicant has ever violated A.R.S. § 32-2044(10); and~~

~~q. A statement by the applicant attesting to the truthfulness of the information provided by the applicant;~~

2. A ~~passport~~ headshot photograph of the applicant ~~no larger than 1 1/2 x 2 i~~nches that was taken not more than six months before the date of the application;
3. ~~Documentation~~ A copy of documentation, as described under A.R.S. § 41-1080, of the applicant's U.S. citizenship, alien status, legal residency, or lawful presence in the U.S.;
4. A copy of the applicant's valid fingerprint clearance card as required under A.R.S. § 32-2022; and

~~4.~~5. The fee required in R4-24-107.

**B.** In addition to the requirements in subsection (A), an applicant shall arrange to have the original source of the following information submit the information electronically ~~submitted directly~~ to the Board:

1. An official transcript or letter ~~showing that~~ that shows the applicant completed all requirements of an accredited educational program ~~that includes the official seal of~~ , identifies the university or college where the applicant completed the accredited educational program, and contains the electronic signature of the registrar of the university or college,
2. Verification of passing a national examination in physical therapy ~~as evidenced by an original notice of examination results~~, and
3. Verification of passing a jurisprudence examination ~~as evidenced by an original notice of examination results~~.

**C.** In addition to the requirements in subsections (A) and (B), an applicant for a physical therapist license by endorsement or universal recognition shall electronically submit to the Board:

1. The name of the licensing or certifying agency of any jurisdiction in which the applicant is currently or has been previously licensed, certified, or granted a compact privilege, as defined at A.R.S. § 32-2053;
2. A primary-source verification of each license, certificate, or compact privilege identified in subsection (C)(1) ~~signed and dated by an official of the agency licensing or certifying~~ ~~the applicant,~~ that includes ~~the official seal of the licensing or certifying agency and~~ all of the following:
   a. The name of the applicant;
   b. The license or certificate number and date of issuance;
   c. The current status of the license or certificate;
   d. The expiration date of the license or certificate; and
   ~~e. A statement of whether the applicant was ever denied a license by the agency and if so, an explanation; and~~
   ~~f.~~e. A statement of whether any disciplinary action is pending or has ever been taken against the applicant and if so, an explanation.

**D.** The Board shall deny a license to an applicant who fails to meet the requirements of this Section or A.R.S. Title 32, Chapter 19. An applicant denied a license may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**R4-24-202. Reinstatement of License ~~or Certificate~~; Reapplication**

**A.** Reinstatement. An applicant whose Arizona license ~~or certificate~~ is administratively suspended for no more than three consecutive years ~~or less~~ after the date ~~of renewal of~~ on which the license ~~or certificate~~ was not renewed may apply for

reinstatement of the license ~~or certificate~~ by submitting the application in R4-24-208 and the reinstatement fee and renewal fee required in R4-24-107.

**B.** Reapplication. An ~~applicant whose~~ Arizona license ~~or certificate~~ that is administratively suspended for more than three consecutive years after the date ~~of renewal of~~ on which the license ~~or certificate~~ was not renewed expires as specified in A.R.S. § 32-2028(B) and may not be reinstated. The holder of an expired license may ~~apply~~ reapply for ~~reinstatement of the~~ a license ~~or certificate~~ by submitting an application under R4-24-201, R4-24-203, or R4-23-207, as applicable, and the ~~reinstatement fee and renewal~~ fee required in R4-24-107~~, and:~~.

~~1. For an applicant educated in the United States requesting reinstatement of a license, the application in R4-24-201(A) and (B);~~

~~2. For a foreign-educated applicant requesting reinstatement of a license, the application in R4-24-203; or~~

3. ~~For an applicant requesting reinstatement of a certificate, the application in R4-24-207(A) and (B).~~

**C.** If an applicant submits an application according to subsection (B), the Board shall require the applicant to demonstrate competency by doing one or more of the following:

1. Practice physical therapy or work as a physical therapist assistant under an interim permit that allows the applicant to participate in a supervised clinical practice,
2. Complete one or more courses relevant to the practice of physical therapy or the work of a physical therapist assistant,
3. Complete continuing competence requirements for the period ~~of time~~ of the lapsed license, or
4. Take and pass a jurisprudence examination or national examination.

**R4-24-203. Foreign-educated Applicant Requirements**

**A.** A foreign-educated applicant shall meet the requirements in A.R.S. § 32-2022(B) and the following:

1. The applicant shall comply with the requirements in R4-24-201.
2. The applicant shall ensure ~~that~~ a document required by R4-24-201 or this subsection is:
   a. Submitted to the Board in English; or
   b. Accompanied by an original English translation by a qualified translator if the document is submitted to the Board in a language other than English and includes an affidavit of accuracy by the qualified translator affirming:
      i. The qualified translator has translated the entire document,
      ii. The qualified translator has not omitted anything from or added to the translation, and
      iii. The translation is true and accurate.
3. To meet the requirements in A.R.S. § 32-2022(B)(4), the applicant shall state on the application form whether the applicant's practice as a physical therapist was limited in the country where the professional education occurred. If the applicant's practice was limited in the country where the professional education occurred, the applicant shall submit to the Board documentation of the limitation, or arrange to have documentation of limitation sent directly to the Board~~, that includes~~. The applicant shall ensure the documentation includes:
   a. The name, address, and telephone number of the entity that limited the applicant's practice of physical therapy;
   b. ~~A description of the action or lack of action that led to the limitation on~~ An explanation of why the applicant's practice as a physical therapist is limited;
   c. A description of the nature of the limitation on the applicant's practice of physical therapy; and
   d. If the limitation is based on citizenship requirements of the country in which the professional education was obtained, ~~the applicant shall provide the Board with the~~ a legal reference for the ~~restriction~~ limitation in the laws of the country in which the professional education was obtained, a copy of the referenced laws, and an English translation of the laws that meets the standards in subsection (A)(2)(b).
4. If English is not the native language of the foreign-educated applicant, to meet the requirements in A.R.S. § 32-2022(B)(6), the applicant shall take and pass either of the following tests no more than 18 months before the date on which the application submitted under R4-24-201 is administratively complete and ensure ~~that~~ the test scores are sent directly to the Board by the testing entity:
   a. The TOEFL. An applicant who takes the TOEFL passes with the following:
      i. A score of 560 or more if a paper-based test or a score of 220 or more if a computer-based test;
      ii. Test of Spoken English with a score of 50 or more; and
      iii. Test of Written English with a score of 4.5 or more; or
   b. The iBT. An applicant who takes the iBT passes with an overall test score of a minimum of 100 and a:
      i. Writing section with a minimum score of 25,
      ii. Speaking section with a minimum score of 25,
      iii. Reading section with a minimum score of 25, and
      iv. Listening section with a minimum score of 25.

5. To demonstrate that the applicant meets uniform criteria for educational requirements according to A.R.S. § 32-2022(E)(3), the applicant shall undergo a credential evaluation to determine that the applicant meets the requirements in the course evaluation tool and arrange to have a credential evaluation report, prepared within 18 months from the date of the application, sent directly to the Board by the credential evaluation agency.
6. To meet the requirements in A.R.S. § 32-~~2022(B)(5)~~ 2022(B)(4), the applicant shall obtain a work visa to reside and seek employment in the United States issued by the ~~Bureau of~~ United States Citizenship and Immigration Services and submit a copy of the work visa to the Board.

**B.** After receiving a credential evaluation report from a credential evaluation agency, the Board:
1. If the credential evaluation report does not establish that the education obtained by the foreign-educated applicant is substantially equivalent to the education required of a physical therapist in an accredited education program, may require the applicant to complete:
   a. ~~Complete one~~ One or more university or college courses and obtain a grade of C or better in each course;
   b. ~~Complete a~~ A college level examination program; or
   c. ~~If an applicant for a license, complete one~~ One or more continuing competence courses; and
2. Shall issue, within the ~~time-frames~~ time frames stated in Table 1, an interim permit to complete a supervised clinical practice to the applicant if:
   a. The applicant was required to meet one or more of the requirements in subsection (B)(1) and completes the requirements; or
   b. The credential evaluation report establishes that the education obtained by the foreign-educated applicant is substantially equivalent to the education required of a physical therapist in an accredited education program; and
   c. The applicant has passed the national examination and jurisprudence examination; and
   d. The applicant meets the requirements in A.R.S. Title 32, Chapter 19 and R4-24-201.

**R4-24-204. Supervised Clinical Practice**

**A.** An interim permit holder shall complete a supervised clinical practice under onsite supervision. The supervised clinical practice shall consist of at least 500 hours.

**B.** Before an individual is issued an interim permit, the individual shall submit to the Board:
1. A written request for Board approval of the facility where supervised clinical practice will take place that includes:
   a. The name, address, and telephone number of the facility; and
   b. A description of the physical therapy services provided at the facility; and
2. The name of the individual who holds an unrestricted license to practice physical therapy in this state and agrees to provide onsite supervision of the individual.

**C.** The Board shall approve or deny a request made under subsection (B)(1):
1. After assessing whether the facility provides the opportunity for an interim permit holder to attain the knowledge, skills, and attitudes to be evaluated according to ~~the Physical Therapist Assistant Clinical Performance Instrument or Physical Therapist Clinical Performance Instrument~~ an approved clinical performance instrument; and
2. According to the ~~time-frames~~ time frames in Table 1.

**D.** An onsite supervisor shall:
1. Observe the interim permit holder during the supervised clinical practice and:
   a. Rate the interim permit holder's performance, at both the mid-point and completion of the clinical practice, on each of the clinical performance criteria in ~~the Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument Instrument~~ the clinical performance instrument used, including the dates and hours the onsite supervisor provided onsite supervision;
   b. Recommend following the mid-point rating whether the interim permit holder be allowed to continue the clinical practice and changes needed, if any, to ensure successful completion of the clinical practice; and
   c. Recommend following the completion rating whether the interim permit holder be licensed or required to complete further supervised clinical practice; and
2. Submit the ratings ~~on~~ from the ~~Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument~~ clinical performance instrument used to the Board as follows:
   a. No later than the 55th day of the clinical practice for the mid-point rating, and
   b. No later than 30 days after the end of the supervised clinical practice for the completion rating.

**E.** After the Board receives the mid-point rating ~~on~~ from the ~~Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument~~ clinical performance instrument, the Board shall review the rating and recommendation of the onsite supervisor and decide whether to allow the interim permit holder to continue the clinical practice or recommend changes in the clinical practice to the onsite supervisor.

**F.** After the Board receives the completion rating ~~on~~ from the ~~Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument~~ clinical performance instrument, the Board:

1. May require the interim permit holder to complete additional onsite supervision under the interim permit if the additional onsite supervision does not cause the interim permit holder to exceed six months from the date the interim permit was issued and:
   a. The onsite supervisor does not approve one or more of the skills ~~listed on~~ from the ~~Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument~~ clinical performance instrument;
   b. The onsite supervisor recommends that the interim permit holder complete further supervised clinical practice; or
   c. The Board determines that the interim permit holder has not met the requirements in A.R.S. Title 32, Chapter 19 and this Chapter.
2. If the interim permit holder meets all of the requirements in A.R.S. Title 32, Chapter 19 and this Chapter, shall issue~~:~~
   ~~a. A~~ a license ~~to an applicant for a license, or~~
   ~~b. A certificate to an applicant for a certificate~~.
3. If the ~~applicant, licensee, or certificate holder~~ interim permit holder does not meet all of the requirements in A.R.S. Title 32, Chapter 19 and this Chapter, shall deny~~:~~
   ~~a. A~~ a license ~~to an applicant for a license, or~~
   ~~b. A certificate to an applicant for a certificate~~.

**G.** An applicant who has been denied a license ~~or certificate~~ may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**R4-24-205. Examination Scores**

**A.** To be licensed as a physical therapist or physical therapist assistant, an applicant shall obtain:

1. A scaled score of 600 or more, based on a scale ranging from 200 to 800 on a national examination for physical therapists or physical therapist assistants, as applicable, taken on or after March 14, 1996; or
2. A raw score that is no ~~lower~~ fewer than 1.50 standard ~~deviation~~ deviations below the national average for a national examination for physical therapists or physical therapist assistants, as applicable, taken before March 14, 1996.

~~**B.** To be certified as a physical therapist assistant, an applicant for certification shall obtain:~~

~~1. A scaled score of 600 or more based on a scale ranging from 200 to 800 on a national examination for physical therapist assistants taken on or after March 14, 1996; or~~

~~2. A raw score that is no lower than 1.50 standard deviation below the national average for a national examination for physical therapist assistants taken before March 14, 1996.~~

~~**C.**~~**B.** In addition to the requirements in ~~subsections~~ subsection (A) ~~and (B)~~, to be licensed as a physical therapist or ~~certified as a~~ physical therapist assistant, an applicant shall obtain a scaled score of 600 or more based on a scale ranging from 200 to 800 on a jurisprudence examination.

**R4-24-207. Application for a Physical Therapist Assistant ~~Certificate~~ License**

**A.** An applicant for an original physical therapist assistant ~~certificate~~ license shall submit to the Board an application packet that includes:

1. An electronic application form, which is available on ~~provided by~~ the ~~Board, signed, dated, and verified by the applicant that contains:~~ Board's website;
   ~~a. The applicant's name, business, residential, and e-mail addresses, business and residential telephone numbers, birth date, and Social Security number;~~
   ~~b. The name and address of the college or university where the applicant completed an accredited educational program for physical therapist assistants, dates of attendance, and date of completion;~~
   ~~c. A statement of whether the applicant has ever been licensed or certified as a physical therapist assistant in any other jurisdiction of the United States or foreign country~~;
   ~~d. Professional employment history for the five years before the date of application including the name, address, and telephone number for each place of employment, job title, description of the work completed, and explanation of any breaks in employment, if applicable;~~
   ~~e. A statement of whether the applicant has ever been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country and if so, an explanation;~~
   ~~f. A statement of whether the applicant has ever had an application for a professional or occupational license, certificate, or registration, other than a driver's license, denied, rejected, suspended, or revoked by any jurisdiction of the United States or foreign country and if so, an explanation;~~

g. A statement of whether the applicant is currently or ever has been under investigation, suspension, or restriction by a professional licensing board in any jurisdiction of the United States or foreign country for any act that occurred in that jurisdiction that would be the subject of discipline under this Chapter and if so, an explanation;
h. A statement of whether the applicant has ever been the subject of disciplinary action by a professional association or postsecondary educational institution;
i. A statement of whether the applicant has committed any of the actions referenced in the definition of good moral character in R4-24-101;
j. A statement of whether the applicant has ever had a malpractice judgment or has a lawsuit currently pending for malpractice and if so, an explanation;
k. A statement of whether the applicant is currently more than 30 days in arrears for payment required by a judgment and order for child support in Arizona or any other jurisdiction;
l. A statement of whether the applicant has any impairment to the applicant's cognitive, communicative, or physical ability to participate in therapeutic interventions with skill and safety and if so, an explanation;
m. A statement of whether the applicant has, within the past 10 years, used alcohol, any illegal chemical substance, or prescription medications, that in any way has impaired or limited the applicant's ability to participate in therapeutic interventions with skill and safety and if so, an explanation;
n. A statement of whether the applicant has, within the past 10 years, been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited the applicant's ability to participate in therapeutic interventions with skill and safety and if so, an explanation;
o. A statement of whether the applicant has ever violated A.R.S. § 32-2044(10); and
p. A sworn statement by the applicant verifying the truthfulness of the information provided by the applicant;

2. A headshot passport photograph of the applicant no larger than 1-1/2 x 2 inches that was taken not more than six months before the date of the application;
3. Documentation A copy of documentation, as described under A.R.S. § 41-1080, of the applicant's U.S. citizenship, alien status, legal residency, or lawful presence in the U.S.;
4. A copy of the applicant's valid fingerprint clearance card as required under A.R.S. § 32-2022; and
4.5. The fee required in R4-24-107.

**B.** In addition to the requirements in subsection (A), an applicant shall arrange to have the primary source of the following information submit the information electronically directly submitted to the Board:
1. An official transcript or letter showing the applicant completed all requirements of an accredited educational program that includes the official seal of identifies the school or college where the applicant completed the accredited educational program and contains the electronic signature of the registrar of the school or college;
2. Verification of passing a national examination for physical therapist assistants as evidenced by an original notice of examination results; and
3. Verification of passing a jurisprudence examination as evidenced by an original notice of examination results.

**C.** In addition to the requirements in subsections (A) and (B), an applicant for a physical therapist assistant certificate license by endorsement or universal recognition shall electronically submit to the Board:
1. The name of the licensing or certifying agency of any jurisdiction in which the applicant is currently or has been previously licensed, or certified, or granted a compact privilege, as defined at A.R.S. § 32-2053; and
2. A primary-source verification of any license, or certificate, signed and dated by an official of the agency licensing or certifying the applicant, or compact privilege identified under subsection (C)(1) that includes the official seal of the licensing or certifying agency and all of the following:
   a. The name of the applicant;
   b. The license or certificate number and date of issuance;
   c. The current status of the license or certificate;
   d. The expiration date of the license or certificate; and
   e. A statement of whether the applicant was ever denied a license or certificate by the agency and if so, an explanation; and
   f.e. A statement of whether any disciplinary action is pending or has ever been taken against the applicant and if so, an explanation.

**D.** The Board shall deny a certificate license to an applicant who fails to meet the requirements of this Section or A.R.S. Title 32, Chapter 19. A person denied a certificate license may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**R4-24-208. License or Certificate Renewal; Address Change in Contact Information**

**A.** A licensee or certificate holder shall submit a an electronic renewal application packet to the Board on or before August 31 of an even-numbered year that includes:

1. ~~The~~ An electronic renewal application form, which is available on the Board's website, and ~~following~~ information for the compliance period immediately preceding the renewal application~~:~~;
   a. ~~The licensee's or certificate holder's:~~
      i. ~~Name;~~
      ii. ~~Home, business, and e-mail addresses; and~~
      iii. ~~Home and business telephone numbers;~~
   b. ~~A statement of whether the licensee or certificate holder has been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country and if so, an explanation;~~
   c. ~~A statement of whether the licensee or certificate holder has had an application for a professional or occupational license, certificate, or registration, other than a driver's license, denied, rejected, suspended, or revoked by any jurisdiction of the United States or foreign country and if so, an explanation;~~
   d. ~~A statement of whether the licensee or certificate holder is currently or ever has been under investigation, suspension, or restriction by a professional licensing board in any jurisdiction of the United States or foreign country for any act that occurred in that jurisdiction that would be the subject of discipline under this Chapter and if so, an explanation;~~
   e. ~~A statement of whether the licensee or certificate holder has been the subject of disciplinary action by a professional association or postsecondary educational institution;~~
   f. ~~A statement of whether the licensee or certificate holder has had a malpractice judgment against the licensee or certificate holder or has a lawsuit currently pending for malpractice and if so, an explanation;~~
   g. ~~A statement of whether the licensee or certificate holder is currently more than 30 days in arrears for payment required by a judgment and order for child support in Arizona or any other jurisdiction;~~
   h. ~~A statement of whether the licensee or certificate holder has adhered to the recognized standards of ethics;~~
   i. ~~A statement of whether the licensee or certificate holder has or has not committed any of the actions referenced in the definition of good moral character in R4-24-101;~~
   j. ~~A statement of whether the licensee or certificate holder has been the subject of any criminal investigation by a federal, state, or local agency or had criminal charges filed against the licensee or certificate holder;~~
   k. ~~If a licensee, a statement of whether the licensee has:~~
      i. ~~Any impairment to the licensee's cognitive, communicative, or physical ability to engage in the practice of physical therapy with skill and safety and if so, an explanation;~~
      ii. ~~Used alcohol, any illegal chemical substance, or prescription medicine, that in any way has impaired or limited the licensee's ability to practice physical therapy with skill and safety and if so, an explanation;~~
      iii. ~~Been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited the licensee's ability to practice physical therapy with skill and safety and if so, an explanation;~~
   l. ~~If a certificate holder, a statement of whether the certificate holder has:~~
      i. ~~Any impairment to the certificate holder's cognitive, communicative, or physical ability to work as a physical therapist assistant with skill and safety and if so, an explanation;~~
      ii. ~~Used alcohol, any illegal chemical substance or prescription medicine, that in any way has impaired or limited the certificate holder's ability to work as a physical therapist assistant with skill and safety and if so, an explanation;~~
      iii. ~~Been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited certificate holder's ability to work as a physical therapist assistant with skill and safety and if so, an explanation;~~
   m. ~~A statement of whether the licensee or certificate holder has ever violated A.R.S. § 32-2044(10);~~
   n. ~~If a licensee, a statement of whether the licensee has completed the 20 contact hours of continuing competence for the previous compliance period as required in R4-24-401;~~
   o. ~~If a certificate holder, a statement of whether the certificate holder has completed the 10 contact hours of continuing competence for the previous compliance period as required in R4-24-401;~~
   p. ~~If a licensee, a statement of whether the licensee has complied with the medical records protocol as required in A.R.S. § 32-3211; and~~
   q. ~~If a licensee, a statement of whether the licensee has completed the dry needling course content requirements in A.A.C. R4-24-313~~.
2. ~~The signature of the applicant attesting to the truthfulness of the information provided by the licensee or certificate holder;~~
3~~.~~2. If the documentation previously submitted under R4-24-201(A)(3) or R4-24-207(A)(3) did not establish citizenship in the United States or was not a non-expiring work authorization, documentation specified under A.R.S. § 41-1080 that the

presence of the licensee ~~or certificate holder~~ in the United States continues to be authorized under federal law; and

~~4.~~3. The fee required by the Board in R4-24-107.

**B.** Failure of the Board to inform a licensee ~~or certificate holder~~ of license ~~or certificate~~ expiration does not excuse the licensee's ~~or certificate holder's~~ non-renewal or untimely renewal.

**C.** The Board shall:

1. Approve or deny the application within the time frames in R4-24-209 and Table 1, and
2. Deny the application of an applicant who does not meet the requirements in A.R.S. § 32-2001 et seq. or this Chapter.

**D.** A licensee ~~or certificate holder~~ denied renewal of a license ~~or certificate~~ may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**E.** A licensee ~~or certificate holder~~ shall ~~send to the Board written notification of a~~ update electronically any change in ~~any of the information provided under subsection (A)(1)(a)~~ the licensee's name, home, business, or e-mail address, or home or business telephone number no later than 30 days after the date of the change.

**R4-24-209. ~~Time-frames~~ Time Frames for Board Approvals**

**A.** The overall ~~time-frame~~ time frame described in A.R.S. § 41-1072(2) for each type of approval granted by the Board is listed in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend the substantive review ~~time-frame~~ time frame ~~and overall time-frame. The overall time-frame and the substantive review time-frame may not be extended~~ by no more than 25~~%~~ percent of the overall time-frame.

**B.** The administrative completeness review ~~time-frame~~ time frame described in A.R.S. § 41-1072(1) for each type of approval granted by the Board is listed in Table 1.

1. The administrative completeness review ~~time-frame~~ time frame begins:
   a. When the Board receives an application packet for an initial or renewal license ~~or certificate~~ or registration of a business entity or
   b. When the Board receives a request for approval of a facility.
2. If the application packet is incomplete, the Board shall send to the applicant a written notice specifying the missing document or incomplete information.
   a. The administrative completeness review ~~time-frame~~ time frame and the overall ~~time-frame~~ time frame are suspended from the postmark date of the notice until the date the Board receives a complete application packet from the applicant.
   b. An applicant who disagrees with the Board's statement of deficiencies may request a hearing as provided in A.R.S. § 32-2023.
3. If an application packet is complete, the Board shall send a written notice of administrative completeness to the applicant.
4. If the Board grants a license~~, certificate,~~ or approval during the time provided to assess administrative completeness, the Board shall not issue a separate written notice of administrative completeness.

**C.** The substantive review ~~time-frame~~ time frame described in A.R.S. § 41-1072(3) is listed in Table 1 and begins on the postmark date of the notice of administrative completeness.

1. During the substantive review ~~time-frame~~ time frame, the Board may make one comprehensive written request for additional information or documentation. The ~~time-frame~~ time frame for the Board to complete the substantive review is suspended from the postmark date of the comprehensive written request for additional information or documentation until the Board receives the additional information or documentation.
2. The Board shall send a written notice of approval ~~of a license or certificate~~ to an applicant who meets the qualifications in A.R.S. §§ 32-2001 through 32-2027 and this Chapter.
3. The Board shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S. §§ 32-2001 through 32-2027 and ~~these rules~~ this Chapter.

**D.** The Board shall consider an application withdrawn if within 360 days from the application submission date the applicant fails to:

1. Supply the missing information requested under subsection (B)(2) or (C)(1); or
2. Take the national physical therapist examination or national physical therapist assistant examination.

~~**E.** An applicant who does not wish an application withdrawn may request a denial in writing within 360 days from the application submission date.~~

~~**F.**~~**E.** If ~~a time-frame's~~ the last day of a time frame falls on a Saturday, Sunday, or an official state holiday, the Board shall consider the next business day the ~~time-frame's~~ last day.

**Table 1. Time Frames (in days)**

| Type of Applicant | Type of Approval | Statutory Authority | Overall Time Frame | Administrative Completeness Time Frame | Substantive Review Time Frame |
|---|---|---|---|---|---|
| Original License (R4-24-201 or R4-24-207) or Registration as an Out-of-state Health Care Provider of Telehealth Services (A.R.S. § 36-3606) | License<br><br>Registration | A.R.S. §§ 32-2022; 32-2023; 36-3606 | 75 | 30 | 45 |
| Physical Therapist or Physical Therapist Assistant License ~~or Certificate~~ by Endorsement or Universal Recognition (R4-24-201; R4-24-207) | License ~~or certificate~~ by Endorsement or Universal Recognition | A.R.S. §§ 32-2022; 32-2023; 32-2026; 32-4302 | 75 | 30 | 45 |
| ~~Physical Therapist Assistant Certificate (R4-24-207)~~ | ~~Certificate~~ | ~~A.R.S. §§ 32-2022; 32-2023~~ | ~~75~~ | ~~30~~ | ~~45~~ |
| Foreign-educated (R4-24-203) | License | A.R.S. §§ 32-2022; 32-2025 | 75 | 45 | 30 |
| Renewal of license ~~or certificate~~ (R4-24-208) | License ~~or certificate~~ | A.R.S. § 32-2027 | 30 | 15 | 15 |
| Foreign-educated and Supervised Clinical Practice (R4-24-203, R4-24-204) | Interim Permit and Approval of Facility | A.R.S. § 32-2025 | 60 | 30 | 30 |
| Reinstatement (R4-24-202) | Reinstatement of License ~~or Certificate~~ | A.R.S. § 32-2028 | 30 | 15 | 15 |
| Initial Registration of a Business Entity (R4-24-210) | Registration | A.R.S. § 32-2030 | 30 | 15 | 15 |
| Renewal of Registration of a Business Entity (R4-24-211) | Registration | A.R.S. § 32-2030(D) | 15 | 7 | 8 |

**R4-24-210. Business Entity Registration; Display of Registration Certificate**

**A.** A business entity that offers physical therapy services to the public and is not exempt from registration under A.R.S. § 32-2030(H) shall separately register with the Board each location from which physical therapy services are offered in Arizona.

**B.** A business entity shall not offer physical therapy services at a location in Arizona until that location is registered with the Board.

**C.** To register with the Board an Arizona location at which physical therapy services are offered, a business entity shall submit to the Board an electronic application packet that includes the following:

1. An application form, which is available ~~from~~ on the ~~Board and requires the following information:~~ Board's website;
   ~~a. Name, primary address, and e-mail address of the business entity;~~
   ~~b. Name, title, address, e-mail address, and telephone number of the manager of the location being registered;~~
   ~~c. Name and business address of each officer or director of the business entity;~~
   ~~d. Name and license number of each physical therapist who provides physical therapy services at the location being registered;~~

e. ~~Name and certificate number of each physical therapy assistant who works at the location being registered;~~
f. ~~Description of the physical therapy services offered at the location being registered;~~
g. ~~For the business entity, a statement of whether any state, territory, district, or country has ever:~~
i. ~~Refused to issue or renew a registration, permit, license, or other authorization;~~
ii. ~~Accepted surrender of a registration, permit, license, or other authorization in lieu of other disciplinary action; or~~
iii. ~~Suspended, revoked, cancelled, or taken other disciplinary action against a registration, permit, license, or other authorization; and~~
h. ~~Dated signature of an officer or director attesting that:~~
i. ~~The business entity has a written protocol that meets the standards in A.R.S. § 32-2030(F) for the secure storage, transfer, and access of the physical therapy records of the business entity's patients; and~~
ii. ~~The information provided is true and correct;~~ and
2. The application fee required under R4-24-107~~(A)(3)~~.

**D.** For each location registered, a business entity shall display, in a location accessible to public view, the:
1. Registration certificate and current renewal verification of the business entity,
2. License and current renewal verification of every physical therapist who provides physical therapy services at the location, and
3. Certificate and current renewal verification of every physical therapy assistant who works at the location.

**R4-24-211. Renewal of Business Entity Registration**

**A.** The registration of a business entity expires for each location registered on August 31 of every odd-numbered year.

**B.** A business entity shall separately renew the registration of each location from which the business entity offers physical therapy services in Arizona.

**C.** To renew the registration of an Arizona location from which physical therapy services are offered, a business entity shall submit to the Board an electronic application form, which is available ~~from~~ on the ~~Board and requires the following information:~~ Board's website and the renewal fee specified at R4-24-107.
1. ~~Name, primary address, and e-mail address of the business entity;~~
2. ~~Name, title, address, e-mail address, and telephone number of the manager of the location being registered;~~
3. ~~Name and business address of each officer or director of the business entity;~~
4. ~~Name and license number of each physical therapist who provides physical therapy services at the location being registered;~~
5. ~~Name and certificate number of each physical therapy assistant who works at the location being registered;~~
6. ~~Description of the physical therapy services offered at the location being registered;~~
7. ~~For the business entity, a statement of whether any state, territory, district, or country has ever:~~
a. ~~Refused to issue or renew a registration, permit, license, or other authorization;~~
b. ~~Accepted surrender of a registration, permit, license, or other authorization in lieu of other disciplinary action; or~~
c. ~~Suspended, revoked, cancelled, or taken other disciplinary action against a registration, permit, license, or other authorization;~~
8. ~~Statement of whether the business entity complies with A.R.S. § 32-2030(F); and~~
9. ~~Dated signature of an officer or director attesting that the information provided is true and correct.~~

**D.** A business entity that timely complies with subsection (C) may continue to offer physical therapy services from the location for which application is made until the Board grants or denies the renewed registration.

**E.** A business entity that fails to comply timely with subsection (C) shall immediately stop offering physical therapy services from the location for which application is not made. To be authorized to offer physical therapy services again from that location, the business entity shall comply with R4-24-210 and pay both the application and late fee specified in R4-24-107~~(A)(3)~~.

## ARTICLE 3. PRACTICE OF PHYSICAL THERAPY

**R4-24-302. Use of Titles**

**A.** As required under A.R.S. § 32-2042, a licensed physical therapist shall use the designation ~~"P.T."~~ "PT" immediately following the licensee's name or signature to denote licensure. A licensed physical therapist shall not use the designations ~~"R.P.T."~~ "RPT" or ~~"L.P.T."~~ "LPT" in connection with the physical therapist's name or place of business.

**B.** As required under A.R.S. § 32-2042, a physical therapist assistant shall use the designation "PTA" immediately following the physical therapist assistant's name to denote licensure.

~~B.~~**C.** In addition to and immediately following the ~~"P.T."~~ designation specified in subsection (A) or (B), as applicable, a physical therapist or physical therapist assistant may list academic degrees earned and professional specialty certifications held.

~~C. As required under A.R.S. § 32-2042, a physical therapist assistant shall use the designation "P.T.A."" immediately following the physical therapist assistant's name to denote certification.~~

**D.** As required under A.R.S. § 32-2042, a physical therapist or physical therapist assistant who is on retired status shall use "(retired)" or "(ret.)" immediately after the designation required under subsection (A) or (C), as applicable.

**R4-24-303. Patient Care Management**

**A.** A physical therapist is responsible for the scope of patient management in the practice of physical therapy as defined by A.R.S. § 32-2001. For each patient, the physical therapist shall:
1. Perform and document an initial evaluation;
2. Perform and document periodic reevaluation;
3. Document a discharge summary and the patient's response to the course of treatment at discharge;
4. Ensure ~~that~~ the patient's physical therapy record is complete and accurate; and
5. Ensure ~~that~~ services reported for billing, whether billed directly to the patient or through a third party, are accurate and consistent with information in the patient's physical therapy record.

**B.** On each date of service, a physical therapist shall:
1. Perform and document each therapeutic intervention that requires the expertise of a physical therapist; and
2. Determine, based on a patient's acuity and treatment plan, whether it is appropriate to use assistive personnel to perform a selected treatment intervention or physical therapy task for the patient.

**C.** A physical therapist shall not supervise more than three assistive personnel at any time. If a physical therapist supervises three assistive personnel, the physical therapist shall ensure ~~that~~:
1. At least one of the assistive personnel is a physical therapist assistant,
2. No more than two of the assistive personnel are physical therapist assistants performing selected treatment interventions under general supervision, and
3. Assistive personnel other than a physical therapist assistant perform a physical therapy task only under the onsite supervision of a physical therapist.

**D.** Before delegating performance of a selected treatment intervention to a physical therapist assistant working under general supervision, the supervising physical therapist shall ensure ~~that~~ the physical therapist assistant:
1. Is ~~certified~~ licensed under this Chapter, and
2. Has completed at least 2,000 hours of experience as a physical therapist assistant working with patients under onsite supervision.

**E.** Before delegating performance of a selected physical therapy intervention or physical therapy task to assistive personnel working under general or onsite supervision, the supervising physical therapist shall ensure ~~that~~ the assistive personnel is qualified by education or training to perform the selected physical therapy intervention or physical therapy task in a safe, effective, and efficient manner.

**F.** A physical therapist who provides general supervision for a physical therapist assistant shall:
1. Be licensed under this Chapter;
2. Respond to a communication from the physical therapist assistant within 15 minutes;
3. Go to the location at which and on the same day that the physical therapist assistant provides a selected treatment intervention if the physical therapist, after consultation with the physical therapist assistant, determines that going to the location is in the best interest of the patient; and
4. Perform a reevaluation and provide each therapeutic intervention for the patient that is done on the day of the reevaluation every fourth treatment visit or every 30 days, whichever occurs first.

**G.** A physical therapist assistant who provides a selected treatment intervention under general supervision shall document in the patient record:
1. The name and license number of the supervising physical therapist;
2. The name of the patient to whom the selected treatment intervention is provided;
3. The date on which the selected treatment intervention is provided;
4. The selected treatment intervention provided; and
5. Whether the physical therapist assistant consulted with the supervising physical therapist during the course of the selected treatment intervention and if so, the subject of the consultation and any decision made.

**R4-24-304. Adequate Patient Records**

**A.** A physical therapist shall ensure ~~that~~ a patient record meets the following minimum standards:
1. Each entry in the patient record is:

a. Legible,
b. Accurately dated, and
c. Signed with the name and legal designation of the individual making the entry;

2. If an electronic signature is used to sign an entry, the electronic signature is secure;
3. The patient record contains sufficient information to:
   a. Identify the patient on each page of the patient record,
   b. Justify the therapeutic intervention,
   c. Document results of the therapeutic intervention,
   d. Indicate advice or cautionary warnings provided to the patient,
   e. Enable another physical therapist to assume the patient's care at any point in the course of therapeutic intervention, and
   f. Describe the patient's medical history.
4. If an individual other than a physical therapist or physical therapist assistant makes an entry into the patient record, the supervising physical therapist co-signs the entry;
5. If it is determined that erroneous information is entered into the patient record:
   a. The error is corrected in a manner that allows the erroneous information to remain legible, and
   b. The individual making the correction dates and initials the correct information; and
6. For each date of service there is an accurate record of the physical therapy services provided and billed.

**B.** Initial evaluation. As required by A.R.S. § 32-2043(F)(1), a physical therapist shall perform the initial evaluation of a patient. The physical therapist who performs an initial evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's reason for seeking physical therapy services;
2. The patient's relevant medical diagnoses or conditions;
3. The patient's current functional status;
~~3.~~4. The patient's signs and symptoms;
~~4.~~5. Objective data from tests or measurements;
~~5.~~6. The physical therapist's interpretation of the results of the examination;
~~6.~~7. Clinical rationale for therapeutic intervention;
~~7.~~8. A plan of care that includes the proposed therapeutic intervention, measurable goals, and frequency and duration of therapeutic intervention; and
~~8.~~9. The patient's prognosis.

**C.** Therapeutic-intervention notes. For each date that a therapeutic intervention is provided to a patient, the individual who provides the therapeutic intervention shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's current functional status;
~~1.~~2. The patient's subjective report of current status or response to therapeutic intervention;
~~2.~~3. The therapeutic intervention provided or appropriately supervised;
~~3.~~4. Objective data from tests or measures, if collected;
~~4.~~5. Instructions provided to the patient, if any; and
~~5.~~6. Any change in the plan of care required under subsection ~~(B)(7)~~ (B)(8).

**D.** Re-evaluation. As required by A.R.S. § 32-2043(F)(2), a physical therapist shall perform a re-evaluation when a patient fails to progress as expected, progresses sufficiently to warrant a change in the plan of care, or in accordance with R4-24-303(F)(4). A physical therapist who performs a re-evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:

1. The patient's subjective report of current status or response to therapeutic intervention;
2. Assessment of the patient's progress;
3. The patient's current functional status;
4. Objective data from tests or measures, if collected;
5. Rationale for continuing therapeutic intervention; and
6. Any change in the plan of care required under subsection ~~(B)(7)~~(B)(8).

**E.** Discharge summary. As required by A.R.S. § 32-2043(F)(3), a physical therapist shall document the conclusion of care in a patient's record regardless of the reason that care is concluded.

1. If care is provided in an acute-care hospital, the entry made under subsection (C) on the last date that a therapeutic intervention is provided constitutes documentation of the conclusion of care if the entry is made by a physical therapist.
2. If care is not provided in an acute-care hospital or if a physical therapist does not make the entry under subsection (C) on the last date that a therapeutic intervention is provided, a physical therapist shall make an entry that meets the standards in subsection (A) in the patient record and document:

a. The date on which therapeutic intervention terminated;
b. The reason that therapeutic intervention terminated;
c. Inclusive dates for the episode of care being terminated;
d. The total number of days on which therapeutic intervention was provided during the episode of care;
e. The patient's current functional status;
f. The patient's progress toward achieving the goals in the plan of care required under subsection ~~(B)(7)~~(B)(8); and
g. The recommended discharge plan.

**R4-24-305. Complaints and Investigations**

**A.** A complainant shall ensure that a complaint filed with the Board is about:
1. An individual licensed ~~or certified~~ under this Chapter;
2. A business entity registered with the Board; or
~~2.~~3. An individual believed to be engaged in unlawful practice as described in A.R.S. § 32-2048.

**B.** If the Board determines under A.R.S. § 32-2045(A)(2) that there is reason to believe ~~that~~ an individual or business entity may have violated A.R.S. Title 32, Chapter 19, or this Chapter, the Board shall prepare a complaint and serve the complaint as described in subsection (D)(2).

**C.** Complaint requirements. A complainant shall:
1. Submit the complaint to the Board in writing; and
2. Provide the following information:
   a. Name of licensee, ~~certificate holder,~~ business entity, or other individual who is the subject of complaint;
   b. Name and address of complainant;
   c. Nature of the complaint;
   d. Details of the complaint with pertinent dates and activities;
   e. Whether the complainant has contacted any other organization regarding the complaint; and
   f. Whether complainant has contacted the licensee, ~~certificate holder,~~ business entity, or other individual concerning the complaint, and if so, the response, if any.

**D.** Within 90 days after receiving a complaint, the Board shall ensure ~~that~~ the complaint is reviewed to determine whether the complaint is within the Board's jurisdiction, and:
1. If the complaint is not within the Board's jurisdiction, dismiss the complaint and provide written notice of the dismissal to the complainant; or
2. If the complaint is within the Board's jurisdiction, serve a copy of the complaint on the individual or business entity complained against and provide the individual or business entity complained against with 30 days to respond and admit, deny, or further explain each allegation in the complaint.

**E.** If a complaint is within the Board's jurisdiction, the Board shall ensure ~~that~~ an investigation regarding the matters alleged in the complaint is conducted.

**F.** After expiration of the 30 days provided under subsection (D)(2), the Board shall review the complaint, response, and investigation results and take action as prescribed under A.R.S. §§ 32-2045(B) or 32-2046.

**R4-24-306. Hearings**

**A.** To facilitate investigation of a complaint, the Board may conduct an informal hearing. The Board shall send written notice of an informal hearing to the ~~individual~~ person who is the subject of the complaint, by personal service or certified mail, return receipt requested, at least 30 days before the informal hearing.

**B.** The Board shall ensure that the written notice of informal hearing contains the following information:
1. The time, date, and place of the informal hearing;
2. An explanation of the informal nature of the proceedings;
3. The ~~individual's~~ person's right to appear with or without legal counsel;
4. A statement of the allegations and issues involved with a citation to relevant statutes and rules;
5. The ~~individual's~~ person's right to a formal hearing under A.R.S. Title 41, Chapter 6, Article 10 instead of the informal hearing;
6. The ~~licensee's or certificate holder's~~ person's right to request ~~under A.R.S. § 32-3206(A)~~ a copy of information the Board will use in making its determination; and
7. Notice that the Board may take disciplinary action as a result of the informal hearing if it finds the ~~individual~~ person violated A.R.S. Title 32, Chapter 19, or this Chapter;

**C.** The Board shall ensure ~~that~~ an informal hearing proceeds as follows:
1. Introduction of the respondent and, if applicable, legal counsel for the respondent;
2. Introduction of the Board members, staff, and Assistant Attorney General present;

3. Swearing in of the respondent and witnesses;
4. Brief summary of the allegations and purpose of the informal hearing;
5. Optional opening comment by the respondent;
6. Questioning of the respondent by the Board and questioning of witnesses by the Board and the respondent;
7. Optional additional comments by the respondent; and
8. Deliberation and deciding the case by the Board.

**R4-24-308. Rehearing or Review of Board Decisions**

**A.** The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10.

**B.** Except as provided in subsection (I), a party is required to file a motion for rehearing or review of a decision of the Board to exhaust the party's administrative remedies.

**C.** A party may amend a motion for rehearing or review at any time before the Board rules on the motion.

**D.** The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
1. Irregularity in the proceedings of the Board or any order or abuse of discretion that deprived the moving party of a fair hearing;
2. Misconduct of the Board, its staff, or an administrative law judge;
3. Accident or surprise that could not have been prevented by ordinary prudence;
4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
5. Excessive or insufficient penalty;
6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings; and
7. The findings of fact or decision is not justified by the evidence or is contrary to law.

**E.** The Board may affirm or modify a decision or grant a rehearing or review to any or all of the parties on all or part of the issues for any of the reasons listed in subsection (D). An order modifying a decision or granting a rehearing or review shall specify with particularity the grounds for the order. If a rehearing or review is granted, the rehearing or review shall cover only the matters specified in the order.

**F.** No later than 30 days after making a decision and after giving the parties notice and an opportunity to be heard, the Board may order a rehearing or review on its own initiative for any of the reasons listed in subsection (D). The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion. An order granting a rehearing or review shall specify with particularity the grounds on which the rehearing or review is granted.

**G.** When a motion for rehearing or review is based upon affidavits, the affidavits shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. This period may be extended for not more than 20 days by the Board ~~for good cause as described in subsection (I) or~~ by written stipulation of the parties or a Board finding that the extension will further justice and cause no harm to any party. The Board may permit reply affidavits.

**H.** If a rehearing is granted, the Board shall hold the rehearing within 60 days after the issue date on the order granting the rehearing.

**I.** If the Board makes a specific finding that immediate effectiveness of a particular decision is necessary for preservation of the public health, safety, or welfare and that rehearing or review is impracticable, unnecessary, or contrary to public interest, the decision may be issued as a final decision without an opportunity for rehearing or review. If an application for judicial review of the decision is made, it shall be made under A.R.S. § 12-901 et seq.

**R4-24-309. Disciplinary Actions**

**A.** As required by A.R.S. § 39-121.01, a record of Board disciplinary actions, including a decree of censure, is a public record open to public inspection.

**B.** If the Board decides to restrict a license ~~or certificate~~, the Board shall ensure that the restriction and any required corrective action address the conduct that led to the restriction and protect the public. If the Board decides to require that an individual with a restricted license ~~or certificate~~ be supervised during the period of restriction, the Board shall appoint an unrestricted licensee to provide the supervision.

**C.** A physical therapist or physical therapist assistant whose license ~~or certificate~~ is suspended, revoked, or voluntarily surrendered shall return the license ~~or certificate~~ to the Board within 10 days after receipt of the Board's final order.

**D.** At the end of a period of license ~~or certificate~~ restriction, the Board shall terminate the restriction only if the licensee ~~or certificate holder~~ submits to the Board evidence of having completed all required corrective actions and complied with all terms of the restriction. If the Board believes it will help the Board determine whether to terminate a restriction, the licensee ~~or certificate holder~~ shall appear before the Board.

**E.** An applicant who had a previous license ~~or certificate~~ revoked by the Board shall appear before the Board before the Board acts on the application.

**R4-24-310. Substance Abuse Recovery Program**

**A.** Under A.R.S. § 32-2044(8), practicing as a physical therapist or working as a physical therapist assistant while mentally or physically impaired is grounds for disciplinary action.

**B.** The Board shall allow an impaired licensee ~~or certificate holder~~ to enter into a substance abuse recovery program rather than conduct a disciplinary proceeding if:

1. The impaired licensee ~~or certificate holder~~ is qualified under A.R.S. § 32-2050(2),
2. The Board believes the proposed program will assist the impaired licensee ~~or certificate holder~~ to recover, and
3. The impaired licensee ~~or certificate holder~~ enters into the written agreement required under A.R.S. § 32-2050(3) and (4).

**R4-24-311. Display of License; Disclosure**

**A.** A licensee ~~or certificate holder~~ shall display a copy or provide documentation of the license ~~or certificate~~ and current renewal verification as specified in A.R.S. § 32-2051(G).

**B.** Upon request, a licensee ~~or certificate holder~~ shall inform a member of the public how to file a complaint by providing the address and telephone number of the Board office and a statement that a complaint against a licensee ~~or certificate holder~~ should be directed to the Board.

**C.** Before conducting an evaluation or initiating physical therapy, a ~~licensee~~ licensed physical therapist shall disclose to a patient when a referring practitioner is deriving direct or indirect compensation from the referral. The ~~licensee~~ licensed physical therapist shall ensure ~~that~~ the disclosure is in writing and states “Under A.R.S. § 32-2051(C), I am required by law to inform you in writing that your referring physician [or specify if different from a physician] derives either direct or indirect compensation related to your physical therapy.”

**R4-24-312. Mandatory Reporting Requirement**

**A.** As required by A.R.S. § 32-3208, an applicant~~,~~ or licensee~~, or certificate holder~~ who is charged with a misdemeanor involving conduct that may affect patient safety or a felony shall provide written notice of the charge to the Board within 10 working days after the charge is filed.

**B.** An applicant~~,~~ or licensee~~, or certificate holder~~ may request a list of reportable misdemeanors from the Board.

**R4-24-313. Professional Standards of Care and Training and Education Qualifications for Delivery of Dry Needling Skilled Intervention**

**A.** ~~Effective July 1, 2015 and in accordance with~~ Under A.R.S. § 32-2044(25), a physical therapist shall meet the qualifications established in subsection (C) before providing the skilled intervention “dry needling”, as defined in A.R.S. § 32-2001(4).

**B.** A physical therapist offering to provide or providing “dry needling” intervention shall provide to the Board documented proof of compliance with the qualifications listed in subsection (C) ~~to the board~~ within 30 days ~~of completion of~~ after completing the course content in subsection (C) or within 30 days of initial licensure as a physical therapist in Arizona.

**C.** ~~Course content~~ The Board has determined that only a “dry needling” course that meets the following standards provides the training and education ~~qualifications for “dry needling” shall contain all of the following~~ necessary to qualify an individual to provide dry needling in Arizona:

1. The course ~~content shall be~~ is approved by one or more of the following entities ~~prior to~~ before the course(s) ~~being~~ is completed by the physical therapist.
   a. Commission ~~On~~ on Accreditation ~~In~~ in Physical Therapy Education,
   b. American Physical Therapy Association,
   c. State Chapters ~~Of The~~ of the American Physical Therapy Association,
   d. Specialty Groups ~~Of The~~ of the American Physical Therapy Association, or
   e. The Federation of State Boards ~~Of~~ of Physical Therapy.
2. The course ~~content shall include~~ includes the following components ~~of education and training~~:
   a. Sterile needle procedures ~~to include one of the following~~ consistent with the standards of one of the following:
      i. The U.S. Centers For Disease Control ~~And~~ and Prevention, or
      ii. The U.S. Occupational Safety ~~And~~ and Health Administration
   b. Anatomical ~~Review~~ review,
   c. ~~Blood Borne Pathogens~~ Blood-borne pathogens, and
   d. Contraindications and indications for “dry needling.”~~,~~

3. The course ~~content required in subsection (C) of this Section shall include, but is not limited to, passing of~~ requires participants to pass both a written ~~examination~~ and practical examination before ~~completion of~~ completing the course ~~content. Practice application course content and examinations shall be done in person to meet the qualifications of subsection (C)~~.
4. The course ~~content required in subsection (C) of this subsection shall total a minimum of~~ requires at least 24 ~~contact~~ hours of education.
5. All practical aspects of the course, including the practical examination, are performed under supervision.

**D.** ~~The standard of care for the intervention "dry needling" includes, but is not limited to the following~~ A physical therapist who performs dry needling shall:

1. "~~Dry needling" cannot be delegated~~ Not delegate performing dry needling to ~~any~~ assistive personnel.
2. ~~Consent~~ Obtain consent for treatment for the ~~intervention~~ "dry needling" intervention ~~is the same~~ as required under R4-24-301.
3. ~~Documentation of~~ Document the ~~intervention~~ "dry needling" intervention ~~shall be done~~ in accordance with R4-24-304.

## ARTICLE 4. CONTINUING COMPETENCE

### R4-24-401. Continuing Competence Requirements for Renewal

**A.** Except as provided in subsection (G), a licensed physical therapist shall earn 20 contact hours of continuing competence for each compliance period to be eligible for license renewal.

1. The ~~licensee~~ licensed physical therapist shall earn at least 10 contact hours from Category A continuing competence activities. No more than five of the required contact hours from Category A may be obtained from nonclinical course work.
2. No more than 10 contact hours may be earned by the ~~licensee~~ licensed physical therapist during any compliance period from Categories B and C continuing competence activities. No more than five contact hours from categories B and C may be obtained from nonclinical course work.
3. If the ~~licensee's~~ licensed physical therapist's initial license is for one year or less, the ~~licensee~~ licensed physical therapist shall earn 10 contact hours from Category A continuing competence activities during the initial compliance period. No more than five of the required contact hours from Category A may be obtained from nonclinical course work.

**B.** Except as provided in subsection (G), a ~~certified~~ licensed physical therapist assistant shall earn 10 contact hours of continuing competence for each compliance period to be eligible for ~~certificate~~ license renewal.

1. The ~~certificate holder~~ licensed physical therapist assistant shall earn at least six contact hours from Category A continuing competence activities. No more than three of the required contact hours from Category A may be obtained from nonclinical course work.
2. No more than four contact hours may be earned by the ~~certificate holder~~ licensed physical therapist assistant during any compliance period from Categories B and C continuing competence activities. No more than two contact hours from Categories B and C may be obtained from nonclinical course work.
3. If the ~~certificate holder's~~ licensed physical therapist assistant's initial ~~certificate~~ license is for one year or less, the ~~certificate holder~~ licensed physical therapist assistant shall earn six contact hours from Category A continuing competence activities during the initial compliance period. No more than three of the required contact hours from Category A may be obtained from nonclinical course work.

**C.** A licensee ~~or certificate holder~~ shall not receive contact hour credit for repetitions of the same activity.

**D.** The continuing competence compliance period for a licensee ~~or certificate holder~~ begins on September 1 following the issuance of an initial or renewal license ~~or certificate~~ and ends on August 31 of even-numbered years.

**E.** A licensee ~~or certificate holder~~ shall not carry over contact hours from one compliance period to another.

**F.** An applicant for renewal shall submit a signed statement to the Board with the renewal application stating whether continuing competence requirements have been fulfilled for the current compliance period.

**G.** The Board may, at its discretion, waive continuing competence requirements on an individual basis for reasons of extreme hardship such as illness, disability, active service in the military, or other extraordinary circumstance as determined by the Board. A licensee ~~or certificate holder~~ who seeks a waiver of the continuing competence requirements shall provide to the Board, in writing, the specific reasons for requesting the waiver and additional information the Board may request in support of the waiver.

**H.** A licensee ~~or certificate holder~~ is subject to Board auditing for continuing competence compliance.

1. Selection for audit shall be random and notice of audit sent within 60 calendar days following the renewal deadline.
2. Within 30 days of receipt of a notice of audit, a licensee ~~or certificate holder~~ shall submit evidence to the Board that shows compliance with the requirements of continuing competence. Documentation of a continuing competence activity shall include:

a. The date, place, course title, sponsor, schedule, and presenter;
b. The number of contact hours received for the activity; and
c. Proof of completion, such as an abstract, certificate of attendance, sign-in log, or other certification of completion.

**I.** A licensee ~~or certificate holder~~ shall retain evidence of participation in a continuing competence activity for two compliance periods after participation.

**J.** The Board shall notify a licensee ~~or certificate holder~~ who has been audited whether the licensee or ~~certificate holder~~ is in compliance with continuing competence requirements. The Board shall provide the notice electronically or by certified mail within 30 working days following the determination by the Board.

**K.** The Board shall provide six months from the date of the notice under subsection (J) for a licensee ~~or certificate holder~~ found not in compliance with continuing competence requirements to satisfy the continuing competence requirements. A licensee ~~or certificate holder~~ may request a hearing to contest the Board's decision under A.R.S. Title 41, Chapter 6, Article 10.

**L.** Penalties for failure to comply with continuing competence requirements may be imposed by the Board under A.R.S § 32-2047 following a hearing conducted under A.R.S. Title 41, Chapter 6, Article 10.

**R4-24-402. Continuing Competence Activities**

**A.** Category A continuing competence activities shall be approved by:
1. An accredited medical, health care, or physical therapy program;
2. A state or national medical, health care, or physical therapy association, or a component of the association; or
3. A national medical, health care, or physical therapy specialty society.

**B.** Category A continuing competence activities include:
1. A physical therapy continuing education course designed to provide necessary understanding of current research, clinical skills, administration, or education related to the practice of physical therapy. Calculation of contact hours is determined by dividing the total minutes of instruction by 60. Breaks shall not be included as part of instructional time;
2. Coursework towards granting or renewal of a physical therapy clinical specialty certification approved by the Board. Each 60 minutes of instruction equals one contact hour;
3. Coursework in a physical therapy clinical residency program. Each 60 minutes of instruction equals one contact hour; and
4. Coursework in a postgraduate physical therapy education from an accredited college or university. Each 60 minutes of instruction equals one contact hour.

**C.** Category B continuing competence activities include:
1. Study group: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. A study group is a structured meeting designed for the study of a clinical physical therapy topic dealing with current research, clinical skills, procedures, or treatment related to the practice of physical therapy.
   b. No change
2. Self instruction: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. Self instruction is a structured course of study relating to one clinical physical therapy topic dealing with current research, clinical skills, procedures, or treatment related to the practice of physical therapy. Self instruction may be directed by a correspondence course, video, internet, or satellite program.
   b. Each 60 minutes of self instruction equals one contact hour.
3. Inservice education: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. Inservice education is attendance at a presentation pertaining to current research, clinical skills, procedures, or treatment related to the practice of physical therapy or relating to patient welfare or safety, including CPR certification.
   b. Each 60 minutes of inservice education equals one contact hour.

**D.** Category C modes of continuing competence include:
1. Physical therapy practice management coursework: Maximum of five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. Physical therapy practice management course work is course work concerning physical therapy administration, professional responsibility, ethical obligations, or legal requirements applicable to physical therapy practice settings.
   b. If the course is graded, a licensee ~~or certificate holder~~ shall receive a "pass" in a pass/fail course or a minimum of a C in a graded course to receive credit.
   c. Each 60 minutes of practice management coursework equals one contact hour.

2. Teaching or lecturing: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
    a. Teaching or lecturing is the presentation of an original educational program dealing with current research, clinical skills, procedures, treatment, or practice management related to the practice of physical therapy principally for health care professionals. Credit may be earned for teaching when the presentation is accompanied by written materials prepared, augmented, or updated by the presenter including course objectives and program content.
    b. One 60 minute instructional period equals 2.5 contact hours.
    c. Credit shall be given only once for a presentation within a compliance period.
3. Publication: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
    a. Publication includes writing for professional publication, platform, or poster presentation abstracts that have direct application to the practice of physical therapy. Credit may be earned for publication of material that is a minimum of 1500 words in length and published by a recognized third-party publisher of physical therapy material.
    b. Each article published in a refereed journal, book chapter, or book equals five contact hours for physical therapists and two contact hours for physical therapist assistants. Articles published in non-refereed journals, magazines, newsletters, or periodicals equal two contact hours for physical therapists and one contact hour for physical therapist assistants.
4. Clinical instruction: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
    a. Clinical instruction involves assisting a student physical therapist or physical therapist assistant or a physical therapist resident or fellow acquire clinical skills required of a physical therapist or physical therapist assistant.
    b. An individual to whom clinical instruction is provided shall be enrolled in:
        i. A physical therapist or physical therapist assistant program accredited by the Commission on Accreditation of Physical Therapy Education; or
        ii. A physical therapist residency or fellowship program approved by the American Physical Therapy Association.
    c. The program referenced under subsection (D)(4)(b) shall provide the enrolled individual with proof of completing the hours of clinical instruction.
    d. Each 120 hours of clinical instruction equals one contact hour.

**R4-24-403. Activities Not Eligible for Continuing Competence Credit**

A licensee ~~or certificate holder~~ shall not receive continuing competence credit for the following activities:

1. A regularly scheduled educational opportunity provided within an institution, such as rounds or case conferences;
2. A staff meeting;
3. A publication or presentation by the licensee ~~or certificate holder~~ to a lay or nonprofessional group; and
4. Routine teaching of personnel, students, or staff as part of a job requirement.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**[1]

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 24. BOARD OF PHYSICAL THERAPY**

1. Identification of the rulemaking:

The Board is completing a rulemaking that addresses the issues identified in a 5YRR approved by the Council on December 3, 2019. In particular, the Board is updating the ethics materials incorporated by reference in R4-24-101. Additionally, relying on the authority provided under A.R.S. §§ 32-2022(B)(7) and 32-2025(D), the Board is removing clinical performance instruments from materials incorporated by reference and will approve available instruments on a case-by-case basis. The Board concluded this flexibility is necessary because multiple entities have expressed the intent to develop clinical performance instruments and because some current instruments are available only online.

Under Laws 2024, Chapter 236, the legislature changed certification of physical therapist assistants to licensure. This change ricochets throughout existing rules. Additional changes are made to be consistent with industry and agency practice.

Other important changes include:

- Eliminating a charge for a duplicate license or registration;
- Adding flexibility to the application process by making the application form electronic;
- Repealing reference to an applicant being of good moral character;
- Adding licensure by universal recognition;
- Clarifying that a compliant may be filed against a registered business entity; and
- Adding an assessment of a patient's current functional status to the initial evaluation requirements.

The conduct and its frequency of occurrence that the rule is designed to change:

Until the rulemaking is completed, the Board's rules will not be consistent with statute or industry and agency practice.

a. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

[1] If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms. (A.R.S. § 41-1055(C)).

It is not good government for an agency to have rules that are inconsistent with statute and industry and agency practice. This is a source of potential confusion for those who must comply with the rules.

b. The estimated change in frequency of the targeted conduct expected from the rule change:

When the rulemaking is completed, the Board's rules will be consistent with statute and current industry and agency practice.

2. A brief summary of the information included in the economic, small business, and consumer impact statement;

The Board believes the rulemaking has minimal economic impact. The updated materials incorporated by reference or approved by the Board simply make the rules consistent with current industry standards. Other changes make the rules consistent with Board practice or legislative change.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

Name: Judy Chepeus
Title: Executive Director
Address: 1740 West Adams Street, Suite 2450, Phoenix, AZ 85007
Telephone: (602) 271-7365
Email: judy.chepeus@ptboard.az.gov
Website: ptboard.az.gov

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

Licensed physical therapists and physical therapist assistants, applicants, business entities, and the Board are persons directly affected by, bear the costs of, and directly benefit from the rulemaking.

The Board currently licenses 8,226 physical therapists, 6,602 of whom are active and 1,624 are inactive, and 2,594 physical therapist assistants, 2,104 of whom are active and 490 are inactive, and registers 273 business entities, 224 of which are active and 49 are inactive. During the last year, the Board received 902 applications for licensure. Of these, 380 (42 percent) were application by endorsement or universal recognition.

During the last year, the Board issued five interim permits to potential licensees. The Board has approved two clinical performance instruments for use by the onsite supervisors of interim permit holders. Most supervisors prefer using the clinical performance instrument that is available online.

The Board estimates that repealing the charge for a duplicate license or registration would have saved licensees and registrants $1,600 during the last year if it had been in effect.

During the last fiscal year, the Board received 45 complaints against licensees and registrants. Generally, the complaints alleged unprofessional conduct, failure to report, improper treatment, failure to maintain adequate patient records, failure to supervise, improper billing, fraud, and sexual misconduct. Of the complaints received, eight went to hearing and 19 resulted in the Board taking disciplinary action. The disciplinary actions taken included continuing education, jurisprudence examination, civil penalty, clinical monitoring, chaperone, therapy, suspension, voluntary surrender, and stayed revocation.

The Board incurred the cost of completing the rulemaking and will incur the cost of implementing and enforcing the rule changes.

5. Cost-benefit analysis:
    a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:
    The Board is the only state agency directly affected by the rulemaking. The Board's costs and benefits are discussed in item 4. The Board will not need a new full-time employee to implement and enforce the rule changes.
    b. Costs and benefits to political subdivisions directly affected by the rulemaking:
    No political subdivision is directly affected by the rulemaking.
    c. Costs and benefits to businesses directly affected by the rulemaking:
    Business entities required to register with the Board are businesses directly affect by the rulemaking. As a result of the rulemaking, business entities will save the cost of a duplicate registration if one is needed. Business entities may now more clearly understand that complaints can be made against business entities believed to have violated statute or rule.

Licensees who are self-employed are also businesses directly affected by the rulemaking. They will save the cost of a duplicate licensee if one is needed. Licensees have the benefit of rules that are consistent with industry practice. This makes it easier for a licensee to move from one state to another.

6. Impact on private and public employment:

   The Board believes the rulemaking will have no impact on private or public employment.

7. Impact on small businesses[2]:

   a. Identification of the small business subject to the rulemaking:

      Business entities and self-employed licensees are small businesses subject to this rulemaking.

   b. Administrative and other costs required for compliance with the rulemaking:

      For business entities, the costs of compliance include making application for registration, paying the registration fee, and making a biennial renewal of registration.

      For self-employed licensees, the costs of compliance include making application for licensure and biennial renewal, paying the licensing and renewal fees, ensuring qualification with statutory requirements including passing both a national and jurisprudence examination, completing continuing competence activities, and complying with ethical standards.

   d. Description of methods that may be used to reduce the impact on small businesses:

      The Board believes the rule amendments have greater benefits than costs for small businesses and the costs are so minimal it is not possible to reduce them and still achieve the goal of having rules consistent with statute and industry standards.

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

   No private persons or consumers are directly affected by the rulemaking.

9. Probable effects on state revenues:

   Repealing the charge for a duplicate license or registration will have a minimal impact on state revenues.

10. Less intrusive or less costly alternative methods considered:

    Because the rules are neither intrusive nor costly, the Board did not consider alternative methods.

[2] Small business has the meaning specified in A.R.S. § 41-1001(23).

# APTA Guide for Professional Conduct

## Purpose

The APTA Guide for Professional Conduct (Guide) is intended to serve physical therapists in interpreting the Code of Ethics for the Physical Therapist (Code of Ethics) of the American Physical Therapy Association (APTA) in matters of professional conduct. The APTA House of Delegates in June of 2009 adopted a revised Code of Ethics, which became effective July 1, 2010.

The Guide provides a framework by which physical therapists may determine the propriety of their conduct. It also is intended to guide the professional development of physical therapist students. The Code of Ethics and the Guide apply to all physical therapists. These guidelines are subject to change as the dynamics of the profession change, and as new patterns of health care delivery are developed and accepted by the professional community and the public.

## Interpreting Ethical Principles

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the APTA Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They address some but not all topics addressed in the principles and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and revise the Guide to address additional topics and principles when and as needed.

## Preamble to the Code of Ethics

### The Preamble states as follows:

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

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This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

**Interpretation:** Upon the Code of Ethics for the Physical Therapist being amended effective July 1, 2010, all the lettered principles in the Code of Ethics contain the word “shall” and are mandatory ethical obligations. The language contained in the Code of Ethics is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Code of Ethics. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” reinforces and clarifies existing ethical obligations. A significant reason that the Code of Ethics was revised was to provide physical therapists with a document that was clear enough to be read on its own without the need to seek extensive additional interpretation.

The Preamble states that “[n]o Code of Ethics is exhaustive nor can it address every situation.” The Preamble also states that physical therapists “are encouraged to seek additional advice or consultation in instances in which the guidance of the Code may not be definitive.” Potential sources for advice and counsel include third parties and the myriad resources available on the APTA website. Inherent in a physical therapist’s ethical decision-making process is the examination of his or her unique set of facts relative to the Code of Ethics.

## Topics

### Respect

**Principle 1A states as follows:**

> 1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

**Interpretation:** Principle 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

### Altruism

**Principle 2A states as follows:**

> 2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

**Interpretation:** Principle 2A reminds physical therapists to adhere to the profession's core values and act in the best interest of patients and clients over the interests of the physical therapist. Often this is done without thought, but, sometimes, especially at the end of the day when the physical therapist is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

### Patient Autonomy

**Principle 2C states as follows:**

> 2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

**Interpretation:** Principle 2C requires the physical therapist to respect patient autonomy. To do so, he or she shall communicate to the patient or client the findings of the physical therapist examination, evaluation, diagnosis, and prognosis. The physical therapist shall use sound professional judgment in informing the patient or client of any substantial risks of the recommended examination and intervention and shall collaborate with the individual to establish the goals of treatment and the plan of care. Ultimately, the physical therapist shall respect the individual's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

### Professional Judgment

**Principles 3, 3A, and 3B state as follows:**

> 3: Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)
>
> 3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.
>
> 3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

**Interpretation:** Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his or her knowledge, skill, training, and experience. Principle 3B further describes the physical therapist's judgment as being informed by 3 elements of evidence- based practice.

With regard to the patient and client management role, once a physical therapist accepts an individual for physical therapy services he or she shall be responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; reexamination and modification of the plan of care; and the maintenance of adequate records, including progress reports. The physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, the physical therapist has primary responsibility for the physical therapy care of a patient or client and shall make independent judgments regarding that care consistent with accepted professional standards.

If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise or that indicate the need for care outside the scope of physical therapy, the physical therapist shall so inform the patient or client and shall refer the individual to an appropriate practitioner.

The physical therapist shall determine when a patient or client will no longer benefit from physical therapist services. When the physical therapist's judgment is that a patient will receive negligible benefit from physical therapist services, the physical therapist shall not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his or her employer. The physical therapist shall avoid overutilization of physical therapist services. See Principle 8C.

### Supervision

**Principle 3E states as follows:**

> 3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

**Interpretation:** Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel. Further information on supervision via applicable local, state, and federal laws and regulations (including state practice acts and administrative codes) is available.

Information on supervision via APTA policies and resources is also available on the APTA website. See Principles 5A and 5B.

### Integrity in Relationships

**Principle 4 states as follows:**

> 4. Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)

**Interpretation:** Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients and clients but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

### Reporting

**Principle 4C states as follows:**

> 4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

**Interpretation:** Physical therapists shall seek to discourage misconduct by health care professionals. Discouraging misconduct can be accomplished through a number of mechanisms. The following is not an exhaustive list:

- Do not engage in misconduct; instead, set a good example for health care professionals and others working in their immediate environment.
- Encourage or recommend to the appropriate individuals that health care and other professionals, such as legal counsel, conduct regular (such as annual) training that addresses federal and state law requirements, such as billing, best practices, harassment, and security and privacy; as such training can educate health care professionals on what to do and not to do.
- Encourage or recommend to the appropriate individuals other types of training that are not law based, such as bystander training.
- Assist in creating a culture that is positive and civil to all.
- If in a management position, think about promotion and hiring decisions and how they can impact the organization.
- Access professional association resources when considering best practices.
- Revisit policies and procedures each year to remain current.

Many other mechanisms may exist to discourage misconduct. The physical therapist should be creative, open-minded, fair, and impartial in considering how to best meet this ethical obligation. Doing so can actively foster an environment in which misconduct does not occur. The main focus when thinking about misconduct is creating an action plan on prevention. Consider that reporting may never make the alleged victim whole or undo the misconduct.

If misconduct has not been prevented, then reporting issues must be considered. This ethical obligation states that the physical therapist reports to the "relevant authority, when appropriate." Before examining the meaning of these words it is important to note that reporting intersects with corporate policies and legal obligations. It is beyond the scope of this interpretation to provide legal advice regarding laws and policies; however, an analysis of reporting cannot end with understanding one's ethical obligations. One may need to seek advice of legal counsel who will take into consideration laws and policies and seek to discover the facts and circumstances.

With respect to ethical obligations, the term "when appropriate" is a fact-based decision and will be impacted by requirements of the law. If a law requires the physical therapist to take an action, then, of course, it is appropriate to do so. If there is no legal requirement and no corporate policy, then the physical therapist must consider what is appropriate given the facts and situation. It may not be appropriate if the physical therapist does not know what occurred, or because there is no legal requirement to act and the physical therapist does not want to assume legal responsibility, or because the matter is being resolved internally. There are many different reasons that something may or may not be appropriate.

If the physical therapist has determined that it is appropriate to report, the ethical obligation requires him or her to consider what entity or person is the "relevant authority." Relevant authority can be a supervisor, human resources, an attorney, the Equal Employment Opportunities Commission, the licensing board, the Better Business Bureau, Office of the Insurance Commissioner, the Medicare hotline, the Office of the Inspector General hotline, the US Department of Health & Human Services, an institution using their internal grievance procedures, the Office of Civil Rights, or another federal agency, state agency, city or local agency, or a state or federal court, among others.

Once the physical therapist has decided to report, he or she must be mindful that reporting does not end his or her involvement, which can include office, regulatory, and/or legal proceedings. In this context, the physical therapist may be asked to be a witness, to testify, or to provide written information.

### Sexual Harassment

**Principe 4F states as follows:**

> 4F. Physical Therapists shall not harass anyone verbally, physically, emotionally, or sexually.

Interpretation: As noted in the House of Delegates policy titled Sexual Harassment, "[m]embers of the association have an obligation to comply with applicable legal prohibitions against sexual harassment…." This statement is in line with Principle 4F that prohibits physical therapists from harassing anyone verbally, physically, emotionally, or sexually. While the principle is clear, it is important for APTA to restate this point, namely that physical therapists shall not harass anyone, period. The association has zero tolerance for any form of harassment, specifically including sexual harassment.

### Exploitation

**Principle 4E states as follows:**

> 4E. Physical therapists shall not engage in any sexual relationship with any of their patient/clients, supervisees or students.

**Interpretation:** The statement is clear—sexual relationships with their patients or clients, supervisees, or students are prohibited. This component of Principle 4 is consistent with Principle 4B, which states:

Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (eg, patients and clients, students, supervisees, research participants, or employees).

Consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients or Former Patients:

> A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he or she must sublimate those feelings in order to avoid sexual exploitation of the patient.
>
> One's ethical decision making process should focus on whether the patient or client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient or client relationship ends. To this question, the EJC has opined as follows:
>
> The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.
>
> The Committee imagines that in some cases a romantic/sexual relationship would not offend…if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

## Colleague Impairment

**Principle 5D and 5E state as follows:**

> 5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
>
> 5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report the information to the appropriate authority.

**Interpretation:** The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination. This may be challenging in the sense that the physical therapist might not know or easily be able to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting his or her professional responsibilities.

Moreover, once the physical therapist does make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance, while the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform; whereas, 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect their professional responsibilities. So, 5D discusses something that may be affecting performance, while 5E addresses a situation in which someone clearly is unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom the physical therapist reports; it provides discretion to determine the appropriate authority.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

## Professional Competence Principle 6A states as follows:

**6A. Physical therapists shall achieve and maintain professional competence.**

**Interpretation:** 6A requires the physical therapist to maintain professional competence within his or her scope of practice throughout their career. Maintaining competence is an ongoing process of self- assessment, identification of strengths and weaknesses, acquisition of knowledge and skills based on that assessment, and reflection on and reassessment of performance, knowledge, and skills. Numerous factors including practice setting, types of patients and clients, personal interests, and the addition of new evidence to practice will influence the depth and breadth of professional competence in a given area of practice. Additional resources on continuing competence are available on the APTA website.

## Professional Growth

**Principle 6D states as follows:**

> 6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

**Interpretation:** 6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea is that this is the physical therapist's responsibility, whether or not the employer provides support.

## Charges and Coding

**Principle 7E states as follows:**

> 7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

**Interpretation:** Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. Additional resources on Documentation and Coding and Billing are available on the APTA website.

## Pro Bono Services

**Principle 8A states as follows:**

> 8A. Physical therapists shall provide pro bono physical therapist services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

**Interpretation:** The key word in Principle 8A is "or." If a physical therapist is unable to provide pro bono services, then he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, or underinsured. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapist Services and Organizational Support. Additional resources on pro bono physical therapist services are available on the APTA website.

8A also addresses supporting organizations to meet health needs. The principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues.

Issued by the Ethics and Judicial Committee
American Physical Therapy Association October 1981

**Last Amended:** March 2019
**Contact:** ejc@apta.org

# Code of Ethics for the Physical Therapist

**HOD S06-20-28-25** [Amended HOD S06-19-47-67; HOD S06-09-07-12; HOD S06-00-12-23; HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-08; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]

## Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient and client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive. The APTA Guide for Professional Conduct and Core Values for the Physical Therapist and Physical Therapist Assistant provide additional guidance.

This Code of Ethics describes the desired behavior of physical therapists in their multiple roles (eg, management of patients and clients, consultation, education, research, and administration), addresses multiple aspects of ethical action (individual, organizational, and societal), and reflects the core values of the physical therapist (accountability, altruism, collaboration, compassion and caring, duty, excellence, integrity, and social responsibility). Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

## Principles

### Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.

(Core Values: Compassion and Caring, Integrity)

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

### Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients and clients.

(Core Values: Altruism, Collaboration, Compassion and Caring, Duty)

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients and clients over the interests of the physical therapist.

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2B. Physical therapists shall provide physical therapist services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.
2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapist care or participation in clinical research.
2D. Physical therapists shall collaborate with patients and clients to empower them in decisions about their health care.
2E. Physical therapists shall protect confidential patient and client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

**Principle #3: Physical therapists shall be accountable for making sound professional judgments.**
(Core Values: Collaboration, Duty, Excellence, Integrity)
3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's or client's best interest in all practice settings.
3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient and client values.
3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

**Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.**
(Core Value: Integrity)
4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).
4C. Physical therapists shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
4D. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.
4E. Physical therapists shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual harassment, to an appropriate authority with jurisdiction over the conduct.
4F. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

**Principle #5: Physical therapists shall fulfill their legal and professional obligations.**
(Core Values: Accountability, Duty, Social Responsibility)
5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.
5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.
5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.
5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.
5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient or client continues to need physical therapist services.

**Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.**
(Core Value: Excellence)
6A. Physical therapists shall achieve and maintain professional competence.
6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.
6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.
6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

**Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society.**
(Core Values: Integrity, Accountability)
7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.
7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.
7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients and clients.
7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapist services accurately reflect the nature and extent of the services provided.
7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients and clients.

**Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.**
(Core Value: Social Responsibility)
8A. Physical therapists shall provide pro bono physical therapist services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.
8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or under- utilization of physical therapist services.
8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

**Explanation of Reference Numbers:**
HOD P00-00-00-00 stands for House of Delegates/month/year/page/vote in the House of Delegates minutes; the "P" indicates that it is a position (see below). For example, HOD P06-17-05-04 means that this position can be found in the June 2017 House of Delegates minutes on Page 5 and that it was Vote 4.

P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure

**Last Updated:** 8/12/2020
**Contact:** nationalgovernance@apta.org

# Standards of Ethical Conduct for the Physical Therapist Assistant

**HOD S06-20-31-26** [Amended HOD S06-19-47-68; HOD S06-09-20-18; HOD S06-00-13-24; HOD 06-91-06-07; Initial HOD 06-82-04-08] [Standard]

## Preamble

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Physical therapist assistants are guided by a set of core values (accountability, altruism, collaboration, compassion and caring, duty, excellence, integrity, and social responsibility). Throughout the document the primary core values that support specific principles are indicated in parentheses. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients and clients to achieve greater independence, health and wellness, and enhanced quality of life.

No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive. The APTA Guide for Conduct of the Physical Therapist Assistant and Core Values for the Physical Therapist and Physical Therapist Assistant provide additional guidance.

## Standards

### Standard #1: Physical therapist assistants shall respect the inherent dignity, and rights, of all individuals.

(Core Values: Compassion and Caring, Integrity)

1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapist services.

### Standard #2: Physical therapist assistants shall be trustworthy and compassionate in addressing the rights and needs of patients and clients.

(Core Values: Altruism, Collaboration, Compassion and Caring, Duty)

2A. Physical therapist assistants shall act in the best interests of patients and clients over the interests of the physical therapist assistant.

2B. Physical therapist assistants shall provide physical therapist interventions with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.

2C. Physical therapist assistants shall provide patients and clients with information regarding the interventions they provide.

2D. Physical therapist assistants shall protect confidential patient and client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

### Standard #3: Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.

(Core Values: Collaboration, Duty, Excellence, Integrity)

3A. Physical therapist assistants shall make objective decisions in the patient's or client's best interest in all practice settings.

3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapist interventions.

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3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient and client values.
3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.
3E. Physical therapist assistants shall provide physical therapist services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient or client status requires modifications to the established plan of care.

**Standard #4: Physical therapist assistants shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants other health care providers, employers, payers, and the public.**

(Core Value: Integrity)

4A. Physical therapist assistants shall provide truthful, accurate, and relevant information and shall not make misleading representations.
4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients and clients, students, supervisees, research participants, or employees).
4C. Physical therapist assistants shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
4D. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.
4E. Physical therapist assistants shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual harassment, to an appropriate authority with jurisdiction over the conduct.
4F. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

**Standard #5: Physical therapist assistants shall fulfill their legal and ethical obligations.**

(Core Values: Accountability, Duty, Social Responsibility)

5A. Physical therapist assistants shall comply with applicable local, state, and federal laws and regulations.
5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient and client safety.
5C. Physical therapist assistants involved in research shall abide by accepted standards governing protection of research participants.
5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

**Standard #6: Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.**

(Core Value: Excellence)

6A. Physical therapist assistants shall achieve and maintain clinical competence.
6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.
6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

**Standard #7: Physical therapist assistants shall support organizational behaviors and business practices that benefit patients and clients and society.**

(Core Values: Integrity, Accountability)

7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.
7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.

7C. Physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients and clients.
7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.
7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients and clients

**Standard #8: Physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, or globally.**
(Core Value: Social Responsibility)
8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.
8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid overutilization or underutilization of physical therapist services.
8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

**Explanation of Reference Numbers:**
HOD P00-00-00-00 stands for House of Delegates/month/year/page/vote in the House of Delegates minutes; the "P" indicates that it is a position (see below). For example, HOD P06-17-05-04 means that this position can be found in the June 2017 House of Delegates minutes on Page 5 and that it was Vote 4.

P: Position | S: Standard | G: Guideline | Y: Policy | R: Procedure

**Last Updated:** 8/12/2020
**Contact:** nationalgovernance@apta.org

Arizona Administrative CODE

4 A.A.C. 24 Supp. 21-2

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Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION

# TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 24. BOARD OF PHYSICAL THERAPY

The table of contents on the first page contains quick links to the referenced page numbers in this Chapter. Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

Sections, Parts, Exhibits, Tables or Appendices codified in this supplement. The list provided contains quick links to the updated rules.

This Chapter contains rule Sections that were filed to be codified in the *Arizona Administrative Code* between the dates of April 1, 2021 through June 30, 2021.



**Questions about these rules? Contact:**

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**The release of this Chapter in Supp. 21-2 replaces Supp. 19-1, 1-20 pages**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. "'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into titles. Titles are divided into chapters. A chapter includes state agency rules. Rules in chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each chapter.
First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31
For example, the first supplement for the first quarter of 2019 is cited as Supp. 19-1.

Please note: The Office publishes by chapter, not by individual rule section. Therefore there might be only a few sections codified in each chapter released in a supplement. Historical notes at the end of a section provide an effective date and information when a rule was last updated.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate chapters of the *Administrative Code* in Supp. 18-1 to comply with A.R.S. § 41-1012(B) and A.R.S. § 5302(1), (2)(d) through (e), and (3)(d) through (e).

A certification verifies the authenticity of each *Code* chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a chapter can be found at the Secretary of State's website, under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a chapter provide information about rulemaking sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### EXEMPTIONS AND PAPER COLOR

At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, managing rules editor, assisted with the editing of this chapter.*

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Date: 2021.07.26 11:00:15 -07'00'



Administrative Rules Division
The Arizona Secretary of State electronically publishes each A.A.C. Chapter with a digital certificate. The certificate-based signature displays the date and time the document was signed and can be validated in Adobe Acrobat Reader.

# TITLE 4. PROFESSIONS AND OCCUPATIONS

# CHAPTER 24. BOARD OF PHYSICAL THERAPY

Authority: A.R.S. § 32-2002 et seq.

## ARTICLE 1. GENERAL PROVISIONS

*Article 1 consisting of Sections R4-24-101 through R4-24-109 adopted effective June 3, 1982 (Supp. 82-3).*

*Former Article 1 consisting of Sections R4-24-01 through R4-24-06 repealed effective June 3, 1982 (Supp. 82-3).*

Section


## ARTICLE 2. LICENSING PROVISIONS

*Article 2 consisting of Sections R4-24-201 through R4-24-203 adopted effective June 3, 1982 (Supp. 82-3).*

*Former Article 2 consisting of Sections R4-24-16 through R4-24-26 repealed effective June 3, 1982 (Supp. 82-3).*

Section


## ARTICLE 3. PRACTICE OF PHYSICAL THERAPY

*Article 3 consisting of Sections R4-24-301 and R4-24-302 adopted effective April 10, 1986 (Supp. 86-2).*

*Former Article 3 consisting of Sections R4-24-301 through R4-24-303 repealed effective April 10, 1986 (Supp. 86-2).*

Section


## ARTICLE 4. CONTINUING COMPETENCE

*Article 4, consisting of Sections R4-24-401 through R4-24-403, adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2).*

Section


## ARTICLE 5. PUBLIC PARTICIPATION PROCEDURES

*Article 5, consisting of Sections R4-24-501 through R4-24-506, adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2).*

Section

## ARTICLE 1. GENERAL PROVISIONS

**R4-24-101. Definitions**

In addition to the definitions in A.R.S. § 32-2001, in this Chapter:

1. "Accredited" means accredited by a nationally recognized accreditation organization.
2. "Accredited educational program" means a physical therapist or physical therapist assistant educational program that is accredited by:
   a. The Commission on Accreditation of Physical Therapy Education, or
   b. An agency recognized as qualified to accredit physical therapist or physical therapist assistant programs by either the U.S. Department of Education or the Council on Higher Education Accreditation at the time of the applicant's graduation.
3. "Administratively suspend," as used in A.R.S. § 32-2027, means the Board places a license or certificate issued under A.R.S. Title 32, Chapter 19 and this Chapter on suspended status because the license or certificate was not renewed timely.
4. "Applicant" means an individual or business entity seeking an initial or renewal license, initial or renewal certificate, initial or renewal registration, interim permit, or reinstatement from the Board.
5. "Applicant packet" means the forms and additional information the Board requires to be submitted by an applicant or on the applicant's behalf.
6. "Campus" means a facility and immediately adjacent buildings.
7. "College Board" means an association composed of schools, colleges, universities, and other educational organizations across the United States that is responsible for the development of assessment tests that are used to provide college credit or for college placement.
8. "College level examination program" means services offered by the College Board for an individual to demonstrate college-level achievement by taking an examination approved by the College Board.
9. "Compliance period" means a two-year license renewal cycle that ends August 31 of even-numbered years.
10. "Continuing competence" means maintaining the professional skill, knowledge, and ability of a physical therapist or physical therapist assistant by successfully completing scholarly and professional activities related to physical therapy.
11. "Course" means an organized subject matter in which instruction is offered within a specified period of time.
12. "Course evaluation tool" means the Coursework Evaluation Tool for Foreign Educated Physical Therapists who Graduated after June 30, 2009, Fifth Edition, 2004 (effective July 1, 2009), published by the Federation of State Boards of Physical Therapy, 124 West Street, South Alexandria, VA, 22314, incorporated by reference and on file with the Board. This incorporation by reference contains no future editions or amendments.
13. "Credential evaluation" means a written assessment of a foreign-educated applicant's general and professional educational course work.
14. "Credential evaluation agency" means an organization that evaluates a foreign-educated applicant's education and provides recommendations to the Board about whether the applicant's education is substantially equivalent to physical therapy education provided in an accredited educational program.
15. "Days" means calendar days.
16. "Endorsement" means a procedure for granting an Arizona license or certificate to an applicant already licensed as a physical therapist or certified as a physical therapist assistant in another jurisdiction of the United States.
17. "ETS" means Educational Testing Service, an organization that provides educational learning and assessment services, including the Test of English as a Foreign Language Program.
18. "Facility" means a building where:
   a. A physical therapist is engaged in the practice of physical therapy;
   b. An applicant, licensee, or certificate holder is engaged in a supervised clinical practice; or
   c. A physical therapist assistant performs physical therapy-related tasks delegated by an onsite supervisor.
19. "Foreign-educated applicant" means an individual who graduated from a physical therapist educational program outside the United States, Puerto Rico, District of Columbia, or a U.S. territory.
20. "Functional limitation" means restriction of the ability to perform a physical action, activity, or task in an efficient, typically expected or competent manner.
21. "Good moral character" means the applicant has not taken any action that is grounds for disciplinary action against a licensee or certificate holder under A.R.S. § 32-2044.
22. "Hour" means 60 minutes.
23. "iBT" means internet-based TOEFL.
24. "National disciplinary database" means the disciplinary database of the U.S. Department of Health and Human Services' Health Integrity and Protection Data Base, which contains previous or current disciplinary actions taken against a licensed physical therapist or certified physical therapist assistant by state licensing agencies.
25. "National examination" means an examination produced by the Federation of State Boards of Physical Therapy or an examination produced by the American Physical Therapy Association.
26. "On call," as used in the definition of "general supervision" prescribed under A.R.S. § 32-2001, means a supervising physical therapist is able to go to the location at which and on the same day that a physical therapist assistant provides a selected treatment intervention if the physical therapist, after consultation with the physical therapist assistant, determines that going to the location is in the best interest of the patient.
27. "Onsite supervisor" means a physical therapist who provides onsite supervision as defined in A.R.S. § 32-2001.
28. "Physical Therapist Assistant Clinical Performance Instrument" means the document used to assess an individual's knowledge, skills, and attitudes to determine the individual's readiness to work as a physical therapist assistant that is published by the American Physical Therapy Association, Division of Education, March 1998, 1111 North Fairfax Street, Alexandria, VA 22314-1488 and incorporated by reference and on file with the Board. This incorporation by reference contains no future editions or amendments.
29. "Physical Therapist Clinical Performance Instrument" means the document used to assess an individual's knowledge, skills, and attitudes to determine the individual's readiness to practice physical therapy that is published by the American Physical Therapy Association, Division of Education, December 1997, 1111 North Fairfax Street, Alexandria, VA 22314-1488 and incorporated

by reference and on file with the Board. This incorporation by reference contains no future editions or amendments.

30. "Physical therapy services" means any of the actions stated in the definition of practice of physical therapy in A.R.S. § 32-2001.
31. "Qualified translator" means an individual, other than an applicant, who is:
    a. An officer or employee of an official translation bureau or government agency,
    b. A professor or instructor who teaches a translated language in an accredited college or university in the United States,
    c. An American consul in the country where the translated document is issued or another individual designated by the American consul in the country where the translated document is issued, or
    d. A consul general or diplomatic representative of the United States or individual designated by the consul general or diplomatic representative.
32. "Readily available," as used in the definition of "general supervision" prescribed under A.R.S. § 32-2001, means a supervising physical therapist is able to respond within 15 minutes to a communication from a physical therapist assistant providing a selected treatment intervention under general supervision.
33. "Recognized standards of ethics" means the *Code of Ethics* (amended June 2000) and the accompanying *Guide for Professional Conduct* (amended January 2004) of the American Physical Therapy Association, 1111 North Fairfax Street, Alexandria, VA 22314-1488, which is incorporated by reference and on file with the Board. This incorporation includes no later editions or amendments.
34. "Supervised clinical practice" means the period of time a physical therapist is engaged in the practice of physical therapy or a physical therapist assistant is engaged in work as a physical therapist assistant after being issued an interim permit by the Board.
35. "Supervising physical therapist" means an individual licensed under this Chapter who provides onsite or general supervision to assistive personnel.
36. "Suspend" means the Board places a license, certificate, permit, or registration in a status that restricts the holder of the license, certificate, permit, or registration from practicing as a physical therapist, working as a physical therapist assistant, or offering physical therapy services.
37. "TOEFL" means test of English as a foreign language.
38. "Week" means the period beginning on Sunday at 12:00 a.m. and ending the following Saturday at 11:59 p.m.

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Amended effective April 10, 1986 (Supp. 86-2). Amended effective May 7, 1990 (Supp. 90-2). Amended effective March 14, 1996 (Supp. 96-1). Amended by final rulemaking at 5 A.A.R. 2988, effective August 12, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 307, effective January 13, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 1640, effective June 30, 2007 (Supp. 07-2). Amended by final rulemaking at 15 A.A.R. 1788, effective December 5, 2009 (Supp. 09-4). Amended by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-102. Expired**

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Former Section R4-24-102 repealed, former Section R4-24-103 renumbered and amended as Section R4-24-102 effective April 10, 1986 (Supp. 86-2). Former Section R4-24-102 renumbered to R4-24-103; new Section R4-24-102 adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3).

**R4-24-103. Board Officers**

The Board shall elect a president, vice-president, and secretary at its first regular Board meeting each year.

1. The president shall preside at all Board meetings.
2. When the president is unable to preside at a Board meeting, the vice-president shall preside.

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Former Section R4-24-103 renumbered and amended as Section R4-24-102, former Section R4-24-104 renumbered and amended as Section R4-24-103 effective April 10, 1986 (Supp. 86-2). Former Section R4-24-103 renumbered to Section R4-24-204 effective May 7, 1990 (Supp. 90-2). New Section R4-24-103 renumbered from R4-24-102 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

**R4-24-104. Confidential Information and Records**

The following information or a record containing this information is confidential and is not provided to the public by the Board:

1. An applicant's, licensee's, or certificate-holder's:
    a. Social Security number;
    b. Home address or home telephone number unless the address or telephone number is the only address or telephone number of record;
    c. Credential evaluation report, education transcript, grades, or examination scores;
    d. National physical therapist or physical therapist assistant examination score;
    e. Diagnosis and treatment records; and
2. According to A.R.S. § 32-2045, information or a document related to investigations by the Board until the information or document becomes a public record or as required by law.

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Former Section R4-24-104 renumbered and amended as Section R4-24-103 effective April 10, 1986 (Supp. 86-2). New Section R4-24-104 adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

**R4-24-105. Expired**

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Amended subsection (B) effective April 10, 1986 (Supp. 86-2). Amended effective May 7, 1990 (Supp. 90-2). Amended effective March 14, 1996 (Supp. 96-1). Section repealed;

new Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3).

**R4-24-106. Repealed**

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Amended subsection (A) effective April 10, 1986 (Supp. 86-2). Amended effective May 7, 1990 (Supp. 90-2). Amended effective March 14, 1996 (Supp. 96-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

**R4-24-107. Fees**

**A.** Under the authority provided by A.R.S. §§ 32-2029 and 32-2030, the Board establishes and shall collect the following fees:

1. For a physical therapist:
   a. Application for an original license if the applicant applies on or after September 1 in an even-numbered year and no later than August 31 in an odd-numbered year, $260;
   b. Application for an original license if the applicant applies on or after September 1 in an odd-numbered year and no later than August 31 in an even-numbered year, $190;
   c. Renewal of an active license, $160;
   d. Renewal of an inactive license, $80;
   e. Reinstatement of an administratively suspended license, $100 plus the renewal fee; and
   f. Duplicate license, $10.
2. For a physical therapist assistant:
   a. Application for an original certificate if the applicant applies on or after September 1 in an even-numbered year and no later than August 31 in an odd-numbered year, $160;
   b. Application for an original certificate if the applicant applies on or after September 1 in an odd-numbered year and no later than August 31 in an even-numbered year, $120;
   c. Renewal of an active certificate, $55;
   d. Renewal of an inactive certificate, $27.50;
   e. Reinstatement of an administratively suspended certificate, $50 plus the renewal fee; and
   f. Duplicate certificate, $10.
3. For a business entity:
   a. Application for an original registration, $50;
   b. Renewal, $50;
   c. Late fee, $25; and
   d. Duplicate registration, $10.

**B.** Under the authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect a registration fee from an out-of-state health care provider of telehealth services: $100.

**C.** The fees specified in subsections (A) and (B) are nonrefundable unless A.R.S. § 41-1077 applies.

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Amended effective May 7, 1990 (Supp. 90-2). Section R4-24-107 renumbered to R4-24-306 by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section R4-24-107 renumbered from R4-24-206 by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1). Amended by final rulemaking at 18 A.A.R. 1858, effective July 10, 2012 (Supp. 12-3). Amended by final exempt rulemaking at 27 A.A.R. 1105, with an immediate effective date of June 29, 2021 (Supp. 21-2).

**R4-24-108. Repealed**

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Repealed effective May 7, 1990 (Supp. 90-2).

**R4-24-109. Renumbered**

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Amended effective May 7, 1990 (Supp. 90-2). Amended effective March 14, 1996 (Supp. 96-1). Section R4-24-109 renumbered to R4-24-307 by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2).

## ARTICLE 2. LICENSING PROVISIONS

**R4-24-201. Application for a Physical Therapist License**

**A.** An applicant for a physical therapist license shall submit to the Board an application packet that includes:

1. An application form provided by the Board that is signed, dated, and verified by the applicant and contains:
   a. The applicant's name, business, residential, and e-mail addresses, business and residential telephone numbers, birth date, and Social Security number;
   b. The name and address of each university or college attended by the applicant, the dates of attendance, and the date of graduation and degree received, if applicable;
   c. The name and address of the university or college where the applicant completed an accredited educational program and dates of attendance;
   d. A statement of whether the applicant has ever been licensed as a physical therapist in any other jurisdiction of the United States or foreign country;
   e. Professional employment history for the past five years, including the name, address, and telephone number for each place of employment, job title, description of the work completed, and explanation of any breaks in employment, if applicable;
   f. A statement of whether the applicant has ever been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country and if so, an explanation;
   g. A statement of whether the applicant has ever had an application for a professional or occupational license, certificate, or registration, other than a driver's license, denied, rejected, suspended, or revoked by any jurisdiction of the United States or foreign country and if so, an explanation;
   h. A statement of whether the applicant is currently or ever has been under investigation, suspension, or restriction by a professional licensing board in any jurisdiction of the United States or foreign country for any act that occurred in that jurisdiction that would be the subject of discipline under this Chapter and if so, an explanation;
   i. A statement of whether the applicant has ever been the subject of disciplinary action by a professional association or postsecondary educational institution;

j. A statement of whether the applicant has committed any of the actions referenced in the definition of good moral character in R4-24-101;
k. A statement of whether the applicant has ever had a malpractice judgment, has a lawsuit currently pending for malpractice, or entered into a settlement from a malpractice suit and if so, an explanation;
l. A statement of whether the applicant is currently more than 30 days in arrears for payment required by a judgment and order for child support in Arizona or any other jurisdiction;
m. A statement of whether the applicant has any impairment to the applicant's cognitive, communicative, or physical ability to engage in the practice of physical therapy with skill and safety and if so, an explanation;
n. A statement of whether the applicant has, within the past 10 years, used alcohol, any illegal chemical substance, or prescription medications, that in any way has impaired or limited the applicant's ability to practice physical therapy with skill and safety and if so, an explanation;
o. A statement of whether the applicant has, within the past 10 years, been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited the applicant's ability to practice physical therapy with skill and safety and if so, an explanation;
p. A statement of whether the applicant has ever violated A.R.S. § 32-2044(10); and
q. A statement by the applicant attesting to the truthfulness of the information provided by the applicant;

2. A passport photograph of the applicant no larger than 1 1/2 x 2 inches that was taken not more than six months before the date of the application;
3. Documentation, as described under A.R.S. § 41-1080, of the applicant's U.S. citizenship, alien status, legal residency, or lawful presence in the U.S.; and
4. The fee required in R4-24-107.

**B.** In addition to the requirements in subsection (A), an applicant shall arrange to have submitted directly to the Board:
1. An official transcript or letter showing that the applicant completed all requirements of an accredited educational program that includes the official seal of the university or college where the applicant completed the accredited educational program and signature of the registrar of the university or college,
2. Verification of passing a national examination in physical therapy as evidenced by an original notice of examination results, and
3. Verification of passing a jurisprudence examination as evidenced by an original notice of examination results.

**C.** In addition to the requirements in subsections (A) and (B), an applicant for a physical therapist license by endorsement shall submit to the Board:
1. The name of the licensing or certifying agency of any jurisdiction in which the applicant is currently or has been previously licensed;
2. A verification of each license, signed and dated by an official of the agency licensing or certifying the applicant, that includes the official seal of the licensing or certifying agency and all of the following:
   a. The name of the applicant;
   b. The license number and date of issuance;
   c. The current status of the license;
   d. The expiration date of the license;
   e. A statement of whether the applicant was ever denied a license by the agency and if so, an explanation; and
   f. A statement of whether any disciplinary action is pending or has ever been taken against the applicant and if so, an explanation.

**D.** The Board shall deny a license to an applicant who fails to meet the requirements of this Section or A.R.S. Title 32, Chapter 19. An applicant denied a license may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**
Adopted effective June 3, 1982 (Supp. 82-3). Amended subsection (C) and added subsection (D) effective April 10, 1986 (Supp. 86-2). Amended effective May 7, 1990 (Supp. 90-2). Amended effective March 14, 1996 (Supp. 96-1). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 2988, effective August 12, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008, (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-202. Reinstatement of License or Certificate**

**A.** An applicant whose Arizona license or certificate is administratively suspended for three consecutive years or less after the date of renewal of the license or certificate may apply for reinstatement of the license or certificate by submitting the application in R4-24-208 and the reinstatement fee and renewal fee required in R4-24-107.

**B.** An applicant whose Arizona license or certificate is administratively suspended for more than three consecutive years after the date of renewal of the license or certificate may apply for reinstatement of the license or certificate by submitting the reinstatement fee and renewal fee in R4-24-107, and:
1. For an applicant educated in the United States requesting reinstatement of a license, the application in R4-24-201(A) and (B);
2. For a foreign-educated applicant requesting reinstatement of a license, the application in R4-24-203; or
3. For an applicant requesting reinstatement of a certificate, the application in R4-24-207(A) and (B).

**C.** If an applicant submits an application according to subsection (B), the Board shall require the applicant to demonstrate competency by doing one or more of the following:
1. Practice physical therapy or work as a physical therapist assistant under an interim permit that allows the applicant to participate in a supervised clinical practice,
2. Complete one or more courses relevant to the practice of physical therapy or the work of a physical therapist assistant,
3. Complete continuing competence requirements for the period of time of the lapsed license, or
4. Take and pass a jurisprudence examination or national examination.

**Historical Note**
Adopted effective June 3, 1982 (Supp. 82-3). Amended subsection (C) effective April 10, 1986 (Supp. 86-2). Amended effective May 7, 1990 (Supp. 90-2). Amended effective March 14, 1996 (Supp. 96-1). Former Section R4-24-202 renumbered to R4-24-204; new Section R4-24-202 adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final

rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Subsection (A) corrected at request of the Board, Office File No. M12-209, filed June 8, 2012 (Supp. 12-1). Amended by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1).

**R4-24-203. Foreign-educated Applicant Requirements**

**A.** A foreign-educated applicant shall meet the requirements in A.R.S. § 32-2022(B) and the following:
1. The applicant shall comply with the requirements in R4-24-201.
2. The applicant shall ensure that a document required by R4-24-201 or this subsection is:
   a. Submitted to the Board in English; or
   b. Accompanied by an original English translation by a qualified translator if the document is submitted to the Board in a language other than English and includes an affidavit of accuracy by the qualified translator affirming:
      i. The qualified translator has translated the entire document,
      ii. The qualified translator has not omitted anything from or added to the translation, and
      iii. The translation is true and accurate.
3. To meet the requirements in A.R.S. § 32-2022(B)(4), the applicant shall state on the application form whether the applicant's practice as a physical therapist was limited in the country where the professional education occurred. If the applicant's practice was limited in the country where the professional education occurred, the applicant shall submit to the Board documentation of the limitation, or arrange to have documentation of limitation sent directly to the Board, that includes:
   a. The name, address, and telephone number of the entity that limited the applicant's practice of physical therapy;
   b. A description of the action or lack of action that led to the limitation on the applicant's practice as a physical therapist;
   c. A description of the limitation on the applicant's practice of physical therapy; and
   d. If the limitation is based on citizenship requirements of the country in which the professional education was obtained, the applicant shall provide the Board with the legal reference for the restriction in the laws of the country in which the professional education was obtained, a copy of the referenced laws, and an English translation of the laws that meets the standards in subsection (A)(2)(b).
4. If English is not the native language of the foreign-educated applicant, to meet the requirements in A.R.S. § 32-2022(B)(6), the applicant shall take and pass either of the following tests no more than 18 months before the date on which the application submitted under R4-24-201 is administratively complete and ensure that the test scores are sent directly to the Board by the testing entity:
   a. The TOEFL. An applicant who takes the TOEFL passes with the following:
      i. A score of 560 or more if a paper-based test or a score of 220 or more if a computer-based test;
      ii. Test of Spoken English with a score of 50 or more; and
      iii. Test of Written English with a score of 4.5 or more; or
   b. The iBT. An applicant who takes the iBT passes with an overall test score of a minimum of 100 and a:
      i. Writing section with a minimum score of 25,
      ii. Speaking section with a minimum score of 25,
      iii. Reading section with a minimum score of 25, and
      iv. Listening section with a minimum score of 25.
5. To demonstrate that the applicant meets uniform criteria for educational requirements according to A.R.S. § 32-2022(E)(3), the applicant shall undergo a credential evaluation to determine that the applicant meets the requirements in the course evaluation tool and arrange to have a credential evaluation report, prepared within 18 months from the date of the application, sent directly to the Board by the credential evaluation agency.
6. To meet the requirements in A.R.S. § 32-2022(B)(5), the applicant shall obtain a work visa to reside and seek employment in the United States issued by the Bureau of Citizenship and Immigration Services and submit a copy of the work visa to the Board.

**B.** After receiving a credential evaluation report from a credential evaluation agency, the Board:
1. If the credential evaluation report does not establish that the education obtained by the foreign-educated applicant is substantially equivalent to the education required of a physical therapist in an accredited education program, may require the applicant to:
   a. Complete one or more university or college courses and obtain a grade of C or better in each course;
   b. Complete a college level examination program; or
   c. If an applicant for a license, complete one or more continuing competence courses; and
2. Shall issue, within the time-frames stated in Table 1, an interim permit to complete a supervised clinical practice to the applicant if:
   a. The applicant was required to meet one or more of the requirements in subsection (B)(1) and completes the requirements; or
   b. The credential evaluation report establishes that the education obtained by the foreign-educated applicant is substantially equivalent to the education required of a physical therapist in an accredited education program; and
   c. The applicant has passed the national examination and jurisprudence examination; and
   d. The applicant meets the requirements in A.R.S. Title 32, Chapter 19 and R4-24-201.

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Amended subsection (B) effective April 10, 1986 (Supp. 86-2). Amended effective March 14, 1996 (Supp. 96-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008, (Supp. 08-3). Amended by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1).

**R4-24-204. Supervised Clinical Practice**

**A.** An interim permit holder shall complete a supervised clinical practice under onsite supervision. The supervised clinical practice shall consist of at least 500 hours.

**B.** Before an individual is issued an interim permit, the individual shall submit to the Board:
1. A written request for Board approval of the facility where supervised clinical practice will take place that includes:

a. The name, address, and telephone number of the facility; and
b. A description of the physical therapy services provided at the facility; and
2. The name of the individual who holds an unrestricted license to practice physical therapy in this state and agrees to provide onsite supervision of the individual.

**C.** The Board shall approve or deny a request made under subsection (B)(1):
1. After assessing whether the facility provides the opportunity for an interim permit holder to attain the knowledge, skills, and attitudes to be evaluated according to the Physical Therapist Assistant Clinical Performance Instrument or Physical Therapist Clinical Performance Instrument; and
2. According to the time-frames in Table 1.

**D.** An onsite supervisor shall:
1. Observe the interim permit holder during the supervised clinical practice and:
a. Rate the interim permit holder's performance, at both the mid-point and completion of the clinical practice, on each of the clinical performance criteria in the Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument, including the dates and hours the onsite supervisor provided onsite supervision;
b. Recommend following the mid-point rating whether the interim permit holder be allowed to continue the clinical practice and changes needed, if any, to ensure successful completion of the clinical practice; and
c. Recommend following the completion rating whether the interim permit holder be licensed or required to complete further supervised clinical practice; and
2. Submit the ratings on the Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument to the Board as follows:
a. No later than the 55th day of the clinical practice for the mid-point rating, and
b. No later than 30 days after the end of the supervised clinical practice for the completion rating.

**E.** After the Board receives the mid-point rating on the Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument, the Board shall review the rating and recommendation of the onsite supervisor and decide whether to allow the interim permit holder to continue the clinical practice or recommend changes in the clinical practice to the onsite supervisor.

**F.** After the Board receives the completion rating on the Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument, the Board:
1. May require the interim permit holder to complete additional onsite supervision under the interim permit if the additional onsite supervision does not cause the interim permit holder to exceed six months from the date the interim permit was issued and:
a. The onsite supervisor does not approve one or more of the skills listed on the Physical Therapist Clinical Performance Instrument or Physical Therapist Assistant Clinical Performance Instrument;
b. The onsite supervisor recommends that the interim permit holder complete further supervised clinical practice; or
c. The Board determines that the interim permit holder has not met the requirements in A.R.S. Title 32, Chapter 19 and this Chapter.
2. If the interim permit holder meets all of the requirements in A.R.S. Title 32, Chapter 19 and this Chapter, shall issue:
a. A license to an applicant for a license, or
b. A certificate to an applicant for a certificate.
3. If the applicant, licensee, or certificate-holder does not meet all of the requirements in A.R.S. Title 32, Chapter 19 and this Chapter, shall deny:
a. A license to an applicant for a license, or
b. A certificate to an applicant for a certificate.

**G.** An applicant who has been denied a license or certificate may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Adopted effective June 3, 1982 (Supp. 82-3). Former Section R4-24-103 renumbered and amended as Section R4-24-102, former Section R4-24-104 renumbered and amended as Section R4-24-103 effective April 10, 1986 (Supp. 86-2). Former Section R4-24-204 renumbered to R4-24-205, new Section R4-24-204 renumbered from Section R4-24-103 and amended effective May 7, 1990 (Supp. 90-2). Amended effective march 14, 1996 (Supp. 96-1). Former Section R4-24-204 renumbered to R4-24-206; new Section R4-24-204 renumbered from R4-24-202 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 307, effective January 13, 2003 (Supp. 03-1). Former Section R4-24-204 renumbered to R4-24-205; new Section R4-24-204 made by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 376, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008, (Supp. 08-3).

**R4-24-205. Examination Scores**

**A.** To be licensed as a physical therapist, an applicant shall obtain:
1. A scaled score of 600 or more, based on a scale ranging from 200 to 800 on a national examination for physical therapists taken on or after March 14, 1996; or
2. A raw score that is no lower than 1.50 standard deviation below the national average for a national examination for physical therapists taken before March 14, 1996.

**B.** To be certified as a physical therapist assistant, an applicant for certification shall obtain:
1. A scaled score of 600 or more based on a scale ranging from 200 to 800 on a national examination for physical therapist assistants taken on or after March 14, 1996; or
2. A raw score that is no lower than 1.50 standard deviation below the national average for a national examination for physical therapist assistants taken before March 14, 1996.

**C.** In addition to the requirements in subsections (A) and (B), to be licensed as a physical therapist or certified as a physical therapist assistant, an applicant shall obtain a scaled score of 600 or more based on a scale ranging from 200 to 800 on a jurisprudence examination.

**Historical Note**

Adopted effective April 10, 1986 (Supp. 86-2). Former Section R4-24-205 renumbered to R4-24-206, new Section R4-24-205 renumbered from Section R4-24-204 and amended effective May 7, 1990 (Supp. 90-2). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 2988, effective August 12, 1999 (Supp. 99-3).

Former Section R4-24-205 renumbered to R4-24-207; new Section R4-24-205 adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Former Section R4-24-205 repealed; new Section R4-24-205 renumbered from R4-24-204 and amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

**R4-24-206. Renumbered**

**Historical Note**

Section R4-24-205 adopted effective April 10, 1986 (Supp. 86-2). Section R4-24-206 renumbered from Section R4-24-205 and amended effective May 7, 1990 (Supp. 90-2). Amended by final rulemaking at 5 A.A.R. 2988, effective August 12, 1999 (Supp. 99-3). Former Section R4-24-206 repealed; new Section R4-24-206 renumbered from R4-24-204 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 5465, effective February 4, 2006 (Supp. 05-4). Section R4-24-206 renumbered to R4-24-107 by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

**R4-24-207. Application for a Physical Therapist Assistant Certificate**

**A.** An applicant for an original physical therapist assistant certificate shall submit to the Board an application packet that includes:

1. An application form provided by the Board, signed, dated, and verified by the applicant that contains:
   a. The applicant's name, business, residential, and e-mail addresses, business and residential telephone numbers, birth date, and Social Security number;
   b. The name and address of the college or university where the applicant completed an accredited educational program for physical therapist assistants, dates of attendance, and date of completion;
   c. A statement of whether the applicant has ever been licensed or certified as a physical therapist assistant in any other jurisdiction of the United States or foreign country;
   d. Professional employment history for the five years before the date of application including the name, address, and telephone number for each place of employment, job title, description of the work completed, and explanation of any breaks in employment, if applicable;
   e. A statement of whether the applicant has ever been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country and if so, an explanation;
   f. A statement of whether the applicant has ever had an application for a professional or occupational license, certificate, or registration, other than a driver's license, denied, rejected, suspended, or revoked by any jurisdiction of the United States or foreign country and if so, an explanation;
   g. A statement of whether the applicant is currently or ever has been under investigation, suspension, or restriction by a professional licensing board in any jurisdiction of the United States or foreign country for any act that occurred in that jurisdiction that would be the subject of discipline under this Chapter and if so, an explanation;
   h. A statement of whether the applicant has ever been the subject of disciplinary action by a professional association or postsecondary educational institution;
   i. A statement of whether the applicant has committed any of the actions referenced in the definition of good moral character in R4-24-101;
   j. A statement of whether the applicant has ever had a malpractice judgment or has a lawsuit currently pending for malpractice and if so, an explanation;
   k. A statement of whether the applicant is currently more than 30 days in arrears for payment required by a judgment and order for child support in Arizona or any other jurisdiction;
   l. A statement of whether the applicant has any impairment to the applicant's cognitive, communicative, or physical ability to participate in therapeutic interventions with skill and safety and if so, an explanation;
   m. A statement of whether the applicant has, within the past 10 years, used alcohol, any illegal chemical substance, or prescription medications, that in any way has impaired or limited the applicant's ability to participate in therapeutic interventions with skill and safety and if so, an explanation;
   n. A statement of whether the applicant has, within the past 10 years, been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited the applicant's ability to participate in therapeutic interventions with skill and safety and if so, an explanation;
   o. A statement of whether the applicant has ever violated A.R.S. § 32-2044(10); and
   p. A sworn statement by the applicant verifying the truthfulness of the information provided by the applicant;
2. A passport photograph of the applicant no larger than 1 1/2 x 2 inches that was taken not more than six months before the date of the application;
3. Documentation, as described under A.R.S. § 41-1080, of the applicant's U.S. citizenship, alien status, legal residency, or lawful presence in the U.S.; and
4. The fee required in R4-24-107.

**B.** In addition to the requirements in subsection (A), an applicant shall arrange to have directly submitted to the Board:

1. An official transcript or letter showing the applicant completed all requirements of an accredited educational program that includes the official seal of the school or college where the applicant completed the accredited educational program and signature of the registrar of the school or college;
2. Verification of passing a national examination for physical therapist assistants as evidenced by an original notice of examination results; and
3. Verification of passing a jurisprudence examination as evidenced by an original notice of examination results.

**C.** In addition to the requirements in subsections (A) and (B), an applicant for a physical therapist assistant certificate by endorsement shall submit to the Board:

1. The name of the licensing or certifying agency of any jurisdiction in which the applicant is currently or has been previously licensed or certified; and
2. A verification of license or certificate, signed and dated by an official of the agency licensing or certifying the applicant, that includes the official seal of the licensing or certifying agency and all of the following:

a. The name of the applicant;
b. The license or certificate number and date of issuance;
c. The current status of the license or certificate;
d. The expiration date of the license or certificate;
e. A statement of whether the applicant was ever denied a license or certificate by the agency and if so, an explanation; and
f. A statement of whether any disciplinary action is pending or has ever been taken against the applicant and if so, an explanation.

**D.** The Board shall deny a certificate to an applicant who fails to meet the requirements of this Section or A.R.S. Title 32, Chapter 19. A person denied a certificate may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 2988, effective August 12, 1999 (Supp. 99-3). Former Section R4-24-207 renumbered to R4-24-209; new Section R4-24-207 renumbered from R4-24-205 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 376, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008, (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-208. License or Certificate Renewal; Address Change**

**A.** A licensee or certificate holder shall submit a renewal application packet to the Board on or before August 31 of an even-numbered year that includes:
1. The following information for the compliance period immediately preceding the renewal application:
   a. The licensee's or certificate holder's:
      i. Name;
      ii. Home, business, and e-mail addresses; and
      iii. Home and business telephone numbers;
   b. A statement of whether the licensee or certificate holder has been convicted of, pled guilty or no contest to, or entered into diversion in lieu of prosecution for any criminal offense in any jurisdiction of the United States or foreign country and if so, an explanation;
   c. A statement of whether the licensee or certificate holder has had an application for a professional or occupational license, certificate, or registration, other than a driver's license, denied, rejected, suspended, or revoked by any jurisdiction of the United States or foreign country and if so, an explanation;
   d. A statement of whether the licensee or certificate holder is currently or ever has been under investigation, suspension, or restriction by a professional licensing board in any jurisdiction of the United States or foreign country for any act that occurred in that jurisdiction that would be the subject of discipline under this Chapter and if so, an explanation;
   e. A statement of whether the licensee or certificate holder has been the subject of disciplinary action by a professional association or postsecondary educational institution;
   f. A statement of whether the licensee or certificate holder has had a malpractice judgment against the licensee or certificate holder or has a lawsuit currently pending for malpractice and if so, an explanation;
   g. A statement of whether the licensee or certificate holder is currently more than 30 days in arrears for payment required by a judgment and order for child support in Arizona or any other jurisdiction;
   h. A statement of whether the licensee or certificate holder has adhered to the recognized standards of ethics;
   i. A statement of whether the licensee or certificate holder has or has not committed any of the actions referenced in the definition of good moral character in R4-24-101;
   j. A statement of whether the licensee or certificate holder has been the subject of any criminal investigation by a federal, state, or local agency or had criminal charges filed against the licensee or certificate holder;
   k. If a licensee, a statement of whether the licensee has:
      i. Any impairment to the licensee's cognitive, communicative, or physical ability to engage in the practice of physical therapy with skill and safety and if so, an explanation;
      ii. Used alcohol, any illegal chemical substance, or prescription medicine, that in any way has impaired or limited the licensee's ability to practice physical therapy with skill and safety and if so, an explanation;
      iii. Been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited the licensee's ability to practice physical therapy with skill and safety and if so, an explanation;
   l. If a certificate holder, a statement of whether the certificate holder has:
      i. Any impairment to the certificate holder's cognitive, communicative, or physical ability to work as a physical therapist assistant with skill and safety and if so, an explanation;
      ii. Used alcohol, any illegal chemical substance or prescription medicine, that in any way has impaired or limited the certificate holder's ability to work as a physical therapist assistant with skill and safety and if so, an explanation;
      iii. Been diagnosed as having or is being treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorder that in any way has impaired or limited certificate holder's ability to work as a physical therapist assistant with skill and safety and if so, an explanation;
   m. A statement of whether the licensee or certificate holder has ever violated A.R.S. § 32-2044(10);
   n. If a licensee, a statement of whether the licensee has completed the 20 contact hours of continuing competence for the previous compliance period as required in R4-24-401;
   o. If a certificate holder, a statement of whether the certificate holder has completed the 10 contact hours of continuing competence for the previous compliance period as required in R4-24-401;
   p. If a licensee, a statement of whether the licensee has complied with the medical records protocol as required in A.R.S. § 32-3211; and

q. If a licensee, a statement of whether the licensee has completed the dry needling course content requirements in A.A.C. R4-24-313.

2. The signature of the applicant attesting to the truthfulness of the information provided by the licensee or certificate holder;

3. If the documentation previously submitted under R4-24-201(A)(3) or R4-24-207(A)(3) did not establish citizenship in the United States or was not a non-expiring work authorization, documentation specified under A.R.S. § 41-1080 that the presence of the licensee or certificate holder in the United States continues to be authorized under federal law; and

4. The fee required by the Board in R4-24-107.

**B.** Failure of the Board to inform a licensee or certificate holder of license or certificate expiration does not excuse the licensee's or certificate holder's non-renewal or untimely renewal.

**C.** The Board shall:

1. Approve or deny the application within the time frames in R4-24-209 and Table 1, and

2. Deny the application of an applicant who does not meet the requirements in A.R.S. § 32-2001 et seq. or this Chapter.

**D.** A licensee or certificate holder denied renewal of a license or certificate may request a hearing under A.R.S. Title 41, Chapter 6, Article 10.

**E.** A licensee or certificate holder shall send to the Board written notification of a change in any of the information provided under subsection (A)(1)(a) no later than 30 days after the date of the change.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 376, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008, (Supp. 08-3). Amended by final rulemaking at 18 A.A.R. 1858, effective July 10, 2012 (Supp. 12-3). Amended by final exempt rulemaking at 21 A.A.R. 924, effective July 1, 2015 (Supp. 15-2). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-209. Time-frames for Board Approvals**

**A.** The overall time-frame described in A.R.S. § 41-1072(2) for each type of approval granted by the Board is listed in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend the substantive review time-frame and overall time-frame. The overall time-frame and the substantive review time-frame may not be extended by more than 25% of the overall time-frame.

**B.** The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of approval granted by the Board is listed in Table 1.

1. The administrative completeness review time-frame begins:

a. When the Board receives an application packet for an initial or renewal license or certificate or

b. When the Board receives a request for approval of a facility.

2. If the application packet is incomplete, the Board shall send to the applicant a written notice specifying the missing document or incomplete information.

a. The administrative completeness review time-frame and the overall time-frame are suspended from the postmark date of the notice until the date the Board receives a complete application packet from the applicant.

b. An applicant who disagrees with the Board's statement of deficiencies may request a hearing as provided in A.R.S. § 32-2023.

3. If an application packet is complete, the Board shall send a written notice of administrative completeness to the applicant.

4. If the Board grants a license, certificate, or approval during the time provided to assess administrative completeness, the Board shall not issue a separate written notice of administrative completeness.

**C.** The substantive review time-frame described in A.R.S. § 41-1072(3) is listed in Table 1 and begins on the postmark date of the notice of administrative completeness.

1. During the substantive review time-frame, the Board may make one comprehensive written request for additional information or documentation. The time-frame for the Board to complete the substantive review is suspended from the postmark date of the comprehensive written request for additional information or documentation until the Board receives the additional information or documentation.

2. The Board shall send a written notice of approval of a license or certificate to an applicant who meets the qualifications in A.R.S. §§ 32-2001 through 32-2027 and this Chapter.

3. The Board shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S. §§ 32-2001 through 32-2027 and these rules.

**D.** The Board shall consider an application withdrawn if within 360 days from the application submission date the applicant fails to:

1. Supply the missing information requested under subsection (B)(2) or (C)(1); or

2. Take the national physical therapist examination or national physical therapist assistant examination.

**E.** An applicant who does not wish an application withdrawn may request a denial in writing within 360 days from the application submission date.

**F.** If a time-frame's last day falls on a Saturday, Sunday, or an official state holiday, the Board shall consider the next business day the time-frame's last day.

**Historical Note**

New Section R4-24-209 renumbered from R4-24-207 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

**Table 1. Time Frames (in days)**

| Type of Applicant | Type of Approval | Statutory Authority | Overall Time Frame | Administrative Completeness Time Frame | Substantive Review Time Frame |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Original License (R4-24-201) or Registration as an Out-of-state Health Care Provider of Telehealth Services (A.R.S. § 36-3606) | License<br><br>Registration | A.R.S. §§ 32-2022; 32-2023; 36-3606 | 75 | 30 | 45 |
| License or Certificate by Endorsement (R4-24-201; R4-24-207) | License or certificate by Endorsement | A.R.S. § 32-2026 | 75 | 30 | 45 |
| Physical Therapist Assistant Certificate (R4-24-207) | Certificate | A.R.S. §§ 32-2022; 32-2023 | 75 | 30 | 45 |
| Foreign-educated (R4-24-203) | License | A.R.S. §§ 32-2022; 32-2025 | 75 | 45 | 30 |
| Renewal of license or certificate (R4-24-208) | License or certificate | A.R.S. § 32-2027 | 30 | 15 | 15 |
| Foreign-educated and Supervised Clinical Practice (R4-24-203, R4-24-204) | Interim Permit and Approval of Facility | A.R.S. § 32-2025 | 60 | 30 | 30 |
| Reinstatement (R4-24-202) | Reinstatement of License or Certificate | A.R.S. § 32-2028 | 30 | 15 | 15 |
| Initial Registration of a Business Entity | Registration | A.R.S. § 32-2030 | 30 | 15 | 15 |
| Renewal of Registration of a Business Entity | Registration | A.R.S. § 32-2030(D) | 15 | 7 | 8 |

**Historical Note**

Table 1 adopted by final rulemaking at 5 A.A.R. 2988, effective August 12, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2). Amended by final rulemaking at 15 A.A.R. 1788, effective December 5, 2009 (Supp. 09-4). Amended by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 27 A.A.R. 1105, with an immediate effective date of June 29, 2021 (Supp. 21-2).

**R4-24-210. Business Entity Registration; Display of Registration Certificate**

**A.** A business entity that offers physical therapy services to the public and is not exempt from registration under A.R.S. § 32-2030(H) shall separately register with the Board each location from which physical therapy services are offered in Arizona.

**B.** A business entity shall not offer physical therapy services at a location in Arizona until that location is registered with the Board.

**C.** To register with the Board an Arizona location at which physical therapy services are offered, a business entity shall submit to the Board an application packet that includes the following:

1. An application form, which is available from the Board and requires the following information:
   a. Name, primary address, and e-mail address of the business entity;
   b. Name, title, address, e-mail address, and telephone number of the manager of the location being registered;
   c. Name and business address of each officer or director of the business entity;
   d. Name and license number of each physical therapist who provides physical therapy services at the location being registered;
   e. Name and certificate number of each physical therapy assistant who works at the location being registered;
   f. Description of the physical therapy services offered at the location being registered;
   g. For the business entity, a statement of whether any state, territory, district, or country has ever:
      i. Refused to issue or renew a registration, permit, license, or other authorization;
      ii. Accepted surrender of a registration, permit, license, or other authorization in lieu of other disciplinary action; or
      iii. Suspended, revoked, cancelled, or taken other disciplinary action against a registration, permit, license, or other authorization; and
   h. Dated signature of an officer or director attesting that:
      i. The business entity has a written protocol that meets the standards in A.R.S. § 32-2030(F) for the secure storage, transfer, and access of the physical therapy records of the business entity's patients; and
      ii. The information provided is true and correct; and
2. The application fee required under R4-24-107(A)(3).

**D.** For each location registered, a business entity shall display, in a location accessible to public view, the:

1. Registration certificate and current renewal verification of the business entity,
2. License and current renewal verification of every physical therapist who provides physical therapy services at the location, and
3. Certificate and current renewal verification of every physical therapy assistant who works at the location.

**Historical Note**
New Section made by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-211. Renewal of Business Entity Registration**

**A.** The registration of a business entity expires for each location registered on August 31 of every odd-numbered year.

**B.** A business entity shall separately renew the registration of each location from which the business entity offers physical therapy services in Arizona.

**C.** To renew the registration of an Arizona location from which physical therapy services are offered, a business entity shall submit to the Board an application form, which is available from the Board and requires the following information:
1. Name, primary address, and e-mail address of the business entity;
2. Name, title, address, e-mail address, and telephone number of the manager of the location being registered;
3. Name and business address of each officer or director of the business entity;
4. Name and license number of each physical therapist who provides physical therapy services at the location being registered;
5. Name and certificate number of each physical therapy assistant who works at the location being registered;
6. Description of the physical therapy services offered at the location being registered;
7. For the business entity, a statement of whether any state, territory, district, or country has ever:
   a. Refused to issue or renew a registration, permit, license, or other authorization;
   b. Accepted surrender of a registration, permit, license, or other authorization in lieu of other disciplinary action; or
   c. Suspended, revoked, cancelled, or taken other disciplinary action against a registration, permit, license, or other authorization;
8. Statement of whether the business entity complies with A.R.S. § 32-2030(F); and
9. Dated signature of an officer or director attesting that the information provided is true and correct.

**D.** A business entity that timely complies with subsection (C) may continue to offer physical therapy services from the location for which application is made until the Board grants or denies the renewed registration.

**E.** A business entity that fails to comply timely with subsection (C) shall immediately stop offering physical therapy services from the location for which application is not made. To be authorized to offer physical therapy services again from that location, the business entity shall comply with R4-24-210 and pay both the application and late fee specified in R4-24-107(A)(3).

**Historical Note**
New Section made by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-212. Regulation of a Business Entity**

**A.** A business entity may submit a complaint under A.R.S. § 32-2030 or 32-2045(D) by complying with R4-24-305.

**B.** The Board shall investigate and act on a complaint, whether submitted by or against a business entity, in a manner consistent with R4-24-305, R4-24-306, R4-24-307, R4-24-308, and R4-24-309.

**C.** As provided under A.R.S. § 32-2047, a business entity that violates a requirement of A.R.S. § 32-2030 is subject to disciplinary action by the Board.

**Historical Note**
New Section made by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1).

**R4-24-213. Business Entity Participation**

A registered business entity may provide assistance and advice to the Board relating to the regulation of business entities by:
1. Participating in the rulemaking process in a manner described under A.R.S. Title 41, Chapter 6, Article 3;
2. Submitting a petition under A.R.S. § 41-1033 and R4-24-502;
3. Submitting an appeal under A.R.S. § 41-1056.01 and R4-24-502;
4. Submitting a written criticism under R4-24-506; and
5. Attending a Board meeting.

**Historical Note**
New Section made by final rulemaking at 18 A.A.R. 841, effective May 11, 2012 (Supp. 12-1).

**Exhibit 1. Repealed**

**Historical Note**
Exhibit 1 adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Exhibit 1 repealed by final rulemaking at 12 A.A.R. 2401, effective August 5, 2006 (Supp. 06-2).

## ARTICLE 3. PRACTICE OF PHYSICAL THERAPY

**R4-24-301. Lawful Practice**

**A.** A physical therapist shall provide the referring practitioner, if any, with information from the patient assessment, diagnosis, and plan of care. Within one week after a patient is initially evaluated, the physical therapist shall provide this information:
1. In writing and place a copy of the written notice in the patient's record, or
2. Orally and place a contemporaneously made note of the verbal communication in the patient's record.

**B.** A physical therapist shall maintain the confidentiality of patient records as required by federal and state law.

**C.** On written request by a patient or the patient's health care decision maker, a physical therapist shall provide access to or a copy of the patient's medical or payment record in accordance with A.R.S. § 12-2293.

**D.** A physical therapist shall obtain a patient's consent before examination and treatment and document the consent in the patient's record.

**E.** A physical therapist shall respect a patient's right to make decisions regarding examination and the recommended plan of care including the patient's decision regarding consent, modification of the plan of care, or refusal of examination or treatment. To assist the patient in making these decisions, the physical therapist shall:
1. Communicate to the patient:
   a. Examination findings,
   b. Evaluation of the findings, and

c. Diagnosis and prognosis,
2. Collaborate with the patient to establish the goals of treatment and the plan of care, and
3. Inform the patient that the patient is free to select another physical therapy provider.

**Historical Note**
Adopted effective June 3, 1982 (Supp. 82-3). Former Section R4-24-301 repealed, new Section R4-24-301 adopted effective April 10, 1986 (Supp. 86-2). Amended effective March 14, 1996 (Supp. 96-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 15 A.A.R. 1788, effective December 5, 2009 (Supp. 09-4).

**R4-24-302. Use of Titles**

**A.** As required under A.R.S. § 32-2042, a licensed physical therapist shall use the designation "P.T." immediately following the licensee's name or signature to denote licensure. A licensed physical therapist shall not use the designations "R.P.T." or "L.P.T." in connection with the physical therapist's name or place of business.

**B.** In addition to and immediately following the "P.T." designation, a physical therapist may list academic degrees earned and professional specialty certifications held.

**C.** As required under A.R.S. § 32-2042, a physical therapist assistant shall use the designation "P.T.A." immediately following the physical therapist assistant's name to denote certification.

**D.** As required under A.R.S. § 32-2042, a physical therapist or physical therapist assistant who is on retired status shall use "(retired)" or "(ret.)" immediately after the designation required under subsection (A) or (C), as applicable.

**Historical Note**
Adopted effective June 1, 1982 (Supp. 82-3). Former Section R4-24-302 repealed, new Section R4-24-302 adopted effective April 10, 1986 (Supp. 86-2). Amended effective March 14, 1996 (Supp. 96-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 18 A.A.R. 1858, effective July 10, 2012 (Supp. 12-3).

**R4-24-303. Patient Care Management**

**A.** A physical therapist is responsible for the scope of patient management in the practice of physical therapy as defined by A.R.S. § 32-2001. For each patient, the physical therapist shall:
1. Perform and document an initial evaluation;
2. Perform and document periodic reevaluation;
3. Document a discharge summary and the patient's response to the course of treatment at discharge;
4. Ensure that the patient's physical therapy record is complete and accurate; and
5. Ensure that services reported for billing, whether billed directly to the patient or through a third party, are accurate and consistent with information in the patient's physical therapy record.

**B.** On each date of service, a physical therapist shall:
1. Perform and document each therapeutic intervention that requires the expertise of a physical therapist; and
2. Determine, based on a patient's acuity and treatment plan, whether it is appropriate to use assistive personnel to perform a selected treatment intervention or physical therapy task for the patient.

**C.** A physical therapist shall not supervise more than three assistive personnel at any time. If a physical therapist supervises three assistive personnel, the physical therapist shall ensure that:
1. At least one of the assistive personnel is a physical therapist assistant,
2. No more than two of the assistive personnel are physical therapist assistants performing selected treatment interventions under general supervision, and
3. Assistive personnel other than a physical therapist assistant perform a physical therapy task only under the onsite supervision of a physical therapist.

**D.** Before delegating performance of a selected treatment intervention to a physical therapist assistant working under general supervision, the supervising physical therapist shall ensure that the physical therapist assistant:
1. Is certified under this Chapter, and
2. Has completed at least 2,000 hours of experience as a physical therapist assistant working with patients under onsite supervision.

**E.** Before delegating performance of a selected physical therapy intervention or physical therapy task to assistive personnel working under general or onsite supervision, the supervising physical therapist shall ensure that the assistive personnel is qualified by education or training to perform the selected physical therapy intervention or physical therapy task in a safe, effective, and efficient manner.

**F.** A physical therapist who provides general supervision for a physical therapist assistant shall:
1. Be licensed under this Chapter;
2. Respond to a communication from the physical therapist assistant within 15 minutes;
3. Go to the location at which and on the same day that the physical therapist assistant provides a selected treatment intervention if the physical therapist, after consultation with the physical therapist assistant, determines that going to the location is in the best interest of the patient; and
4. Perform a reevaluation and provide each therapeutic intervention for the patient that is done on the day of the reevaluation every fourth treatment visit or every 30 days, whichever occurs first.

**G.** A physical therapist assistant who provides a selected treatment intervention under general supervision shall document in the patient record:
1. The name and license number of the supervising physical therapist;
2. The name of the patient to whom the selected treatment intervention is provided;
3. The date on which the selected treatment intervention is provided;
4. The selected treatment intervention provided; and
5. Whether the physical therapist assistant consulted with the supervising physical therapist during the course of the selected treatment intervention and if so, the subject of the consultation and any decision made.

**Historical Note**
Adopted effective June 3, 1982 (Supp. 82-3). Repealed effective April 10, 1986 (Supp. 86-2). New Section R-24-303 adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 13 A.A.R. 1640, effective June 30, 2007 (Supp. 07-2).

**R4-24-304. Adequate Patient Records**

**A.** A physical therapist shall ensure that a patient record meets the following minimum standards:
1. Each entry in the patient record is:
   a. Legible,
   b. Accurately dated, and
   c. Signed with the name and legal designation of the individual making the entry;
2. If an electronic signature is used to sign an entry, the electronic signature is secure;
3. The patient record contains sufficient information to:
   a. Identify the patient on each page of the patient record,
   b. Justify the therapeutic intervention,
   c. Document results of the therapeutic intervention,
   d. Indicate advice or cautionary warnings provided to the patient,
   e. Enable another physical therapist to assume the patient's care at any point in the course of therapeutic intervention, and
   f. Describe the patient's medical history.
4. If an individual other than a physical therapist or physical therapist assistant makes an entry into the patient record, the supervising physical therapist co-signs the entry;
5. If it is determined that erroneous information is entered into the patient record:
   a. The error is corrected in a manner that allows the erroneous information to remain legible, and
   b. The individual making the correction dates and initials the correct information; and
6. For each date of service there is an accurate record of the physical therapy services provided and billed.

**B.** Initial evaluation. As required by A.R.S. § 32-2043(F)(1), a physical therapist shall perform the initial evaluation of a patient. The physical therapist who performs an initial evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:
1. The patient's reason for seeking physical therapy services;
2. The patient's relevant medical diagnoses or conditions;
3. The patient's signs and symptoms;
4. Objective data from tests or measurements;
5. The physical therapist's interpretation of the results of the examination;
6. Clinical rationale for therapeutic intervention;
7. A plan of care that includes the proposed therapeutic intervention, measurable goals, and frequency and duration of therapeutic intervention; and
8. The patient's prognosis.

**C.** Therapeutic-intervention notes. For each date that a therapeutic intervention is provided to a patient, the individual who provides the therapeutic intervention shall make an entry that meets the standards in subsection (A) in the patient record and document:
1. The patient's subjective report of current status or response to therapeutic intervention;
2. The therapeutic intervention provided or appropriately supervised;
3. Objective data from tests or measures, if collected;
4. Instructions provided to the patient, if any; and
5. Any change in the plan of care required under subsection (B)(7).

**D.** Re-evaluation. As required by A.R.S. § 32-2043(F)(2), a physical therapist shall perform a re-evaluation when a patient fails to progress as expected, progresses sufficiently to warrant a change in the plan of care, or in accordance with R4-24-303(F)(4). A physical therapist who performs a re-evaluation shall make an entry that meets the standards in subsection (A) in the patient record and document:
1. The patient's subjective report of current status or response to therapeutic intervention;
2. Assessment of the patient's progress;
3. The patient's current functional status;
4. Objective data from tests or measures, if collected;
5. Rationale for continuing therapeutic intervention; and
6. Any change in the plan of care required under subsection (B)(7).

**E.** Discharge summary. As required by A.R.S. § 32-2043(F)(3), a physical therapist shall document the conclusion of care in a patient's record regardless of the reason that care is concluded.
1. If care is provided in an acute-care hospital, the entry made under subsection (C) on the last date that a therapeutic intervention is provided constitutes documentation of the conclusion of care if the entry is made by a physical therapist.
2. If care is not provided in an acute-care hospital or if a physical therapist does not make the entry under subsection (C) on the last date that a therapeutic intervention is provided, a physical therapist shall make an entry that meets the standards in subsection (A) in the patient record and document:
   a. The date on which therapeutic intervention terminated;
   b. The reason that therapeutic intervention terminated;
   c. Inclusive dates for the episode of care being terminated;
   d. The total number of days on which therapeutic intervention was provided during the episode of care;
   e. The patient's current functional status;
   f. The patient's progress toward achieving the goals in the plan of care required under subsection (B)(7); and
   g. The recommended discharge plan.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). R4-24-304 renumbered to R4-24-305; new Section R4-24-304 made by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-305. Complaints and Investigations**

**A.** A complainant shall ensure that a complaint filed with the Board is about:
1. An individual licensed or certified under this Chapter; or
2. An individual believed to be engaged in unlawful practice as described in A.R.S. § 32-2048.

**B.** If the Board determines under A.R.S. § 32-2045(A)(2) that there is reason to believe that an individual may have violated A.R.S. Title 32, Chapter 19, or this Chapter, the Board shall prepare a complaint and serve the complaint as described in subsection (D)(2).

**C.** Complaint requirements. A complainant shall:
1. Submit the complaint to the Board in writing; and
2. Provide the following information:
   a. Name of licensee, certificate holder, or other individual who is the subject of complaint;
   b. Name and address of complainant;
   c. Nature of the complaint;
   d. Details of the complaint with pertinent dates and activities;
   e. Whether the complainant has contacted any other organization regarding the complaint; and

f. Whether complainant has contacted the licensee, certificate holder, or other individual concerning the complaint, and if so, the response, if any.

**D.** Within 90 days after receiving a complaint, the Board shall ensure that the complaint is reviewed to determine whether the complaint is within the Board's jurisdiction, and:
1. If the complaint is not within the Board's jurisdiction, dismiss the complaint and provide written notice of the dismissal to the complainant; or
2. If the complaint is within the Board's jurisdiction, serve a copy of the complaint on the individual complained against and provide the individual complained against with 30 days to respond and admit, deny, or further explain each allegation in the complaint.

**E.** If a complaint is within the Board's jurisdiction, the Board shall ensure that an investigation regarding the matters alleged in the complaint is conducted.

**F.** After expiration of the 30 days provided under subsection (D)(2), the Board shall review the complaint, response, and investigation results and take action as prescribed under A.R.S. §§ 32-2045(B) or 32-2046.

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). R4-24-305 renumbered to R4-24-306; new Section R4-24-305 renumbered from R4-24-304 and amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-306. Hearings**

**A.** To facilitate investigation of a complaint, the Board may conduct an informal hearing. The Board shall send written notice of an informal hearing to the individual who is the subject of the complaint, by personal service or certified mail, return receipt requested, at least 30 days before the informal hearing.

**B.** The Board shall ensure that the written notice of informal hearing contains the following information:
1. The time, date, and place of the informal hearing;
2. An explanation of the informal nature of the proceedings;
3. The individual's right to appear with or without legal counsel;
4. A statement of the allegations and issues involved with a citation to relevant statutes and rules;
5. The individual's right to a formal hearing under A.R.S. Title 41, Chapter 6, Article 10 instead of the informal hearing;
6. The licensee's or certificate holder's right to request under A.R.S. § 32-3206(A) a copy of information the Board will use in making its determination; and
7. Notice that the Board may take disciplinary action as a result of the informal hearing if it finds the individual violated A.R.S. Title 32, Chapter 19, or this Chapter;

**C.** The Board shall ensure that an informal hearing proceeds as follows:
1. Introduction of the respondent and, if applicable, legal counsel for the respondent;
2. Introduction of the Board members, staff, and Assistant Attorney General present;
3. Swearing in of the respondent and witnesses;
4. Brief summary of the allegations and purpose of the informal hearing;
5. Optional opening comment by the respondent;
6. Questioning of the respondent by the Board and questioning of witnesses by the Board and the respondent;
7. Optional additional comments by the respondent; and
8. Deliberation and deciding the case by the Board.

**Historical Note**
New Section R4-24-306 renumbered from R4-24-107 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). R4-24-306 renumbered to R4-24-307; new Section R4-24-306 renumbered from R4-24-305 and amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-307. Subpoenas**

**A.** A party desiring issuance of a subpoena to compel the appearance of a witness or the production of documents or other evidence at a hearing shall file a written request with the Board that includes the following information:
1. The caption and docket number of the matter;
2. A list or description of any documents or other evidence sought;
3. The name and business address of the custodian of the documents or other evidence sought;
4. The name and business or residential address of all persons to be subpoenaed;
5. A brief statement of the reason the evidence is relevant to the matter;
6. The date, time, and place to appear or produce documents or other evidence; and
7. The name, address, and telephone number of the party, or the party's attorney, requesting the subpoena.

**B.** The party requesting a subpoena be issued shall ensure that the subpoena is served in the manner prescribed by the Arizona Rules of Civil Procedure and pay all costs involved in serving the subpoena.

**C.** A party or the person served with a subpoena who objects to the subpoena, in whole or in part, may file a written objection with the Board within five days after service of the subpoena or at the beginning of the hearing if the subpoena is served fewer than five days before the hearing.

**D.** The Board shall quash or modify a subpoena if:
1. It is unreasonable or oppressive,
2. It requests information that is confidential or privileged, or
3. The desired testimony or evidence can be obtained by an alternative method.

**Historical Note**
New Section R4-24-307 renumbered from R4-24-109 and amended by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). R4-24-307 renumbered to R4-24-308; new Section R4-24-307 renumbered from R4-24-306 and amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-308. Rehearing or Review of Board Decisions**

**A.** The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10.

**B.** Except as provided in subsection (I), a party is required to file a motion for rehearing or review of a decision of the Board to exhaust the party's administrative remedies.

**C.** A party may amend a motion for rehearing or review at any time before the Board rules on the motion.

**D.** The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
1. Irregularity in the proceedings of the Board or any order or abuse of discretion that deprived the moving party of a fair hearing;
2. Misconduct of the Board, its staff, or an administrative law judge;
3. Accident or surprise that could not have been prevented by ordinary prudence;

4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
5. Excessive or insufficient penalty;
6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings; and
7. The findings of fact or decision is not justified by the evidence or is contrary to law.

**E.** The Board may affirm or modify a decision or grant a rehearing or review to any or all of the parties on all or part of the issues for any of the reasons listed in subsection (D). An order modifying a decision or granting a rehearing or review shall specify with particularity the grounds for the order. If a rehearing or review is granted, the rehearing or review shall cover only the matters specified in the order.

**F.** No later than 30 days after making a decision and after giving the parties notice and an opportunity to be heard, the Board may order a rehearing or review on its own initiative for any of the reasons listed in subsection (D). The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion. An order granting a rehearing or review shall specify with particularity the grounds on which the rehearing or review is granted.

**G.** When a motion for rehearing or review is based upon affidavits, the affidavits shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. This period may be extended for not more than 20 days by the Board for good cause as described in subsection (I) or by written stipulation of the parties. The Board may permit reply affidavits.

**H.** If a rehearing is granted, the Board shall hold the rehearing within 60 days after the issue date on the order granting the rehearing.

**I.** If the Board makes a specific finding that immediate effectiveness of a particular decision is necessary for preservation of the public health, safety, or welfare and that rehearing or review is impracticable, unnecessary, or contrary to public interest, the decision may be issued as a final decision without an opportunity for rehearing or review. If an application for judicial review of the decision is made, it shall be made under A.R.S. § 12-901 et seq.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). R4-24-308 renumbered to R4-24-309; new Section R4-24-308 renumbered from R4-24-307 and amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 18 A.A.R. 1858, effective July 10, 2012 (Supp. 12-3).

**R4-24-309. Disciplinary Actions**

**A.** As required by A.R.S. § 39-121.01, a record of Board disciplinary actions, including a decree of censure, is a public record open to public inspection.

**B.** If the Board decides to restrict a license or certificate, the Board shall ensure that the restriction and any required corrective action address the conduct that led to the restriction and protect the public. If the Board decides to require that an individual with a restricted license or certificate be supervised during the period of restriction, the Board shall appoint an unrestricted licensee to provide the supervision.

**C.** A physical therapist or physical therapist assistant whose license or certificate is suspended, revoked, or voluntarily surrendered shall return the license or certificate to the Board within 10 days after receipt of the Board's final order.

**D.** At the end of a period of license or certificate restriction, the Board shall terminate the restriction only if the licensee or certificate holder submits to the Board evidence of having completed all required corrective actions and complied with all terms of the restriction. If the Board believes it will help the Board determine whether to terminate a restriction, the licensee or certificate holder shall appear before the Board.

**E.** An applicant who had a previous license or certificate revoked by the Board shall appear before the Board before the Board acts on the application.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). R4-24-309 renumbered to R4-24-310; new Section R4-24-309 renumbered from R4-24-308 and amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-310. Substance Abuse Recovery Program**

**A.** Under A.R.S. § 32-2044(8), practicing as a physical therapist or working as a physical therapist assistant while mentally or physically impaired is grounds for disciplinary action.

**B.** The Board shall allow an impaired licensee or certificate holder to enter into a substance abuse recovery program rather than conduct a disciplinary proceeding if:

1. The impaired licensee or certificate holder is qualified under A.R.S. § 32-2050(2),
2. The Board believes the proposed program will assist the impaired licensee or certificate holder to recover, and
3. The impaired licensee or certificate holder enters into the written agreement required under A.R.S. § 32-2050(3) and (4).

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3). New Section R4-24-310 renumbered from R4-24-309 and amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-311. Display of License; Disclosure**

**A.** A licensee or certificate holder shall display a copy or provide documentation of the license or certificate and current renewal verification as specified in A.R.S. § 32-2051(G).

**B.** Upon request, a licensee or certificate holder shall inform a member of the public how to file a complaint by providing the address and telephone number of the Board office and a statement that a complaint against a licensee or certificate holder should be directed to the Board.

**C.** Before conducting an evaluation or initiating physical therapy, a licensee shall disclose to a patient when a referring practitioner is deriving direct or indirect compensation from the referral. The licensee shall ensure that the disclosure is in writing and states "Under A.R.S. § 32-2051(C), I am required by law to inform you in writing that your referring physician [or specify if different from a physician] derives either direct or indirect compensation related to your physical therapy."

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3).

**R4-24-312. Mandatory Reporting Requirement**

**A.** As required by A.R.S. § 32-3208, an applicant, licensee, or certificate holder who is charged with a misdemeanor involving conduct that may affect patient safety or a felony shall provide written notice of the charge to the Board within 10 working days after the charge is filed.

**B.** An applicant, licensee, or certificate holder may request a list of reportable misdemeanors from the Board.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 3418, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 18 A.A.R. 1858, effective July 10, 2012 (Supp. 12-3).

**R4-24-313. Professional Standards of Care and Training and Education Qualifications for Delivery of Dry Needling Skilled Intervention**

**A.** Effective July 1, 2015 and in accordance with A.R.S. § 32-2044(25), a physical therapist shall meet the qualifications established in subsection (C) before providing the skilled intervention "dry needling", as defined in A.R.S. § 32-2001(4).

**B.** A physical therapist offering to provide or providing "dry needling" intervention shall provide documented proof of compliance with the qualifications listed in subsection (C) to the board within 30 days of completion of the course content in subsection (C) or within 30 days of initial licensure as a physical therapist in Arizona.

**C.** Course content that meets the training and education qualifications for "dry needling" shall contain all of the following:

1. The course content shall be approved by one or more of the following entities prior to the course(s) being completed by the physical therapist.
   a. Commission On Accreditation In Physical Therapy Education,
   b. American Physical Therapy Association,
   c. State Chapters Of The American Physical Therapy Association,
   d. Specialty Groups Of The American Physical Therapy Association, or
   e. The Federation of State Boards Of Physical Therapy.
2. The course content shall include the following components of education and training:
   a. Sterile needle procedures to include one of the following standards:
      i. The U.S. Centers For Disease Control And Prevention, or
      ii. The U.S. Occupational Safety And Health Administration
   b. Anatomical Review,
   c. Blood Borne Pathogens
   d. Contraindications and indications for "dry needling",
3. The course content required in subsection (C) of this Section shall include, but is not limited to, passing of both a written examination and practical examination before completion of the course content. Practice application course content and examinations shall be done in person to meet the qualifications of subsection (C).
4. The course content required in subsection (C) of this subsection shall total a minimum of 24 contact hours of education.

**D.** The standard of care for the intervention "dry needling" includes, but is not limited to the following:

1. "Dry needling" cannot be delegated to any assistive personnel.
2. Consent for treatment for the intervention "dry needling" is the same as required under R4-24-301.
3. Documentation of the intervention "dry needling" shall be done in accordance with R4-24-304.

**Historical Note**

New Section made by exempt rulemaking at 21 A.A.R. 924, effective July 1, 2015 (Supp. 15-2).

**Appendix A. Repealed**

**Historical Note**

Appendix A adopted effective June 3, 1982 (Supp. 82-3). Amended effective April 10, 1986 (Supp. 86-2). Repealed effective May 7, 1990 (Supp. 90-2)

**Appendix B. Repealed**

**Historical Note**

Appendix B adopted effective June 3, 1982 (Supp. 82-3). Amended effective April 10, 1986 (Supp. 86-2). Repealed effective May 7, 1990 (Supp. 90-2).

## ARTICLE 4. CONTINUING COMPETENCE

**R4-24-401. Continuing Competence Requirements for Renewal**

**A.** Except as provided in subsection (G), a licensed physical therapist shall earn 20 contact hours of continuing competence for each compliance period to be eligible for license renewal.

1. The licensee shall earn at least 10 contact hours from Category A continuing competence activities. No more than five of the required contact hours from Category A may be obtained from nonclinical course work.
2. No change
3. If the licensee's initial license is for one year or less, the licensee shall earn 10 contact hours from Category A continuing competence activities during the initial compliance period. No more than five of the required contact hours from Category A may be obtained from nonclinical course work.

**B.** Except as provided in subsection (G), a certified physical therapist assistant shall earn 10 contact hours of continuing competence for each compliance period to be eligible for certificate renewal.

1. The certificate holder shall earn at least six contact hours from Category A continuing competence activities. No more than three of the required contact hours from Category A may be obtained from nonclinical course work.
2. No more than four contact hours may be earned by the certificate holder during any compliance period from Categories B and C continuing competence activities. No more than two contact hours from Categories B and C may be obtained from nonclinical course work.
3. If the certificate holder's initial certificate is for one year or less, the certificate holder shall earn six contact hours from Category A continuing competence activities during the initial compliance period. No more than three of the required contact hours from Category A may be obtained from nonclinical course work.

**C.** A licensee or certificate holder shall not receive contact hour credit for repetitions of the same activity.

**D.** The continuing competence compliance period for a licensee or certificate holder begins on September 1 following the issuance of an initial or renewal license or certificate and ends on August 31 of even-numbered years.

**E.** A licensee or certificate holder shall not carry over contact hours from one compliance period to another.

**F.** An applicant for renewal shall submit a signed statement to the Board with the renewal application stating whether continuing competence requirements have been fulfilled for the current compliance period.

**G.** The Board may, at its discretion, waive continuing competence requirements on an individual basis for reasons of extreme hardship such as illness, disability, active service in the military, or other extraordinary circumstance as determined by the Board. A licensee or certificate holder who seeks a waiver of the continuing competence requirements shall provide to the Board, in writing, the specific reasons for requesting the waiver and additional information the Board may request in support of the waiver.

**H.** A licensee or certificate holder is subject to Board auditing for continuing competence compliance.
1. Selection for audit shall be random and notice of audit sent within 60 calendar days following the renewal deadline.
2. Within 30 days of receipt of a notice of audit, a licensee or certificate holder shall submit evidence to the Board that shows compliance with the requirements of continuing competence. Documentation of a continuing competence activity shall include:
   a. The date, place, course title, sponsor, schedule, and presenter;
   b. The number of contact hours received for the activity; and
   c. Proof of completion, such as an abstract, certificate of attendance, sign-in log, or other certification of completion.

**I.** A licensee or certificate holder shall retain evidence of participation in a continuing competence activity for two compliance periods after participation.

**J.** The Board shall notify a licensee or certificate holder who has been audited whether the licensee or certificate holder is in compliance with continuing competence requirements. The Board shall provide the notice electronically or by certified mail within 30 working days following the determination by the Board.

**K.** The Board shall provide six months from the date of the notice under subsection (J) for a licensee or certificate holder found not in compliance with continuing competence requirements to satisfy the continuing competence requirements. A licensee or certificate holder may request a hearing to contest the Board's decision under A.R.S. Title 41, Chapter 6, Article 10.

**L.** Penalties for failure to comply with continuing competence requirements may be imposed by the Board under A.R.S § 32-2047 following a hearing conducted under A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-402. Continuing Competence Activities**

**A.** Category A continuing competence activities shall be approved by:
1. An accredited medical, health care, or physical therapy program;
2. A state or national medical, health care, or physical therapy association, or a component of the association; or
3. A national medical, health care, or physical therapy specialty society.

**B.** Category A continuing competence activities include:
1. A physical therapy continuing education course designed to provide necessary understanding of current research, clinical skills, administration, or education related to the practice of physical therapy. Calculation of contact hours is determined by dividing the total minutes of instruction by 60. Breaks shall not be included as part of instructional time;
2. Coursework towards granting or renewal of a physical therapy clinical specialty certification approved by the Board. Each 60 minutes of instruction equals one contact hour;
3. Coursework in a physical therapy clinical residency program. Each 60 minutes of instruction equals one contact hour; and
4. Coursework in a postgraduate physical therapy education from an accredited college or university. Each 60 minutes of instruction equals one contact hour.

**C.** Category B continuing competence activities include:
1. Study group: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. A study group is a structured meeting designed for the study of a clinical physical therapy topic dealing with current research, clinical skills, procedures, or treatment related to the practice of physical therapy.
   b. No change
2. Self instruction: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. Self instruction is a structured course of study relating to one clinical physical therapy topic dealing with current research, clinical skills, procedures, or treatment related to the practice of physical therapy. Self instruction may be directed by a correspondence course, video, internet, or satellite program.
   b. Each 60 minutes of self instruction equals one contact hour.
3. Inservice education: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. Inservice education is attendance at a presentation pertaining to current research, clinical skills, procedures, or treatment related to the practice of physical therapy or relating to patient welfare or safety, including CPR certification.
   b. Each 60 minutes of inservice education equals one contact hour.

**D.** Category C modes of continuing competence include:
1. Physical therapy practice management coursework: Maximum of five contact hours for physical therapists and two contact hours for physical therapist assistants.
   a. Physical therapy practice management course work is course work concerning physical therapy administration, professional responsibility, ethical obligations, or legal requirements applicable to physical therapy practice settings.
   b. If the course is graded, a licensee or certificate holder shall receive a "pass" in a pass/fail course or a minimum of a C in a graded course to receive credit.
   c. Each 60 minutes of practice management coursework equals one contact hour.
2. Teaching or lecturing: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.

a. Teaching or lecturing is the presentation of an original educational program dealing with current research, clinical skills, procedures, treatment, or practice management related to the practice of physical therapy principally for health care professionals. Credit may be earned for teaching when the presentation is accompanied by written materials prepared, augmented, or updated by the presenter including course objectives and program content.
b. One 60 minute instructional period equals 2.5 contact hours.
c. Credit shall be given only once for a presentation within a compliance period.

3. Publication: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
a. Publication includes writing for professional publication, platform, or poster presentation abstracts that have direct application to the practice of physical therapy. Credit may be earned for publication of material that is a minimum of 1500 words in length and published by a recognized third-party publisher of physical therapy material.
b. Each article published in a refereed journal, book chapter, or book equals five contact hours for physical therapists and two contact hours for physical therapist assistants. Articles published in non-refereed journals, magazines, newsletters, or periodicals equal two contact hours for physical therapists and one contact hour for physical therapist assistants.

4. Clinical instruction: Maximum five contact hours for physical therapists and two contact hours for physical therapist assistants.
a. Clinical instruction involves assisting a student physical therapist or physical therapist assistant or a physical therapist resident or fellow acquire clinical skills required of a physical therapist or physical therapist assistant.
b. An individual to whom clinical instruction is provided shall be enrolled in:
i. A physical therapist or physical therapist assistant program accredited by the Commission on Accreditation of Physical Therapy Education; or
ii. A physical therapist residency or fellowship program approved by the American Physical Therapy Association.
c. The program referenced under subsection (D)(4)(b) shall provide the enrolled individual with proof of completing the hours of clinical instruction.
d. Each 120 hours of clinical instruction equals one contact hour.

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

**R4-24-403. Activities Not Eligible for Continuing Competence Credit**
A licensee or certificate holder shall not receive continuing competence credit for the following activities:
1. A regularly scheduled educational opportunity provided within an institution, such as rounds or case conferences;
2. A staff meeting;
3. A publication or presentation by the licensee or certificate holder to a lay or nonprofessional group; and
4. Routine teaching of personnel, students, or staff as part of a job requirement.

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 25 A.A.R. 404, effective April 6, 2019 (Supp. 19-1).

## ARTICLE 5. PUBLIC PARTICIPATION PROCEDURES

**R4-24-501. Expired**

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3).

**R4-24-502. Petition for Rulemaking; Review of Agency Practice or Substantive Policy Statement; Objection to a Section Based Upon Economic, Small Business, or Consumer Impact**
A petition to adopt, amend, or repeal a Section or to review an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule under A.R.S. § 41-1033 or to object to a Section in accordance with A.R.S. § 41-1056.01 shall be filed with the Board as prescribed in this Section. Each petition shall contain:
1. The name and current address of the petitioner;
2. For adoption of a new Section, specific language of the proposed new Section;
3. For amendment of a current Section, citation for the applicable Arizona Administrative Code Section number and heading of the current Section and the specific language of the current Section with language to be deleted stricken and new language underlined;
4. For the repeal of a current Section, citation for the applicable A.A.C. Section number and heading of the Section proposed for repeal;
5. The reasons a Section should be adopted, amended, or repealed, and if in reference to an existing Section, why the Section is inadequate, unreasonable, unduly burdensome, or otherwise not acceptable. The petitioner may provide additional supporting information, including:
a. Statistical data or other justification, with clear reference to an attached exhibit;
b. Identification of what person or segment of the public would be affected and how the person or segment would be affected; and
c. If the petitioner is a public agency, a summary of a relevant issue raised in any public hearing, or as a written comment offered by the public;
6. For a review of an existing Board practice or substantive policy statement alleged to constitute a rule, the reason the existing Board practice or substantive policy statement constitutes a rule and the proposed action requested of the Board;
7. For an objection to a Section based upon the economic, small business, or consumer impact, evidence that:
a. The actual economic, small business, or consumer impact significantly exceeded the impact estimated in the economic, small business, and consumer impact statement submitted during the making of the Section;
b. The actual economic, small business, or consumer impact was not estimated in the economic, small

business, and consumer impact statement submitted during the making of the Section and that actual impact imposes a significant burden on a person subject to the Section; or

c. The agency did not select the alternative that imposes the least burden and costs to persons regulated by the Section, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective; and

8. The signature of the person submitting the petition.

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 18 A.A.R. 1858, effective July 10, 2012 (Supp. 12-3).

**R4-24-503. Expired**

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3).

**R4-24-504. Expired**

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3).

**R4-24-505. Expired**

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3).

**R4-24-506. Written Criticism of Rule**

**A.** Any person may file a written criticism of an existing rule with the Board.

**B.** The criticism shall clearly identify the rule and specify why the existing rule is inadequate, unduly burdensome, unreasonable, or otherwise improper.

**C.** The Board shall acknowledge receipt of a criticism within 15 days and shall place the criticism in the official record for review by the Board under A.R.S. § 41-1056.

**Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 2399, effective June 9, 2000 (Supp. 00-2).

As of October 28, 2024

32-2001. Definitions

In this chapter, unless the context otherwise requires:

1. "Assistive personnel":

(a) Includes:

(i) Physical therapist assistants.

(ii) Physical therapy aides.

(iii) Other assistive personnel who are trained or educated health care providers and who are not physical therapist assistants or physical therapy aides but who perform specific designated tasks related to physical therapy under the supervision of a physical therapist. At the discretion of the supervising physical therapist, and if properly credentialed and not prohibited by any other law, other assistive personnel may be identified by the title specific to their training or education.

(b) Does not include either:

(i) Personnel assisting other health care professionals licensed pursuant to this title in performing delegable treatment responsibilities within their scope of practice.

(ii) Student physical therapists and student physical therapist assistants.

2. "Board" means the board of physical therapy.

3. "Business entity" means a business organization that has an ownership that includes any persons who are not licensed or certified to provide physical therapy services in this state, that offers to the public professional services regulated by the board and that is established pursuant to the laws of any state or foreign country.

4. "Dry needling" means a skilled intervention performed by a physical therapist that uses a thin filiform needle to penetrate the skin and stimulate underlying neural, muscular and connective tissues to evaluate and manage neuromusculoskeletal conditions, pain and movement impairments.

5. "General supervision":

(a) Means that the supervising physical therapist is on call and is readily available via telecommunications when the physical therapist assistant is providing treatment interventions.

(b) Includes supervision provided through telehealth as defined in section 36-3601.

6. "Interim permit" means a permit issued by the board that allows a person to practice as a physical therapist in this state or to work as a physical therapist assistant for a specific period of time and under conditions prescribed by the board before that person is issued a license.

7. "Manual therapy techniques" means a broad group of passive interventions in which physical therapists use their hands to administer skilled movements designed to modulate pain, increase joint range of motion, reduce or eliminate soft tissue swelling, inflammation or restriction, induce relaxation, improve contractile and noncontractile tissue extensibility, and improve pulmonary function. These interventions involve a variety of techniques, such as the application of graded forces.

8. "On-site supervision" means that the supervising physical therapist is on-site and is present in the facility or on the campus where assistive personnel, a holder of an interim permit, a student physical therapist or a student physical therapist assistant is performing services, is immediately available to assist

the person being supervised in the services being performed and maintains continued involvement in appropriate aspects of each treatment session in which a component of treatment is delegated.

9. "Physical therapist" means a person who is licensed pursuant to this chapter.

10. "Physical therapist assistant" means a person who meets the requirements of this chapter for licensure and who performs physical therapy procedures according to the physical therapy plan of care of the supervising physical therapist.

11. "Physical therapy" means the care and services provided by or under the direction and supervision of a physical therapist who is licensed pursuant to this chapter.

12. "Physical therapy aide" means a person who is trained under the direction of a physical therapist and who performs designated and supervised routine physical therapy tasks.

13. "Practice of physical therapy" means:

(a) Examining, evaluating and testing persons who have mechanical, physiological and developmental impairments, functional limitations and disabilities or other health and movement related conditions in order to determine a diagnosis, a prognosis and a plan of therapeutic intervention and to assess the ongoing effects of intervention, including ordering imaging.

(b) Alleviating impairments and functional limitations by managing, designing, implementing and modifying therapeutic interventions including:

(i) Therapeutic exercise.

(ii) Functional training in self-care and in home, community or work reintegration.

(iii) Manual therapy techniques.

(iv) Therapeutic massage.

(v) Assistive and adaptive orthotic, prosthetic, protective and supportive devices and equipment.

(vi) Pulmonary hygiene.

(vii) Debridement and wound care.

(viii) Physical agents or modalities.

(ix) Mechanical and electrotherapeutic modalities.

(x) Patient related instruction.

(c) Reducing the risk of injury, impairments, functional limitations and disability by means that include promoting and maintaining a person's fitness, health and quality of life.

(d) Engaging in administration, consultation, education and research.

14. "Restricted license" means a license on which the board places restrictions or conditions, or both, as to the scope of practice, place of practice, supervision of practice, duration of licensed status or type or condition of a patient to whom the licensee may provide services.

15. "Restricted registration" means a registration on which the board places any restrictions as the result of disciplinary action.

16. "Student physical therapist" means a person who is enrolled in a doctor of physical therapy program that is accredited by or has candidate status by the commission on accreditation in physical therapy education.

17. "Student physical therapist assistant" means a person who is enrolled in an academic physical therapist assistant program that is accredited by or has candidate status by the commission on accreditation in physical therapy education.

32-2002. Board of physical therapy; membership; appointment; qualifications; terms; removal; reimbursement; immunity

A. The board of physical therapy is established consisting of members appointed by the governor pursuant to section 38-211. Four members shall be physical therapists who are residents of this state, possess an unrestricted license to practice physical therapy in this state and have been practicing in this state for at least five years before their appointment. One member shall be a physical therapist assistant who is a resident of this state, possesses an unrestricted license issued pursuant to this chapter and has been performing selected interventions in this state for at least five years before the person's appointment. The governor shall also appoint two public members who are residents of this state and who are not affiliated with, and do not have a financial interest in, any health care profession but who have an interest in consumer rights.

B. Board members serve staggered four-year terms. Board members shall not serve for more than two successive four-year terms or for more than ten consecutive years. By approval of a majority of the board, a member's service may extend at the completion of a four-year term until a new member is appointed or the current member is reappointed.

C. If requested by the board the governor may remove a board member for misconduct, incompetence or neglect of duty.

D. Board members are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2 to cover necessary expenses for attending each board meeting or for representing the board in an official board approved activity.

E. A board member who acts within the scope of board duties, without malice and in the reasonable belief that the person's action is warranted by law is immune from civil liability.

32-2003. Board; powers and duties

A. The board shall:

1. Evaluate the qualifications of applicants for licensure.

2. Provide for national examinations for physical therapists and physical therapist assistants and adopt passing scores for these examinations.

3. Issue licenses and permits to persons who meet the requirements of this chapter.

4. Regulate the practice of physical therapy by interpreting and enforcing this chapter.

5. Adopt and revise rules to enforce this chapter.

6. Meet at least once each quarter in compliance with the open meeting requirements of title 38, chapter 3, article 3.1 and keep an official record of these meetings.

7. Establish the mechanisms for assessing continuing professional competence of physical therapists to engage in the practice of physical therapy and the competence of physical therapist assistants to work in the field of physical therapy.

8. At its first regular meeting after the start of each calendar year, elect officers from among its members and as necessary to accomplish board business.

9. Provide for the timely orientation and training of new professional and public appointees to the board regarding board licensing and disciplinary procedures, this chapter, board rules and board procedures.

10. Maintain a current list of all persons regulated under this chapter. This list shall include the person's name, current business and residential addresses, telephone numbers and license number.

11. Subject to title 41, chapter 4, article 4, employ necessary personnel to carry out the administrative work of the board. Board personnel are eligible to receive compensation pursuant to section 38-611.

12. Enter into contracts for services necessary for adequate enforcement of this chapter.

13. Report final disciplinary action taken against a licensee to a national disciplinary database recognized by the board.

14. Publish, at least annually, final disciplinary actions taken against a licensee.

15. Publish, at least annually, board rulings, opinions and interpretations of statutes or rules in order to guide persons who are regulated pursuant to this chapter.

16. Not later than December 31 of each year, submit a written report of its actions and proceedings to the governor.

17. Establish and collect fees.

18. Provide information to the public regarding the board, its processes and consumer rights.

B. The board may establish a committee or committees to assist it in carrying out its duties for a time prescribed by the board. The board may require a committee appointed pursuant to this subsection to make regular reports to the board.

32-2004. Board of physical therapy fund

(L24, Ch. 222, sec. 29. Eff. until 7/1/28)

A. The board of physical therapy fund is established. The board shall administer the fund.

B. Except as provided in section 32-2048, pursuant to sections 35-146 and 35-147, the board shall deposit fifteen percent of all monies collected under this chapter in the state general fund and deposit the remaining eighty-five percent in the board of physical therapy fund.

C. Monies deposited in the physical therapy fund are subject to section 35-143.01.

32-2004. Board of physical therapy fund

(L24, Ch. 222, sec. 30. Eff. 7/1/28)

A. The board of physical therapy fund is established. The board shall administer the fund.

B. Except as provided in section 32-2048, pursuant to sections 35-146 and 35-147, the board shall deposit ten percent of all monies collected under this chapter in the state general fund and deposit the remaining ninety percent in the board of physical therapy fund.

C. Monies deposited in the physical therapy fund are subject to section 35-143.01.

32-2021. Persons and activities not required to be licensed

A. This chapter does not restrict a person who is licensed under any other law of this state from engaging in the profession or practice for which that person is licensed if that person does not claim to be a physical therapist or a provider of physical therapy.

B. This chapter does not restrict the use of physical agents, modalities or devices by persons qualified under this title to personally render or delegate the use of this treatment.

C. The following persons are exempt from the licensure requirements of this chapter:

1. A person in a professional education program approved by the board who is satisfying supervised clinical education requirements related to the person's physical therapist or physical therapist assistant education while under the on-site supervision of a physical therapist.

2. A physical therapist who is practicing or a physical therapist assistant who is working in the United States armed services, United States public health service or veterans administration pursuant to federal regulations for state licensure of health care providers.

3. A physical therapist who is licensed in another jurisdiction of the United States or a foreign educated physical therapist credentialed in another country if that person is performing physical therapy in connection with teaching or participating in an educational seminar for not more than sixty days in any twelve month period.

4. A physical therapist who is licensed in another jurisdiction of the United States or who is credentialed in another country if that person by contract or employment is providing physical therapy to persons who are affiliated with or employed by established athletic teams, athletic organizations or performing arts companies temporarily practicing, competing or performing in this state for not more than sixty days in a calendar year.

5. A physical therapist who is licensed in another jurisdiction of the United States and who enters this state to provide physical therapy to victims of a declared local, state or national disaster or emergency. This exemption applies for the duration of the declared emergency but not longer than sixty days. The physical therapist must also register with the board before practicing.

32-2022. Qualifications for licensure; fingerprint clearance card

A. An applicant for a license as a physical therapist who has been educated in the United States shall:

1. Complete the application process.

2. Be a graduate of a professional physical therapy education program that is accredited by a national accreditation agency approved by the board.

3. Have successfully passed the national examination approved by the board.

4. Have successfully passed a jurisprudence examination that tests the applicant's knowledge of board statutes and rules.

5. Obtain a valid fingerprint clearance card issued pursuant to section 41-1758.03.

B. An applicant for a license as a physical therapist who has been educated outside of the United States shall:

1. Complete the application process.

2. Provide satisfactory evidence that the applicant's education is substantially equivalent to the requirements of physical therapists educated in accredited educational programs as determined by the board. If the board determines that a foreign-educated applicant's education is not substantially equivalent, it may require the person to complete additional coursework before it proceeds with the application process. It is not necessary that coursework completed by the applicant be identical in all respects to that required by an education program in the United States for an entry-level physical therapy degree, but all required content areas must be evident as required by board rules. Deficiencies may occur only in coursework and not in essential areas of professional education and shall not be of a magnitude that would cause the education to be deemed below entry-level preparation for practice in this state.

3. Provide written proof of legal authorization to practice as a physical therapist without limitation in the country where the professional education occurred. The board may waive this requirement on receipt of written proof that the applicant cannot demonstrate legal authorization based on the citizenship requirements of the country where the professional education occurred.

4. Provide proof of legal authorization to reside and seek employment in the United States or its territories.

5. Have passed the board-approved English proficiency examinations if the applicant's native language is not English.

6. Have participated in an interim supervised clinical practice period before licensure as approved by the board or shall have already met this requirement to the board's satisfaction by virtue of the applicant's clinical practice in another jurisdiction of the United States.

7. Have successfully passed the national examination approved by the board.

8. Have successfully passed a jurisprudence examination that tests the applicant's knowledge of board statutes and rules.

9. Obtain a valid fingerprint clearance card issued pursuant to section 41-1758.03.

C. Notwithstanding the requirements of subsection B of this section, if the foreign-educated physical therapist applicant is a graduate of an accredited educational program as determined by the board, the board may waive the requirements of subsection B, paragraphs 2 and 6 of this section.

D. An applicant for licensure as a physical therapist assistant shall meet the following requirements:

1. Complete the application process.

2. Be a graduate of a physical therapist assistant education program accredited by an agency approved by the board.

3. Have successfully passed the national examination approved by the board.

4. Have successfully passed a jurisprudence examination that tests the applicant's knowledge of board statutes and rules.

5. Obtain a valid fingerprint clearance card issued pursuant to section 41-1758.03.

E. For the purposes of subsection B, paragraph 2 of this section, "substantially equivalent" means that the applicant provides documentation satisfactory to the board that:

1. The applicant graduated from a physical therapist education program that prepares the applicant to engage without restriction in the practice of physical therapy.

2. The applicant's school of physical therapy education is recognized by its own ministry of education. The board may waive this requirement for good cause shown.

3. The applicant has undergone a credentials evaluation as directed by the board that determines that the applicant has met uniform criteria for educational requirements pursuant to board rules.

4. The applicant has completed any additional education required by the board.

### 32-2023. Application; denial; hearing

A. An applicant for licensure shall file a completed application as required by the board. The applicant shall include the application fee prescribed in section 32-2029.

B. The board may deny a license to an applicant or a licensee for any of the following:

1. Knowingly making a false statement of fact required to be revealed in the initial application, renewal application or reinstatement application for a license.

2. Committing fraud in the procurement of a license.

3. Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case conviction by a court of competent jurisdiction is conclusive evidence of the commission.

4. Attempting to engage in conduct that subverts or undermines the integrity of the examination or the examination process, including using in any manner recalled or memorized examination questions from or with a person or entity, failing to comply with all test center security procedures, communicating or attempting to communicate with other examinees during the examination or copying or sharing examination questions or portions of questions.

5. Engaging in any conduct that would be considered a violation of section 32-2044.

C. If the board denies an application because of deficiencies or reasons in an application or for a reason prescribed in subsection B of this section, the board must inform an applicant of those specific deficiencies. On receipt of a written request by an applicant who disagrees with the board's decision to deny an application, the board shall hold a hearing pursuant to title 41, chapter 6, article 10.

### 32-2024. Examinations

A. The board shall prescribe examinations for licensure and determine the passing score.

B. An applicant may take the examinations for licensure if either of the following applies:

1. The applicant has met all of the requirements of section 32-2022, subsection A, paragraphs 1 and 2 and has paid the fees prescribed by this chapter.

2. The applicant has:

(a) Met all of the requirements of section 32-2022, subsection A, paragraph 1.

(b) Paid the fees prescribed by this chapter.

(c) Submitted with the application a letter on the official letterhead of the accredited educational institution where the applicant is completing an accredited educational program that includes the signature

of the program director, the department chairperson or a similarly authorized person of the university or college and that states that:

(i) The applicant is a candidate for a degree as a physical therapist at the next scheduled graduation date.

(ii) The date the national examination for licensure is to be taken by the applicant is the one nearest to and before the applicant's expected graduation date and is not more than one hundred twenty days before the date of the applicant's expected graduation date.

(iii) The applicant meets any other established requirements of the accredited educational program, if applicable.

C. An applicant may take the examinations for licensure if the applicant has met all of the requirements of section 32-2022, subsection B, paragraphs 1 through 5 and has paid the fees prescribed by this chapter.

D. An applicant may take the examinations for licensure if either of the following applies:

1. The applicant has met all of the requirements of section 32-2022, subsection D, paragraphs 1 and 2 and has paid the fees prescribed by this chapter.

2. The applicant has:

(a) Met all of the requirements of section 32-2022, subsection D, paragraph 1.

(b) Paid the fees prescribed by this chapter.

(c) Submitted with the application a letter on the official letterhead of the accredited educational institution where the applicant is completing an accredited educational program that includes the signature of the program director, the department chairperson or a similarly authorized person of the university, school or college and that states that:

(i) The applicant is a candidate for a certificate or degree as a physical therapist assistant at the next scheduled graduation date.

(ii) The date the national examination for licensure is to be taken by the applicant is the one nearest to and before the applicant's expected graduation date and is not more than one hundred twenty days before the date of the applicant's expected graduation date.

(iii) The applicant meets any other established requirements of the accredited educational program, if applicable.

E. An applicant for licensure who does not pass the national examination after the first attempt may retake the examination one additional time within six months after the first failure without reapplication for licensure. An applicant may retake the examinations as prescribed by the organization that administers the examinations.

F. The board shall not issue a license to a person who passes an examination through fraud.

G. The national examination for licensure as a physical therapist shall test entry-level competence related to physical therapy theory, examination and evaluation, diagnosis, prognosis, treatment intervention, prevention and consultation. The national examination for licensure as a physical therapist assistant shall test for requisite knowledge and skills in the technical application of physical therapy services.

32-2025. Interim permits

A. If a foreign educated applicant satisfies the requirements of section 32-2022, subsection B, before the board issues a license it shall issue an interim permit to the applicant for the purpose of participating in a

supervised clinical practice period. An applicant who fails the national examination is not eligible for an interim permit until the applicant passes the examination.

B. If an applicant who has been educated in the United States satisfies the requirements of section 32-2022, subsection A or D, but the board determines that there is evidence that the applicant lacks the competence to practice as a physical therapist or work as a physical therapist assistant, the board shall issue an interim permit to the applicant to allow that person to participate in a supervised clinical practice.

C. The board may issue an interim permit for at least ninety days but not more than six months.

D. An interim permit holder shall complete, to the satisfaction of the board, a period of clinical practice in a facility approved by the board and under the continuous and on-site supervision of a physical therapist who holds an unrestricted license issued pursuant to this chapter.

E. At any time during an interim supervised clinical practice period, the board may revoke an interim permit because of the permit holder's incompetence or for a violation of this chapter. Pursuant to title 41, chapter 6, article 10, the board shall hold a hearing on request of a permit holder whose permit is revoked.

32-2026. Licensure by endorsement

A. The board shall issue a license to a physical therapist who has a valid unrestricted license from another jurisdiction of the United States if that person, when granted the license, met all of the requirements prescribed in section 32-2022, subsection A or B and any applicable board rules.

B. The board shall issue a license to a physical therapist assistant who has a valid unrestricted license or certificate from another jurisdiction of the United States if that person, when granted the license or certificate, met all of the requirements prescribed in section 32-2022, subsection D and any applicable board rules.

32-2027. License renewal; suspension

A. A licensee shall renew the license pursuant to board rules. Except as provided in section 32-4301, a licensee who fails to renew the license on or before its expiration date shall not practice as a physical therapist or work as a physical therapist assistant in this state.

B. The board shall administratively suspend a license if the licensee does not submit a complete application for renewal and pay the renewal fee pursuant to board rules.

32-2028. Reinstatement of license

A. The board may reinstate a license that it suspended pursuant to section 32-2027, subsection B on payment of a renewal fee and reinstatement fee and completion of the application process as prescribed by the board.

B. If a person's license has been suspended pursuant to section 32-2027, subsection B for more than three consecutive years, the license expires and that person shall reapply for a license pursuant to section 32-2022 or 32-2026 and pay all applicable fees. The person must also demonstrate to the board's satisfaction competency by satisfying one or more of the following as prescribed by the board:

1. Practicing for a specified time under an interim permit.

2. Completing remedial courses.

3. Completing continuing competence requirements for the period of the lapsed license.

4. Passing an examination.

## 32-2029. Fees

The board shall establish and collect fees of not more than:

1. $300 for an application for an original license. This fee is nonrefundable.

2. $300 for a certificate of renewal of a license.

3. $300 for an application for reinstatement of licensure.

4. $50 for each duplicate license.

## 32-2030. Business entities; patient records; protocol; exemptions; rules

A. A business entity shall not offer physical therapy services pursuant to this chapter unless:

1. The business entity is registered with the board pursuant to this section.

2. The physical therapy services are conducted by a licensee pursuant to this chapter.

B. The business entity must file a registration application on a form prescribed by the board. The application shall include:

1. A description of the entity's services offered to the public.

2. The name of the manager who is authorized and who is responsible for managing the physical therapy services offered at each office.

3. The names and addresses of the officers and directors of the business entity.

4. A registration fee prescribed by the board by rule.

C. A business entity must file a separate registration application and pay a fee for each branch office in this state.

D. A registration expires on August 31 of odd-numbered years in accordance with the physical therapist professional licensing schedule. A business entity that wishes to renew a registration must submit an application for renewal as prescribed by the board on a biennial basis on a form prescribed by the board before the expiration date. An entity that fails to renew the registration before the expiration date is subject to a late fee as prescribed by the board by rule.

E. The business entity must notify the board in writing within thirty days after any change:

1. In the business entity's name, address or telephone number.

2. In the officers or directors of the business entity.

3. In the name of the manager who is authorized and who is responsible for managing the physical therapy services in any facility.

F. The business entity must establish and implement a written protocol for the secure storage, transfer and access of the physical therapy records of the business entity's patients. This protocol must include, at a minimum, procedures for:

1. Notifying patients of the future locations of their records if the business entity terminates or sells the practice.

2. Disposing of unclaimed physical therapy records.

3. The timely response to requests by patients for copies of their records.

G. The business entity must notify the board within thirty days after the dissolution of any registered business entity or the closing or relocation of any facility and must disclose to the board the entity's procedure by which its patients may obtain their records.

H. This section does not apply to:

1. A sole proprietorship or partnership that consists exclusively of persons who are licensed by a health profession regulatory board as defined in section 32-3201.

2. A facility regulated by the federal government or a state, district or territory of the United States.

3. An administrator or executor of the estate of a deceased physical therapist or a person who is legally authorized to act for a physical therapist who has been adjudicated to be mentally incompetent for not more than one year from the date the board receives notice of the physical therapist's death or incapacitation.

4. A health care institution that is licensed pursuant to title 36.

I. A facility that offers physical therapy services to the public by persons licensed under this chapter must be registered by the board unless the facility is any of the following:

1. Owned by a licensee.

2. Regulated by the federal government or a state, district or territory of the United States.

J. Except for issues relating to insurance coding and billing that require the name, signature and license number of the physical therapist providing treatment, this section does not:

1. Authorize a licensee in the course of providing physical therapy services for an entity registered pursuant to this section to disregard or interfere with a policy or practice established by the entity for the operation and management of the business.

2. Authorize a business entity registered pursuant to this section to establish or enforce a business policy or practice that may interfere with the professional judgment of the licensee in providing physical therapy services for the business entity or may compromise a licensee's ability to comply with this chapter.

K. The board shall adopt rules that provide a method for the board to receive the assistance and advice of business entities registered pursuant to this section in all matters relating to the regulation of business entities.

L. The board shall adopt rules necessary to enforce this chapter in the practice settings of its licensees and registrants if the practice settings are not regulated by the department of health services.

32-2031. Retired status; reinstatement to active status

A. The board shall place a licensee on retired status and waive the renewal fee and continuing competence requirements if a licensee presents a written affidavit to the board that the licensee has retired from the practice of physical therapy or from work as a physical therapist assistant, is in good standing with the board and has paid all fees required by this chapter before the waiver.

B. During the period of waiver pursuant to subsection A of this section, the retired licensee may not engage in the practice of physical therapy or work as a physical therapist assistant.

C. A retired licensee must renew the retired license every two years by verifying the person's contact information and using the same schedule for renewal of an active license. The board may not charge a fee for renewal of a retired license.

D. If a licensee fails to renew the retired status of the license on or before its expiration date, the retired license expires. If the person seeks to reinstate the person's retired status after the retired license has expired, the person must make a request for retired status pursuant to subsection A of this section.

E. The board may reinstate a retired licensee to active practice or work on payment of the renewal fee and presentation of evidence satisfactory to the board that the retired licensee is professionally able to engage in the practice of physical therapy or work as a physical therapist assistant and still possesses the professional knowledge required. If the retired licensee has held a retired license for more than three consecutive years, the person must also demonstrate competency to the board's satisfaction by satisfying one or more of the following as prescribed by the board:

1. Practicing or working for a specified time under an interim permit.

2. Completing remedial courses.

3. Completing continuing competence requirements for the period of the retired license.

4. Passing an examination as prescribed by the board.

32-2032. Inactive status; reinstatement to active status

A. The board shall place a licensee on inactive status and waive the continuing competence requirements if a licensee presents a written affidavit to the board that the licensee is not currently engaged in the practice of physical therapy or working as a physical therapist assistant in this state, is in good standing with the board and has paid all fees required by this chapter.

B. During the period of inactive status pursuant to subsection A of this section, the inactive licensee may not engage in the practice of physical therapy or work as a physical therapist assistant in this state.

C. A licensee on inactive status must renew the inactive license every two years using the same schedule for renewal of an active license. The board by rule shall prescribe the fee for the renewal of an inactive license.

D. An inactive licensee who applies to the board for reinstatement to active licensure within three years after the date the board issues a notice of inactive status must submit the full annual renewal fee and prove to the board's satisfaction that the licensee has met continuing competence requirements as prescribed by the board by rule.

E. An inactive licensee who applies to the board for reinstatement to active licensure and who has not been actively engaged in the practice of physical therapy or working as a physical therapist assistant in this state for more than three consecutive years after the date the board issues a notice of inactive status must submit the full annual renewal fee and demonstrate competency to the board's satisfaction by satisfying one or more of the following as prescribed by the board:

1. Practicing or working for a specified time under an interim permit.

2. Completing remedial courses.

3. Completing continuing competence requirements for the period of the inactive license.

4. Passing an examination.

32-2041. Lawful practice

A. A physical therapist shall refer a client to appropriate health care practitioners if the physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of practice or if physical therapy is contraindicated.

B. A physical therapist shall adhere to the recognized standards of ethics of the physical therapy profession and as further established by rule.

C. A physical therapist licensed under this chapter shall practice physical therapy as prescribed by this chapter.

32-2041.01. Musculoskeletal imaging; ordering; requirements; reporting

A. A physical therapist may order musculoskeletal imaging consisting of plain film radiographs. The imaging shall be performed by a health care practitioner who is authorized pursuant to this title to perform the imaging and shall be interpreted by a physician who is licensed pursuant to chapter 13, 14 or 17 of this title and trained in radiology interpretation.

B. A physical therapist shall report results for all imaging tests the physical therapist orders pursuant to subsection A of this section to the patient's health care practitioner of record or the referring health care practitioner, if designated, within seven days after receiving the results. If the patient does not have a health care practitioner of record, the physical therapist shall refer the patient to an appropriate health care practitioner if the physical therapist has reasonable cause to believe that any symptoms or conditions are present that may require services beyond the physical therapist's scope of practice.

32-2042. Use of titles; restrictions; violation; classification

A. A physical therapist shall use the letters "PT" in connection with the physical therapist's name or place of business to denote licensure under this chapter. A physical therapist on retired status shall use "(retired)" or "(ret.)" after the letters "PT" in connection with the physical therapist's name or place of business to denote the physical therapist's retired status pursuant to section 32-2031.

B. A physical therapist assistant shall use the letters "PTA" in connection with that person's name to denote licensure pursuant to this chapter. A physical therapist assistant on retired status shall use "(retired)" or "(ret.)" after the letters "PTA" in connection with the physical therapist assistant's name or place of business to denote the physical therapist assistant's retired status pursuant to section 32-2031.

C. A person or business entity or its employees, agents or representatives shall not use in connection with that person's name or the name or activity of the business the words "physical therapy", "physical therapist", "physiotherapy", "physiotherapist" or "registered physical therapist", the letters "PT", "LPT", "RPT", "MPT", "DScPT" or "DPT" or any other words, abbreviations or insignia indicating or implying directly or indirectly that physical therapy is provided or supplied, including the billing of services labeled as physical therapy, unless these services are provided by or under the direction of a physical therapist who is licensed pursuant to this chapter. A person or entity that violates this subsection is guilty of a class 1 misdemeanor.

D. A person or business entity shall not advertise, bill or otherwise promote a person who is not licensed pursuant to this chapter as being a physical therapist or offering physical therapy services.

E. A person shall not use the title "physical therapist assistant" or use the letters "PTA" in connection with that person's name or any other words, abbreviations or insignia indicating or implying directly or indirectly that the person is a physical therapist assistant unless that person is licensed as a physical therapist assistant pursuant to this chapter. A person who violates this subsection is guilty of a class 1 misdemeanor.

32-2043. Supervision; patient care management

A. A physical therapist is responsible for patient care given by assistive personnel, student physical therapists and student physical therapist assistants under the physical therapist's supervision. A physical therapist may delegate to assistive personnel and supervise selected acts, tasks or procedures that fall

within the scope of physical therapy practice but that do not exceed the education or training of the assistive personnel.

B. A physical therapist assistant who is licensed pursuant to this chapter may provide physical therapy services under the general supervision of a physical therapist who is licensed pursuant to this chapter.

C. A physical therapy aide and other assistive personnel shall perform designated routine tasks only under the on-site supervision of a licensed physical therapist.

D. A licensed physical therapist must provide on-site supervision of an interim permit holder.

E. A physical therapist student and a physical therapist assistant student must practice under the on-site supervision of a licensed physical therapist.

F. A physical therapist is responsible for managing all aspects of the physical therapy care of each patient. A physical therapist must provide:

1. The initial evaluation of and documentation for a patient.

2. Periodic reevaluation of and documentation for a patient.

3. The documented discharge of a patient, including the response to therapeutic intervention at the time of discharge.

G. A physical therapist must verify the qualifications of physical therapist assistants and other assistive personnel under the physical therapist's direction and supervision.

H. For each patient on each date of service, a physical therapist must provide and document all of the therapeutic intervention that requires the expertise of a physical therapist to ensure the delivery of care that is safe, effective and efficient. Documentation for each date of service must be as prescribed by the board by rule.

I. A physical therapist assistant must document care provided but may do so without the cosignature of the supervising physical therapist if the physical therapist complies with the requirements of subsections G and H of this section.

J. A physical therapist's responsibility for patient care management includes accurate documentation and billing of the services provided.

32-2044. Grounds for disciplinary action

The following are grounds for disciplinary action:

1. Violating this chapter, board rules or a written board order.

2. Practicing or offering to practice beyond the scope of the practice of physical therapy.

3. Obtaining or attempting to obtain a license by fraud or misrepresentation.

4. Engaging in the performance of substandard care by a physical therapist due to a deliberate or negligent act or failure to act regardless of whether actual injury to the patient is established.

5. Engaging in the performance of substandard care by a physical therapist assistant, including exceeding the authority to perform tasks selected and delegated by the supervising licensee regardless of whether actual injury to the patient is established.

6. Failing to supervise assistive personnel, physical therapy students or interim permit holders in accordance with this chapter and rules adopted pursuant to this chapter.

7. Conviction of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case conviction by a court of competent jurisdiction is conclusive evidence of the commission and the board may take disciplinary action when the time for appeal has lapsed, when the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order. For the purposes of this paragraph, "conviction" means a plea or verdict of guilty or a conviction following a plea of nolo contendere.

8. Practicing as a physical therapist or working as a physical therapist assistant when physical or mental abilities are impaired by disease or trauma, by the use of controlled substances or other habit-forming drugs, chemicals or alcohol or by other causes.

9. Having had a license or certificate revoked or suspended or other disciplinary action taken or an application for licensure or certification refused, revoked or suspended by the proper authorities of another state, territory or country.

10. Engaging in sexual misconduct. For the purposes of this paragraph, "sexual misconduct" includes:

(a) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual, while a provider-patient relationship exists.

(b) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature with patients.

(c) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

11. Directly or indirectly requesting, receiving or participating in the dividing, transferring, assigning, rebating or refunding of an unearned fee or profiting by means of any credit or other valuable consideration such as an unearned commission, discount or gratuity in connection with the furnishing of physical therapy services. This paragraph does not prohibit the members of any regularly and properly organized business entity recognized by law and composed of physical therapists from dividing fees received for professional services among themselves as they determine necessary to defray their joint operating expense.

12. Failing to adhere to the recognized standards of ethics of the physical therapy profession.

13. Charging unreasonable or fraudulent fees for services performed or not performed.

14. Making misleading, deceptive, untrue or fraudulent representations in violation of this chapter or in the practice of the profession.

15. Having been adjudged mentally incompetent by a court of competent jurisdiction.

16. Aiding or abetting a person who is not licensed in this state and who directly or indirectly performs activities requiring a license.

17. Failing to report to the board any direct knowledge of an unprofessional, incompetent or illegal act that appears to be in violation of this chapter or board rules.

18. Interfering with an investigation or disciplinary proceeding by failing to cooperate, by wilful misrepresentation of facts or by the use of threats or harassment against any patient or witness to prevent the patient or witness from providing evidence in a disciplinary proceeding or any legal action.

19. Failing to maintain patient confidentiality without prior written consent of the patient or unless otherwise required by law.

20. Failing to maintain adequate patient records. For the purposes of this paragraph, "adequate patient records" means legible records that comply with board rules and that contain at a minimum an evaluation of objective findings, a diagnosis, the plan of care, the treatment record, a discharge summary and sufficient information to identify the patient.

21. Promoting an unnecessary device, treatment intervention or service for the financial gain of the practitioner or of a third party.

22. Providing treatment intervention unwarranted by the condition of the patient or treatment beyond the point of reasonable benefit.

23. Failing to report to the board a name change or a change in business or home address within thirty days after that change.

24. Failing to complete continuing competence requirements as established by the board by rule.

25. Failing to demonstrate professional standards of care and training and education qualifications, as established by the board by rule, in the performance of dry needling when provided as a therapeutic modality.

32-2045. Investigative powers; emergency action

A. To enforce this chapter the board may:

1. Receive complaints filed against licensees or certificate holders and conduct a timely investigation.

2. Conduct an investigation at any time and on its own initiative without receipt of a written complaint if the board has reason to believe that there may be a violation of this chapter.

3. Issue subpoenas to compel the attendance of any witness or the production of any documentation relative to a case.

4. Take emergency action ordering the summary suspension of a license or certificate or the restriction of the licensee's practice or certificate holder's employment pending proceedings by the board.

5. Require a licensee or certificate holder to be examined in order to determine the licensee's or certificate holder's mental, physical or professional competence to practice or work in the field of physical therapy.

B. If the board finds that the information received in a complaint or an investigation is not of sufficient seriousness to merit direct action against the licensee or certificate holder it may take either of the following actions:

1. Dismiss the complaint if the board believes the information or complaint is without merit.

2. Issue an advisory letter. The issuance of an advisory letter is a nondisciplinary action to notify a licensee or certificate holder that, while there is not sufficient evidence to merit disciplinary action, the board believes that the licensee or certificate holder should be educated about the requirements of this chapter and board rules. An advisory letter is a public document and may be used in future disciplinary actions against a licensee or certificate holder.

3. Issue a nondisciplinary order requiring the licensee or certificate holder to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee or certificate holder with the necessary understanding of current standards, skills, procedures or treatment.

C. The board shall notify a licensee or certificate holder of a complaint and the nature of the complaint within ninety days after receiving the complaint.

D. Any person may submit a complaint regarding any licensee, certificate holder or other person potentially in violation of this chapter. Confidentiality shall be maintained subject to law.

E. The board shall keep confidential all information relating to the receipt and investigation of complaints filed against licensees and certificate holders until the information becomes public record or as required by law.

32-2046. Informal and formal hearings

A. The board may request an informal hearing with a licensee or any unlicensed person in order to further its investigation or to resolve a complaint.

B. If at an informal hearing the board finds a violation of this chapter has occurred that constitutes grounds for disciplinary action, it may take any disciplinary actions prescribed in section 32-2047, paragraph 1, 2 or 6, except that a civil penalty may not exceed $500.

C. If the results of an informal hearing indicate that suspension, revocation or a civil penalty might be in order, the board shall notify the subject of the investigation of the time and place for a hearing pursuant to title 41, chapter 6, article 10.

D. In lieu of or in addition to an informal hearing as provided in subsection A of this section, the board may serve on a licensee a summons and complaint setting forth the grounds for disciplinary action and notice of a hearing to be held before the board at least thirty days after the date of the notice. The notice shall state the time and place of the hearing.

E. A motion for rehearing or review of the board's decision in a disciplinary action shall be filed pursuant to title 41, chapter 6, article 10.

F. The service of a summons and complaint and the service of a subpoena shall be as provided for service in civil cases.

G. If a person disobeys a subpoena, the board may petition the superior court for an order requiring appearance or the production of documents.

32-2047. Disciplinary actions; penalties

On proof that any grounds prescribed in section 32-2044 have been violated or that any requirements prescribed in section 32-2030 have been violated, the board may take the following disciplinary actions singly or in combination:

1. Issue a decree of censure.

2. Restrict a license or registration. The board may require a licensee or registrant to report regularly to the board on matters related to the grounds for the restricted license or registration.

3. Suspend a license or registration for a period prescribed by the board.

4. Revoke a license or registration.

5. Refuse to issue or renew a license or registration.

6. Impose a civil penalty of at least $250 but not more than $10,000 for each violation of this chapter. In addition, the board may assess and collect the reasonable costs incurred in a disciplinary hearing when action is taken against a person's license.

7. Accept a voluntary surrendering of a license or registration pursuant to an order of consent by the board.

## 32-2048. Unlawful practice; classification; injunctive relief; deposit of civil penalties

A. It is unlawful for any person to practice or in any manner to claim to practice physical therapy or for a person to claim the designation of a physical therapist unless that person is licensed pursuant to this chapter. A person who engages in an activity requiring a license pursuant to this chapter or who uses any word, title or representation in violation of section 32-2042 that implies that the person is licensed to engage in the practice of physical therapy is guilty of a class 1 misdemeanor.

B. The board may investigate any person to the extent necessary to determine if the person is engaged in the unlawful practice of physical therapy. If an investigation indicates that a person may be practicing physical therapy unlawfully, the board shall inform the person of the alleged violation. The board may refer the matter for prosecution regardless of whether the person ceases the unlawful practice of physical therapy.

C. The board, through the appropriate county attorney or the office of the attorney general, may apply for injunctive relief in any court of competent jurisdiction to enjoin any person from committing any act in violation of this chapter. Injunction proceedings are in addition to, and not in lieu of, all penalties and other remedies prescribed in this chapter.

D. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it collects from civil penalties pursuant to this chapter in the state general fund.

## 32-2049. Disclosure prohibition

The board shall not disclose the identity of a person who provides information unless this information is essential to proceedings conducted pursuant to sections 32-2045 and 32-2046 or unless required by a court.

## 32-2050. Substance abuse recovery program

In lieu of a disciplinary proceeding prescribed by this article, the board may allow a licensee to actively participate in a board-approved substance abuse recovery program if:

1. The board has evidence that the licensee is an impaired professional.

2. The licensee has not been convicted of a felony relating to a controlled substance in a court of law of the United States or any other territory or country.

3. The licensee enters into a written agreement with the board for a restricted license and complies with all of the terms of the agreement, including making satisfactory progress in the program and adhering to any limitations on the licensee's practice imposed by the board to protect the public. Failure to enter into such an agreement shall activate an immediate investigation and disciplinary proceedings by the board.

4. As part of the agreement established between the licensee and the board, the licensee signs a waiver allowing the substance abuse program to release information to the board if the licensee does not comply with the requirements of this section or is unable to practice with reasonable skill or safety.

## 32-2051. Rights of consumers

A. The public has access to the following information:

1. A list of licensees and interim permit holders that includes the licensee's and interim permit holder's place of practice, license or interim permit number, date of license or interim permit expiration and status of license or interim permit.

2. A list of physical therapist assistants who are licensed in this state, including place of employment, license number, date of license expiration and status of license.

3. Public records.

B. The home addresses and telephone numbers of physical therapists and physical therapist assistants are not public records and shall be kept confidential by the board unless they are the only addresses and telephone numbers of record.

C. If a referring practitioner is deriving direct or indirect compensation from the referral to physical therapy, the physical therapist shall disclose this information in writing to the patient.

D. A physical therapist shall disclose in writing to a patient any financial interest in products the physical therapist endorses and recommends to the patient and shall document this disclosure in the patient's record.

E. A physical therapist shall ensure that each patient understands that the patient has freedom of choice in services and products.

F. Information relating to the physical therapist-patient relationship is confidential and shall not be communicated to a third party who is not involved in that patient's care without the prior written consent of the patient. The physical therapist shall divulge to the board information it requires in connection with any investigation, public hearing or other proceeding. The physical therapist-patient privilege does not extend to cases in which the physical therapist has a duty to report information as required by law. The confidentiality requirements and privileges of this subsection also apply to physical therapist assistants.

G. Each licensee shall display a copy of the license and current renewal verification in a location accessible to public view at the licensee's place of practice. If the licensee is unable to display the license or current renewal verification, the licensee must produce that documentation on request.

H. The board shall keep all information relating to the receipt and investigation of complaints filed against a licensee confidential unless the information is disclosed in the course of the investigation or any subsequent proceeding or if that information is required to be disclosed by law.

I. The following are confidential and are not available to the public:

1. Patient records, including clinical records, patient files and any report or oral statement relating to a diagnostic finding or treatment of a patient.

2. Any information from which a patient or a patient's family might be identified.

3. Information received and records or reports kept by the board as a result of an investigation made pursuant to this chapter.

32-2052. Judicial review

Except as provided in section 41-1092.08, subsection H, final board decisions are subject to judicial review pursuant to title 12, chapter 7, article 6.

32-2053. Physical therapy licensure compact

The physical therapy licensure compact is adopted and enacted into law as follows:

Section 1

Purpose

The purpose of this compact is to facilitate the interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. This compact preserves the

regulatory authority of states to protect the public health and safety through the current system of state licensure. This compact is designed to achieve the following objectives:

1. Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

2. Enhance the states' ability to protect the public health and safety.

3. Encourage the cooperation of member states in regulating multistate physical therapy practice.

4. Support spouses of relocating military members.

5. Enhance the exchange of licensure, investigative and disciplinary information between member states.

6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

Section 2

Definitions

As used in this compact, and except as otherwise provided, the following definitions shall apply:

1. "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the national guard and reserve on active duty orders pursuant to 10 United States Code section 1211.

2. "Adverse action" means disciplinary action taken by a physical therapy licensing board based on misconduct or unacceptable performance, or both.

3. "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a physical therapy licensing board, including a program relating to substance abuse issues.

4. "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

5. "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in or completion of educational and professional activities relevant to the practice or area of work.

6. "Data system" means a repository of information about licensees, including examination, licensure, investigative information, compact privilege and adverse action.

7. "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

8. "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted by, the commission.

9. "Home state" means the member state that is the licensee's primary state of residence.

10. "Investigative information" means information, records and documents received or generated by a physical therapy licensing board pursuant to an investigation.

11. "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a state.

12. "Licensee" means an individual who currently holds an authorization from the state to practice as a physical therapist or to work as a physical therapist assistant.

13. "Member state" means a state that has enacted the compact.

14. "Party state" means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.

15. "Physical therapist" means an individual who is licensed by a state to practice physical therapy.

16. "Physical therapist assistant" means an individual who is licensed or certified by a state and who assists the physical therapist in selected components of physical therapy.

17. "Physical therapy", "physical therapy practice" or "practice of physical therapy" means the care and services provided by or under the direction and supervision of a licensed physical therapist.

18. "Physical therapy compact commission" or "commission" means the national administrative body whose membership consists of all states that have enacted this compact.

19. "Physical therapy licensing board" or "licensing board" means the agency of a state that is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

20. "Remote state" means a member state, other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

21. "Rule" means a regulation, principle or directive adopted by the commission that has the force of law.

22. "State" means any state, commonwealth, district or territory of the United States that regulates the practice of physical therapy.

Section 3

State participation in the compact

A. To participate in the compact, a state must do all of the following:

1. Participate fully in the commission's data system, including using the commission's unique identifier as defined in rules.

2. Have a mechanism in place for receiving and investigating complaints about licensees.

3. Notify the commission, in compliance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

4. Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the federal bureau of investigation record search on criminal background checks and use the results in making licensure decisions.

5. Comply with the rules of the commission.

6. Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the commission.

7. Have continuing competence requirements as a condition for license renewal.

B. On adoption of this compact, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit this information to the federal

bureau of investigation for a criminal background check in accordance with 28 United States Code section 534 and 42 United States Code section 14616.

C. A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

D. Member states may charge a fee for granting a compact privilege.

Section 4

Compact privilege

A. To exercise the compact privilege under the terms and provisions of the compact, the licensee shall meet all of the following requirements:

1. Hold a license in the home state.

2. Have no encumbrance on any state license.

3. Be eligible for a compact privilege in any member state in accordance with subsections D, G and H of this section.

4. Not have had any adverse action taken against any license or compact privilege within the previous two years.

5. Notify the commission that the licensee is seeking the compact privilege within a remote state or states.

6. Pay any applicable fees, including any state fee, for the compact privilege.

7. Meet any jurisprudence requirement established by the remote state or states in which the licensee is seeking a compact privilege.

8. Report to the commission any adverse action taken by any nonmember state within thirty days after the date the adverse action is taken.

B. The compact privilege is valid until the expiration date of the home license. The licensee must comply with the requirements of subsection A of this section to maintain the compact privilege in the remote state.

C. A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

D. A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state, in accordance with due process and that state's laws, may remove a licensee's compact privilege in the remote state for a specific period of time, impose fines or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

E. If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until both of the following occur:

1. The home state license is no longer encumbered.

2. Two years have elapsed from the date of the adverse action.

F. Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection A of this section to obtain a compact privilege in any remote state.

G. If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until all of the following occur:

1. The specific period of time for which the compact privilege was removed has ended.

2. All fines have been paid.

3. Two years have elapsed from the date of the adverse action.

H. Once the requirements of subsection G of this section have been met, the licensee must meet the requirements in subsection A of this section to obtain a compact privilege in a remote state.

Section 5

Active duty military personnel or their spouses

A licensee who is active duty military or is the spouse of an individual who is active duty military may designate one of the following as the home state:

1. The home of record.

2. The permanent change of station.

3. The state of current residence if it is different than the permanent change of station state or home of record.

Section 6

Adverse actions

A. A home state shall have exclusive power to impose an adverse action against a license issued by the home state.

B. A home state may take an adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing an adverse action.

C. Nothing in this compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

D. Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.

E. A remote state shall have the authority to do all of the following:

1. Take adverse actions as set forth in section 4, subsection D of this compact against a licensee's compact privilege in the state.

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses or evidence are located.

3. If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

F. Joint investigations are as follows:

1. In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

Section 7

Establishment of the physical therapy compact commission

A. The compact member states hereby create and establish a joint public agency known as the physical therapy compact commission to which the following apply:

1. The commission is an instrumentality of the compact states.

2. Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this compact shall be construed to be a waiver of sovereign immunity.

B. Membership, voting and meetings are as follows:

1. Each member state shall have and be limited to one delegate selected by that member state's licensing board.

2. The delegate shall be a current member of the licensing board, who is a physical therapist, physical therapist assistant or public member or the board administrator.

3. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

4. The member state board shall fill any vacancy occurring in the commission.

5. Each delegate shall be entitled to one vote with regard to the adoption of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

6. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for the delegate's participation in meetings by telephone or other means of communication.

7. The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

C. The commission shall have the following powers and duties:

1. Establish the fiscal year of the commission.

2. Establish bylaws.

3. Maintain its financial records in accordance with the bylaws.

4. Meet and take such actions as are consistent with the provisions of this compact and the bylaws.

5. Adopt uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and shall be binding in all member states.

6. Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law shall not be affected.

7. Purchase and maintain insurance and bonds.

8. Borrow, accept or contract for services of personnel, including employees of a member state.

9. Hire employees, elect or appoint officers, fix compensation, define duties and grant such individuals appropriate authority to carry out the purposes of the compact and to establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

10. Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and receive, utilize and dispose of the same, if at all times the commission avoids any appearance of impropriety or conflict of interest.

11. Lease, purchase, accept appropriate gifts or donations of or otherwise own, hold, improve or use any property, real, personal or mixed.  at all times the commission shall avoid any appearance of impropriety.

12. Sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed.

13. Establish a budget and make expenditures.

14. Borrow money.

15. Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives and consumer representatives, and such other interested persons as may be designated in this compact and the bylaws.

16. Provide and receive information from, and cooperate with, law enforcement agencies.

17. Establish and elect an executive board.

18. Perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of physical therapy licensure and practice.

D. Provision for the executive board is as follows:

1. The executive board shall have the power to act on behalf of the commission according to the terms of this compact and shall be composed of the following nine members:

(a) Seven voting members who are elected by the commission from the current membership of the commission.

(b) One ex officio, nonvoting member from the recognized national physical therapy professional association.

(c) One ex officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

2. The ex officio members will be selected by their respective organizations.

3. The commission may remove any member of the executive board as provided in bylaws.

4. The executive board shall meet at least annually.

5. The executive board shall have the following duties and responsibilities:

(a) Recommend to the entire commission changes to the rules or bylaws, to this compact legislation, to fees paid by compact member states such as annual dues and to any commission compact fee charged to licensees for the compact privilege.

(b) Ensure compact administration services are appropriately provided, contractual or otherwise.

(c) Prepare and recommend the budget.

(d) Maintain financial records on behalf of the commission.

(e) Monitor compact compliance of member states and provide compliance reports to the commission.

(f) Establish additional committees as necessary.

(g) Other duties as provided in rules or bylaws.

E. Meetings of the commission are as follows:

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in section 9 of this compact.

2. The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

(a) Noncompliance of a member state with its obligations under the compact.

(b) The employment, compensation or discipline of or other matters, practices or procedures related to specific employees, or other matters related to the commission's internal personnel practices and procedures.

(c) Current, threatened or reasonably anticipated litigation.

(d) The negotiation of contracts for the purchase, lease or sale of goods, services or real estate.

(e) Accusing any person of a crime or formally censuring any person.

(f) The disclosure of trade secrets or commercial or financial information that is privileged or confidential.

(g) The disclosure of information of a personal nature for which disclosure would constitute a clearly unwarranted invasion of personal privacy.

(h) The disclosure of investigative records compiled for law enforcement purposes.

(i) The disclosure of information related to any investigative report prepared by or on behalf of or for use of the commission or other committee charged with the responsibility of investigating or determining compliance issues pursuant to this compact.

(j) Matters specifically exempt from disclosure by federal or member state statute.

3. If a meeting, or portion of a meeting, is closed pursuant to this section, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

4. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

F. Financing of the commission is as follows:

1. The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

2. The commission may accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services.

3. The commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based on a formula to be determined by the commission, which shall adopt a rule that is binding on all member states.

4. The commission may not incur obligations of any kind before securing the monies adequate to meet those obligations, and the commission may not pledge the credit of any of the member states, except by and with the authority of the member state.

5. The commission shall keep accurate accounts of all of its receipts and disbursements, which are subject to the audit and accounting procedures established under its bylaws. All receipts and disbursements of monies handled by the commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the commission.

G. Qualified immunity, defense and indemnification provisions are as follows:

1. The members, officers, executive director, employees and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities. this paragraph does not protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or wilful or wanton misconduct of that person.

2. The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities. This paragraph does not prohibit that person from retaining the person's own counsel if the actual or alleged act, error or omission did not result from that person's intentional or wilful or wanton misconduct.

3. The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities if the actual or

alleged act, error or omission did not result from the intentional or wilful or wanton misconduct of that person.

Section 8

Data system

A. The commission shall provide for the development, maintenance and utilization of a coordinated database and reporting system containing licensure, adverse action and investigative information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this compact applies as required by the rules of the commission, including all of the following:

1. Identifying information.

2. Licensure data.

3. Adverse actions against a license or compact privilege.

4. Nonconfidential information related to alternative program participation.

5. Any denial of an application for licensure and the reason or reasons for such denial.

6. Other information that may facilitate the administration of this compact, as determined by the rules of the commission.

C. Investigative information pertaining to a licensee in any member state will only be available to other party states.

D. The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

E. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

F. Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

Section 9

Rulemaking

A. The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules adopted under this section. Rules and amendments become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the member states reject a rule by enactment of a statute or resolution in the same manner used to adopt the compact within four years after the date of adoption of the rule, the rule has no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

D. Before the adoption of a final rule or rules by the commission, and at least thirty days before the meeting at which the rule will be considered and voted on, the commission shall file a notice of proposed rulemaking on both:

1. The website of the commission or other publicly accessible platform.

2. The website of each member state's physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

E. The notice of proposed rulemaking shall include all of the following:

1. The proposed time, date and location of the meeting in which the rule will be considered and voted on.

2. The text of the proposed rule or amendment and the reason for the proposed rule.

3. A request for comments on the proposed rule from any interested person.

4. The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing, and any written comments.

F. Before the adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by any of the following:

1. At least twenty-five persons.

2. A state or federal governmental subdivision or agency.

3. An association having at least twenty-five members.

H. If a hearing is held on the proposed rule or amendment, the commission shall publish the place, time and date of the scheduled public hearing. If the hearing is held via electronic means, the commission shall publish the mechanism for access to the electronic hearing. Additionally:

1. All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing at least five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. This section does not require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with the adoption of the proposed rule without a public hearing.

K. The commission, by majority vote of all members, shall take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. On a determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, an opportunity for comment or a hearing if the usual rulemaking procedures provided in the compact and in this section are retroactively applied to the rule as soon as reasonably possible, but not later than ninety days after the effective date of the rule. For the purposes of this

subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

1. Meet an imminent threat to public health, safety or welfare.

2. Prevent a loss of commission or member state funds.

3. Meet a deadline for the adoption of an administrative rule that is established by federal law or rule.

4. Protect the public health and safety.

M. The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision is subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chairperson of the commission before the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

Section 10

Oversight, dispute resolution and enforcement

A. Oversight of the commission is as follows:

1. The executive, legislative and judicial branches of state government in each member state shall enforce this compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules adopted under this compact have standing as statutory law.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this compact that may affect the powers, responsibilities or actions of the commission.

3. The commission is entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission shall render a judgment or order void as to the commission, this compact or rules adopted under this compact.

B. Default, technical assistance and termination provisions are as follows:

1. If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this compact or rules adopted under this compact, the commission shall do both of the following:

(a) Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default or any other action to be taken by the commission.

(b) Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the compact on an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the governor, the majority and minority leaders of the defaulting state's legislature and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The commission may not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed on in writing between the commission and the defaulting state.

6. The defaulting state may appeal the action of the commission by petitioning the United States district court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute resolution provisions are as follows:

1. On request by a member state, the commission shall attempt to resolve disputes related to the compact that arise among member states and between member and nonmember states.

2. The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement provisions are as follows:

1. The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

2. By majority vote, the commission may initiate legal action in the United States district court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. If judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

3. The remedies in this compact are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

Section 11

Date of implementation of the interstate commission

for physical therapy practice and associated

rules, withdrawal and amendment

A. This compact is effective on the date on which the compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to the implementation and administration of this compact.

B. Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the commission shall have the full force and effect of law on the day the compact becomes law in that state.

C. Any member state may withdraw from this compact by enacting a statute repealing the same:

1. A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

D. This compact does not invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this compact.

E. This compact may be amended by the member states. An amendment to this compact does not become effective and binding on any member state until it is enacted into the laws of all member states.

Section 12

Construction and severability

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable, and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or if the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact is held contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

32-2054. Participation in compact as condition of employment; prohibition

An employer may not require a physical therapist to seek licensure through the physical therapy licensure compact enacted by section 32-2053 as a condition of initial or continued employment as a physical therapist in this state. An employer may require that a physical therapist obtain and maintain a license to practice physical therapy in multiple states, if the physical therapist is free to obtain and maintain the licenses by any means authorized by the laws of the respective states.

32-2055. Open meeting requirements

If a meeting, or a portion of a meeting, of the physical therapy compact commission is closed pursuant to section 32-2053, section 7, subsection E, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision consistent with title 38, chapter 3, article 3.1.

32-2056. Board of physical therapy; notice of commission actions; expenditure of certain monies prohibited

The board of physical therapy:

1. Within thirty days after a physical therapy compact commission action shall post on the board's public website notice of any commission action that may affect a physical therapist's license.

2. May not spend any monies received from physical therapists or applicants for licensure who are not applying for licensure through this compact on any activities, obligations or duties required by this compact.

**DEPARTMENT OF TRANSPORTATION**
Title 17, Chapter 3, Article 6

**Amend:** R17-3-601, R17-3-602

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** **June 17, 2025**

**SUBJECT:** **DEPARTMENT OF TRANSPORTATION**
Title 17, Chapter 3, Article 6

**Amend:** R17-3-601, R17-3-602

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**Summary:**

This regular rulemaking from the Department of Transportation (Department) seeks to amend two (2) rules in Title 17, Chapter 3, Article 6 regarding Highways. The rulemaking relates to the one-year review report approved by the Council on June 4, 2024. The report indicated that amendments were needed to better reflect the Department's process and to clarify that the occupancy rate in R17-3-602 does not apply to providers that are wholly owned by tribes and on sovereign tribal land. 302 is also being amended to clarify that an encroachment permit will not be issued until the telecommunication use and occupancy agreement has been signed. The amendment in R17-3-601 will remove the state milepost system as a defined term because it is being removed from its use in the Article, and the term Lease agreement because it is not used in Article 6.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Department cites both general and specific statutory authority for these rules.

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Department indicates it did not review any study relevant to this rulemaking.

**4. Summary of the agency's economic impact analysis:**

The Department engages in this rulemaking to adopt the changes proposed in ADOT's one-year review report on 17 A.A.C. 3, Article 6, which was approved by the Governor's Regulatory Review Council on June 4, 2024. ADOT determined that these rules should be updated and improved to better reflect ADOT's process, to provide better clarity, and to remove unnecessary language. The Department states that these changes include clarifying that the occupancy rate does not apply to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands; not using the State Milepost System as a means for measuring the distance; and clarifying that an encroachment permit will not be issued until the telecommunication use and occupancy agreement has been signed.

While the Department notes that it incurs substantial costs to implement and enforce the Broadband program, it believes that this rulemaking should not increase those costs for the Department or broadband providers and thus anticipates that the economic impact of this rulemaking is minimal. Instead, the Department believes that it and the broadband providers should benefit from the clearer rules and clarifications about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands and about the encroachment permit. The Department states that the purpose of this rulemaking is for clarification and consistency with current practice, so the impact should be a reduction in misunderstanding, confusion, inefficiencies, and undue burdens for all businesses.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

`The Department has determined that there are no alternative methods of achieving the objectives of the proposed rulemaking which is for clarification and consistency with current practice. The Department states that the clarification about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal

lands will not create a loss of revenue since this is already in practice by ADOT. According to the Department, ADOT benefits from having clearer and updated rules that bring better understandability to its stakeholders and consistency with ADOT's process. Additionally, the Department believes these rule changes could help alleviate some inquiries. It claims that assisting in the allowance for more providers allows for more services to the state and increases the capacity of telecommunications services being provided. Additionally, the Department believes it may benefit from receiving in-kind trades such as fiber optic and conduit, that can be used for the Intelligent Transportation System to make highways safer and more efficient. Overall, the Department does not anticipate new costs given that these rules are not establishing new requirements for the providers. It states that failing to implement this rulemaking could lead to lack of awareness, misunderstanding, confusion, inefficiencies, and undue burdens on broadband providers that could hamper the chances to increase broadband capabilities and thus remove the economic benefit to the broadband providers and the state.

**6. What are the economic impacts on stakeholders?**

The Department states that broadband providers and the general public will benefit from this rulemaking. The Department believes that the broadband providers may benefit from economic growth by being able to provide their services to more customers, which could also allow for an increase in revenue and a potential increase in job creation. Consequently, the Department believes that the general public of private persons and consumers may benefit from more areas in the state having better service and internet capabilities. Furthermore, the Department does not anticipate a loss in revenue for the state from the clarification about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands since according to the Department, this is already in practice.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Department indicates that there were no changes from the proposed rules and the final rules now before the Council.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Department indicates that they received no public comments on these rules.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

These rules require providers to enter into a telecommunication use and occupancy agreement and obtain an encroachment permit in order to be granted longitudinal access to the

right-of-way of a highway for new installation of a telecommunication facility. The Department indicates that an encroachment permit would not allow for a general permit as the activities are specific to a particular encroachment activity and qualify for an exception under ARS 41-1037(A)(3), the issuance of a general permit is not technically feasible or would not meet the applicable statutory requirements.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates that the rules are not more stringent than the corresponding federal law. The Department indicates that The Telecommunications Act of 1996, PL 104-104, 110 Stat. 56, and 23 CFR 645, Subparts B and C, are the corresponding federal law related to these rules.

**11. Conclusion**

This regular rulemaking from the Department of Transportation (Department) seeks to amend two (2) rules in Title 17, Chapter 3, Article 6 regarding Highways. The rulemaking relates to the one-year review report approved by the Council on June 4, 2024. The goal of the rulemaking is to improve the clarity of the rules by better reflecting the procedures used by the Department and to reflect that providers, who are wholly owned by a tribe, and located on sovereign tribal lands are not responsible for the occupancy rate in R17-3-602.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A).

Council staff recommends approval of this rulemaking.

ARIZONA DEPARTMENT OF TRANSPORTATION

206 S. 17th Ave
Phoenix, AZ 85007

KATIE HOBBS
GOVERNOR

JENNIFER TOTH
DIRECTOR

April 29, 2025

VIA EMAIL: grrc@azdoa.gov

Jessica Klein, Chair
Governor's Regulatory Review Council
100 N. 15th Ave., Suite 305
Phoenix, AZ 85007

Re: Department of Transportation, 17. A.A.C. 3, Article 6, Telecommunication Facilities, Notice of Final Rulemaking

Dear Chairperson Jessica Klein:

The Arizona Department of Transportation submits the accompanying final rule package for consideration by the Governor's Regulatory Review Council. The following information is provided to comply with R1-6-201(A)(1):

a. The rulemaking record closed on February 12, 2025, and no written public comments were received on these rules;
b. The rulemaking activity does not relate to a five-year review report, but does relate to a one-year review report, approved by the Governor's Regulatory Review Council on June 4, 2024;
c. The rulemaking does not establish a new fee;
d. The rulemaking does not increase an existing fee;
e. An immediate effective date is not requested for these rules under A.R.S. § 41-1032;
f. The preamble discloses that the Department did not review any studies relevant to the rules and did not rely on any studies in its evaluation of or justification for the rules;
g. No new full-time employees are necessary to implement and enforce the rules;
h. Documents included in this final rule package are as follows:
    1. Signed cover letter;
    2. Notice of Final Rulemaking, including the preamble, table of contents, and text of each rule;
    3. Economic, Small Business and Consumer Impact Statement;
    4. General authorizing statutes and specific statutes, including relevant statutory definitions;
    5. Definitions of terms; and
    6. Request for, and approvals of initial and final rulemaking from the Governor's Office.

Sincerely,

Jennifer Toth
Director

Enclosures

**NOTICE OF FINAL RULEMAKING**

**TITLE 17. TRANSPORTATION**

**CHAPTER 3. DEPARTMENT OF TRANSPORTATION**

**HIGHWAYS**

**PREAMBLE**

**1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039 by the governor on:**

April 16, 2025

| **2. Article, Part, or Section Affected (as applicable)** | **Rulemaking Action** |
|---|---|
| R17-3-601 | Amend |
| R17-3-602 | Amend |

**3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. § 28-366

Implementing statute: A.R.S. §§ 28-7384 and 28-7385

**4. The effective date of the rule:**

This rule shall become effective 60 days after a certified original and preamble are filed in the Office of the Secretary of State pursuant to A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

**a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable

**b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable

**5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:**

Notice of Rulemaking Docket Opening: 31 A.A.R. 134, Issue Date: January 10, 2025, Issue Number: 2, File number: R24-303

Notice of Proposed Rulemaking: 31 A.A.R. 124, Issue Date: January 10, 2025, Issue Number: 2, File number: R24-299

**6. The agency's contact person who can answer questions about the rulemaking:**


Name: Candace Olson

Title: Senior Rules Analyst

Office: Government Relations and Rules

Address: Department of Transportation

206 S. 17th Ave., Mail Drop 180A
Phoenix, AZ 85007
Telephone: (480) 267-6610
Email: COlson2@azdot.gov
Website: https://azdot.gov/about/government-relations

**7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Arizona Department of Transportation (ADOT) engages in this rulemaking to adopt the changes proposed in ADOT's one-year review report on 17 A.A.C. 3, Article 6, which was approved by the Governor's Regulatory Review Council on June 4, 2024. ADOT determined that these rules should be updated and improved to better reflect ADOT's process, to provide better clarity, and to remove unnecessary language. These changes include clarifying that the occupancy rate does not apply to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands; not using the State Milepost System as a means for measuring the distance; and clarifying that an encroachment permit will not be issued until the telecommunication use and occupancy agreement has been signed.

**8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

ADOT did not review or rely on any study relevant to the rules.

**9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**10. A summary of the economic, small business, and consumer impact:**

In general, ADOT incurs substantial costs to implement and enforce the Broadband Program. ADOT incurs costs in administrative and operating costs, personnel, employee-related costs, inspections, reviews, and computer and other equipment costs. The broadband providers can incur a minimal to substantial cost depending on the distance of the longitudinal access of the right-of-way needed. Additionally, there are operational and incidental costs for the installation, maintenance, and operation of the telecommunication facilities.

ADOT anticipates that the economic impact of this rulemaking is minimal since it is removing unnecessary language and updating for better clarity. This rulemaking should not create an increase in costs for ADOT or the broadband providers. The broadband providers and ADOT should benefit from the clearer rules and the clarifications about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands and about the encroachment permit. ADOT benefits from having clearer and updated rules that bring better understandability to its stakeholders and consistency with ADOT's process. The

broadband providers may benefit from economic growth by being able to provide their services to more customers, which could also allow for an increase in revenue and a potential increase in job creation. Overall, assisting in the allowance for more providers allows for more services to the state and increases the capacity of telecommunications services being provided.

**11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

Not applicable

**12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

ADOT did not receive any public or stakeholder comments regarding this rulemaking.

**13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

There are no other matters prescribed by statute applicable to ADOT or to any specific rule or class of rules.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

Pursuant to A.R.S. § 28-7384, R17-3-602 requires providers to enter into a telecommunication use and occupancy agreement and obtain an encroachment permit to be granted longitudinal access to the right-of-way of a highway for the new installation of a telecommunication facility. An encroachment permit allows for the construction of a fixed or temporary improvement within a state highway right-of-way, or for any activity requiring the temporary use of or intrusion upon a state highway right-of-way. While for the purpose of these rules, the issuance of the encroachment permit would be for an activity similar in nature, an encroachment permit, in general, can be issued for various types of activities with some of the requirements general to all and others are specific to a particular encroachment activity. Therefore, encroachment permits fall outside the criteria provided under A.R.S. § 41-1037 and are an exception to the general permit requirement.

ADOT's authorization of providers to have longitudinal access meets the requirements of a general permit since the activities and practices authorized by it are substantially similar in nature for all granted access for the purpose of installation of a telecommunication facility.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

These rules are not more stringent than the following applicable federal laws:

- The Telecommunications Act of 1996, PL 104-104, 110 Stat. 56, which includes provisions on compensation and state authority; and
- 23 CFR 645, Subparts B and C, which includes provisions for accommodating utility facilities

and private lines on federally aided highway projects, use and occupancy agreements, and installation practices that minimize excavation when installing telecommunications infrastructure in highway rights-of-way.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

No analysis was submitted to ADOT.

**14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Not applicable

**15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**16. The full text of the rules follows:**

Rule text begins on the next page.

# TITLE 17. TRANSPORTATION
# CHAPTER 3. DEPARTMENT OF TRANSPORTATION
# HIGHWAYS

## ARTICLE 6. TELECOMMUNICATION FACILITIES

**Section**

## ARTICLE 6. TELECOMMUNICATION FACILITIES

### R17-3-601. Definitions

In addition to the definitions provided under A.R.S. §28-7381, the following terms apply to this Article unless otherwise specified:

"At-grade" means roadways, intersections, or facilities at the same elevation or level.

"Clear zone" means a specific distance from the edge of a travel lane free of above ground obstacles as determined by the Department and in accordance with the American Association of State Highway and Transportation Officials (AASHTO) Roadside Design Guide.

"Controlled access" has the same meaning as a controlled access highway as defined in A.R.S. § 28-601.

"Department" has the same meaning as defined in A.R.S. § 28-101.

"Dig Once" means reducing the number and scale of excavations when installing telecommunication facilities in highway rights-of-way.

"Encroachment permit" has the same meaning as defined in R17-3-501.

"Guideline for Accommodating Utilities on Highway Rights-of-Way" means the guidelines and procedures adopted by the Department for the accommodation of utilities on highway rights-of-way.

"Interstate System" has the same meaning as defined in A.R.S. § 28-7901.

~~"Lease agreement" means the written agreement between the Department and the provider, which authorizes the provider to utilize spare conduit and related facilities of the Department subject to the terms and conditions outlined in the agreement and this Article.~~

"New installation" means an initial installation on a highway right-of-way except in the event of a relocation required by the Department.

"Right-of-way" has the same meaning as defined in A.R.S. § 28-101.

"Right-of-way occupancy rate" means the compensation from a provider for longitudinal access to the right-of-way of a state highway for the purpose of installing telecommunication facilities as authorized under A.R.S. § 28-7385.

"State" means the state of Arizona.

"State highway" has the same meaning as defined in A.R.S. § 28-101.

~~"State Milepost System" means the markers placed on the highway at one-mile intervals that indicate the distance through the state.~~

"Uncontrolled access" means a highway to which owners or occupants of abutting lands and other persons have a legal right of access.

"Telecommunication use and occupancy agreement" means the written agreement between the Department and the provider allowing the provider longitudinal access of highway right-of-way for its telecommunication facilities or private line subject to the terms and conditions outlined in the agreement and this Article.

**R17-3-602. Telecommunication Use and Occupancy Agreement; Time-frames; Compensation for Longitudinal Access to the Right-of-Way**

**A.** A provider must enter into a telecommunication use and occupancy agreement with the Department and obtain an encroachment permit, as prescribed under Article 5 of this Chapter, before being granted longitudinal access for new installation of a telecommunication facility. This Section does not apply to a telecommunication facility with an encroachment permit approved before January 1, 2023.

**B.** A provider seeking to enter into a telecommunication use and occupancy agreement shall complete and provide the following information on a telecommunication use and occupancy agreement application provided by the Department ~~at www.azdot.gov~~:

1. Name of provider;
2. The point of contact's information, which includes name, telephone number, and email address;
3. A description of the proposed work or activity in the right-of-way or facilities; and
4. A map, drawing, or geographical description of the proposed telecommunication facility installation, including the starting and ending milepost to the nearest tenth of a mile, state highway number, the cardinal direction of the highway, the number and size of conduits, and accompanying telecommunication facility locations.

**C.** The Department shall, within five calendar days of receiving an application under subsection (B), provide written notice to the provider acknowledging receipt of the application:

1. If the application is complete, the notice shall acknowledge receipt of a complete application and indicate the date the Department received the complete application; or
2. If the application is incomplete, the notice shall indicate the current date and include an itemized list of all additional information the provider must provide to the Department before the application can be considered complete and subsequently processed.

**D.** A provider with an incomplete application shall respond to the notice provided by the Department under subsection (C)(2) within 15 calendar days after the date indicated on the notice or the Department may deny the application.

**E.** The Department shall render a decision on the application within 15 calendar days after the date on the notice the Department gave to the provider under subsection (C)(1) acknowledging receipt of a complete application.

**F.** For the purpose of A.R.S. § 41-1073, the Department establishes the following time-frames:

1. Administrative completeness review time-frame: five calendar days.
2. Substantive review time-frame: 10 calendar days.
3. Overall time-frame: 15 calendar days.

**G.** A provider shall pay an annual right-of-way occupancy rate as compensation to the Department for longitudinal access to a highway right-of-way for new installations of telecommunication facilities, including overhead, surface, or underground, in accordance with A.R.S. § 28-7385. <u>This subsection does not apply to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands.</u>

1. The annual right-of-way occupancy rate schedule is as follows:

a. Interstate System: $1.00 per linear foot of longitudinal access.
b. Controlled Access Highways (non-interstate): $0.50 per linear foot of longitudinal access.
c. Uncontrolled Access Highways: $0.25 per linear foot of longitudinal access.

2. At the beginning of each calendar year, starting January 1, 2024, the cost per linear foot as prescribed in subsection (G)(1), increases at a rate of 2% per calendar year. The new annual right-of-way occupancy rate applies to any new or renewed telecommunication use and occupancy agreements established within that given year.
3. The annual right-of-way occupancy rate, established at the time of signing the telecommunication use and occupancy agreement, shall be the rate for each year of a 20-year or 30-year agreement.
4. The distance is measured using the ~~State Milepost System~~ information provided in subsection (B)(4), rounded to the nearest tenth of a mile and converted to a linear foot value.
5. The total amount of the annual right-of-way occupancy rate is determined by using the following calculation: cost per linear feet x distance = total annual right-of-way occupancy rate.
6. The Department shall receive monetary compensation in the form of an annual or lump sum payment, unless an in-kind compensation or combination of in-kind and monetary compensation is agreed upon by the Department and the provider.
   a. Annual monetary compensation. The provider shall pay the total annual right-of-way occupancy rate established at the time of signing the telecommunication and occupancy use agreement and at the time of signing any renewals.
   b. Lump-sum monetary compensation. The provider shall pay in accordance with the following:
      i. The total annual right-of-way occupancy rate is multiplied by the number of years of the agreement.
      ii. A discounted rate of 10% is applied utilizing net present value calculation.
   c. In-kind compensation.
      i. Telecommunication facilities shall be valued on a present value basis at the estimated, reasonable cost to the provider for procuring and installing such telecommunication facilities. The in-kind value shall be agreed upon, between the Department and provider, in the telecommunication use and occupancy agreement.
      ii. The Department shall provide the provider with a list of the specific telecommunication facilities and services for consideration as in-kind compensation. The value of such in-kind compensation shall be subtracted from the total amount of monetary compensation due for occupancy of the right-of-way and the remaining balance, if any, shall be remitted as monetary compensation.
      iii. Any telecommunication facilities acquired as in-kind compensation shall be used exclusively for the further development of telecommunications that serve state purposes and may not be sold or leased in competition with providers.
      iv. The provider maintains ownership and is responsible for maintenance of the in-kind compensation provided, however, the associated costs will be agreed upon in the telecommunication use and occupancy agreement.

d. Combination of monetary and in-kind compensation. The provider will pay the total annual right-of-way occupancy rate in accordance with subsections (G)(6)(a) through (c), as applicable, and as agreed upon by the Department and the provider.

7. The payment of the annual right-of-way occupancy rate will be made as follows:
   a. For monetary compensation, the provider shall pay the total annual right-of-way occupancy rate to the Department within 30 calendar days of signing the telecommunication use and occupancy agreement and any renewals.
   b. For in-kind compensation, the agreement shall set forth the timeline for the Department to receive agreed upon telecommunication facilities.

**H.** By signing a telecommunication use and occupancy agreement, a provider agrees to accept the following general obligations and responsibilities:

1. Complying with the encroachment permit rules in Article 5 of this Chapter;
2. Complying with the terms and conditions contained in the telecommunication use and occupancy agreement and encroachment permit documents for installation, operation, maintenance, and relocation of telecommunication facilities;
3. Not having exclusive access or rights to the right-of-way;
4. Having the term length of the telecommunication use and occupancy agreement to be for one year, 20 years, or 30 years with an option to renew the agreement at the current applicable starting rate for the first year of a new agreement or renewal; the rate will be increased annually if the renewal is for a one-year period, otherwise pursuant to the terms of a new 20-year or 30-year agreement; and
5. Terminating the telecommunication use and occupancy agreement due to removal of facilities from the right of way.
   a. For any monetary compensation, the provider shall receive a prorated refund based on the number of months remaining in the term agreement.
   b. For any in-kind compensation, the access to facilities or services provided will terminate at the time of the removal of the facilities.

**I.** The provider will not receive the applicable encroachment permit until the telecommunication use and occupancy agreement has been signed.

# ECONOMIC, SMALL BUSINESS AND CONSUMER IMPACT STATEMENT

## TITLE 17. TRANSPORTATION

## CHAPTER 3. DEPARTMENT OF TRANSPORTATION

## HIGHWAYS

### R17-3-601 and R17-3-602

**A. Economic, small business and consumer impact summary:**

**1. Identification of the proposed rulemaking:**

The Arizona Department of Transportation (ADOT) engages in this rulemaking to adopt the changes proposed in ADOT's one-year review report on 17 A.A.C. 3, Article 6, which was approved by the Governor's Regulatory Review Council on June 4, 2024. ADOT determined that these rules should be updated and improved to better reflect ADOT's process, to provide better clarity, and to remove unnecessary language. These changes include clarifying that the occupancy rate does not apply to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands; not using the State Milepost System as a means for measuring the distance; and clarifying that an encroachment permit will not be issued until the telecommunication use and occupancy agreement has been signed.

**a. The conduct and its frequency of occurrence that the rule is designed to change:**

During ADOT's one-year review of its telecommunication facilities rules, ADOT found the following areas that could be improved and clarified:

a. Subsection (B): Remove the verbiage "at www.azdot.gov" since ADOT determined it was easier for the stakeholders when ADOT emailed the telecommunication use and occupancy agreement application directly to them after they submitted their application for the encroachment permit;

b. Subsection (G): Add a new sentence at the end of the introductory sentence to indicate that this subsection does not apply to providers, wholly owned by a tribe, for access on sovereign tribal lands in an effort to provide more clarity to the process;

c. Subsection (G)(4): Replace the verbiage "'State Milepost System" with "information provided in Subsection (B)(4)" since it is easier, more convenient, and less confusing to use the information provided by the applicant instead of the State Milepost System;

d. Add a new subsection to indicate that the encroachment permit will not be issued until the telecommunication use and occupancy agreement has been signed in an effort to further clarify the process; and

e. Remove the term and definition of "lease agreement" since it is not used in this Article and was relevant to language used in a previous draft of the rules and remove the term and definition of "State Milepost System" since it will no longer be used in this Article.

**b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:**

If these rule changes are not adopted, broadband providers may not be aware of updated processes and be subject to misunderstanding, confusion, inefficiencies, and undue burdens and it could hamper the chances to increase broadband capabilities and remove the economic benefit to the broadband providers and the state. These rules are in the furtherance of the telecommunication facilities statutes which provide greater expansion and capabilities to the telecommunication companies, thus allowing for more customers and giving customers better capabilities and opportunities to be on pace with all that is afforded by greater ease of internet access.

**c. The estimated change in frequency of the targeted conduct expected from the rule change:**

These rules ensure:

1. Reduction and amelioration of the regulatory burden from potentially unclear or misleading verbiage.
2. Consistency in application of ADOT's requirements which will better serve the public and allow for a better public understanding.
3. Facilitating opportunities for better service and capabilities to the state and potential for job creation and economic development.

**2. Brief summary of the information included in the economic, small business and consumer impact statement:**

In general, ADOT incurs substantial costs to implement and enforce the Broadband Program. ADOT incurs costs in administrative and operating costs, personnel, employee-related costs, inspections, reviews, and computer and other equipment costs. The broadband providers can incur a minimal to substantial cost depending on the distance of the longitudinal access of the right-of-way needed. Additionally, there are operational and incidental costs for the installation, maintenance, and operation of the telecommunication facilities.

ADOT anticipates that the economic impact of this rulemaking is minimal since it is removing unnecessary language and updating for better clarity. This rulemaking should not create an increase in costs for ADOT or the broadband providers. The broadband providers and ADOT should benefit from the clearer rules and the clarifications about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands and about the encroachment permit. ADOT benefits from having clearer and updated rules that bring better understandability to its stakeholders and consistency with ADOT's process. The broadband providers may benefit from economic growth by being able to provide their services to more customers, which could also allow for an increase in revenue and a potential increase in job creation. Overall, assisting in the allowance for more providers allows for more services to the state and increases the capacity of telecommunications services being provided.

3. **Name and address of agency employees who may be contacted to submit or request additional data on the information included in the economic, small business and consumer impact statement:**

Name: Candace Olson, Senior Rules Analyst
Address: Government Relations and Rules
Department of Transportation
206 S. 17th Ave., Mail Drop 180A
Phoenix, AZ 85007
Telephone: (480) 267-6610
E-mail: COlson2@azdot.gov

**B. Economic, small business and consumer impact statement:**

1. **Identification of the proposed rulemaking:**

See paragraph (A)(1) above.

2. **Identification of the persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking:**

| **Persons to bear costs** | **Persons directly benefiting** |
|---|---|
| ADOT | ADOT |
| Broadband providers | Broadband providers |
| | General public |

3. **Analysis of costs and benefits occurring in this state:**

Cost-revenue scale. Annual costs or revenues are defined as follows:

Minimal less than $10,000
Moderate $10,000 to $99,999
Substantial $100,000 or more

a. **Probable costs and benefits to ADOT and other agencies directly affected by the implementation and enforcement of the proposed rulemaking:**

In general, ADOT incurs substantial costs to implement and enforce the Broadband Program. ADOT incurs costs in administrative and operating costs, personnel, employee-related costs, inspections, reviews, and computer and other equipment costs.

ADOT anticipates that the economic impact of this rulemaking is minimal since it is removing unnecessary language and updating for better clarity. This rulemaking should not create an increase in costs for ADOT. The clarification about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands will not create a loss of revenue since this is already in practice by ADOT. ADOT benefits from having clearer and updated rules that bring better understandability to its stakeholders and consistency with ADOT's process. These rule changes could help alleviate some inquiries. Overall, assisting in the allowance for more providers allows for more

services to the state and increases the capacity of telecommunications services being provided. In addition, ADOT may benefit from receiving in-kind trades such as fiber optic and conduit, that can be used for the Intelligent Transportation System to make highways safer and more efficient.

ADOT is not required to notify the Joint Legislative Budget Committee under A.R.S. § 41-1055(B)(3)(a), since no new full-time employees are necessary to enforce and implement this proposed rulemaking.

**b. Probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking:**

Any political subdivision subject to these rules would have the same costs and benefits as businesses as discussed in the following paragraph (B)(3)(c).

**c. Probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking:**

In general, a broadband provider can incur a minimal to substantial cost depending on the distance of the longitudinal access of the right-of-way needed. Additionally, there are operational and incidental costs for the installation, maintenance, and operation of the telecommunication facilities.

This rulemaking should not create an increase in costs for the broadband providers as the proposed changes seek to provide better clarity and consistency and do not make any new requirements of the providers. This rulemaking does not change the established annual right-of-way occupancy rate. ADOT does not charge a fee for applying for longitudinal access or for an encroachment permit. The broadband providers should benefit from the clearer rules and the clarifications about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands and about the encroachment permit. The broadband providers may benefit from economic growth by being able to provide their services to more customers, which could also allow for an increase in revenue and a potential increase in job creation.

**4. General description of the probable impact on private and public employment in businesses, agencies and political subdivisions of this state directly affected by the proposed rulemaking:**

ADOT anticipates that with clearer rules there is potential for additional expansion of broadband services to the state which could create a potential increase in job creations for the broadband providers.

**5. Statement of the probable impact of the proposed rulemaking on small businesses:**

**a. Identification of the small businesses subject to the proposed rulemaking:**

Some of the broadband providers, as defined under A.R.S. § 28-7381, may be small businesses, as defined under A.R.S. § 41-1001.

**b. Administrative and other costs required for compliance with the proposed rulemaking:**

General administrative costs for small businesses are the same as discussed under paragraph (B)(3)(c) above.

**c. Description of the methods that ADOT may use to reduce the impact on small businesses:**

The purpose of this rulemaking is for clarification and consistency with current practice so the impact should be a reduction in misunderstanding, confusion, inefficiencies, and undue burdens for all businesses.

**d. Probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking:**

The general public of private persons and consumers may benefit from more areas in the state having better service and internet capabilities. These rules support the public interest and the interests of concerned parties by ensuring consistency between the broadband providers and clarity for the broadband providers to obtain longitudinal access and use of ADOT's right-of-way and thus being able to expand their opportunities and capabilities to their customers and to the general public. In addition, some people may find a job opportunity created by the broadband expansion.

**6. Statement of the probable effect on state revenues:**

As of March 2025, ADOT has granted 71 telecommunication use and occupancy agreements for longitudinal access to 16 broadband providers since the adoption of these rules. ADOT has not rejected any applications. There are currently pending requests from two additional providers. Most of the providers (9) chose a 30-year agreement. For 14 agreements with 7 of the providers, the providers chose to give an in-kind trade for access. Thus far, ADOT has received $225,107 in monetary compensation and $912,826 with in-kind trade valuation. Pursuant to A.R.S. § 28-7385, the monies collected are deposited in the smart highway corridor trust fund under A.R.S. § 28-7387. The clarification about the occupancy rate not applying to a provider, wholly owned by a tribe, for longitudinal access on sovereign tribal lands will not create a loss of revenue since this is already in practice by ADOT.

**7. Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using non-selected alternatives:**

ADOT has determined that there are no alternative methods of achieving the objectives of the proposed rulemaking which is for clarification and consistency with current practice.

**C. Explanation of limitations of the data and the methods that were employed in the attempt to obtain the data and a characterization of the probable impacts in qualitative terms. The absence of adequate data, if explained in accordance with this subsection, shall not be grounds for a legal challenge to the sufficiency of the economic, small business and consumer impact statement:**

None

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ADMINISTRATIVE RULES DIVISION



# TITLE 17. TRANSPORTATION

## CHAPTER 3. DEPARTMENT OF TRANSPORTATION - HIGHWAYS

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
July 1, 2022 through September 30, 2022



**Questions about these rules? Contact:**

Department: Department of Transportation
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Phoenix, AZ 85007
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**The release of this Chapter in Supp. 22-3 replaces Supp. 20-3, 1-24 pages.**
Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State's website, www.azsos.gov under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*


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# TITLE 17. TRANSPORTATION

## CHAPTER 3. DEPARTMENT OF TRANSPORTATION - HIGHWAYS

Authority: A.R.S. §§ A.R.S. §§ 28-366, 28-7384, and 28-7385

**Supp. 22-3**

## CHAPTER TABLE OF CONTENTS

### ARTICLE 1. REPEALED



### ARTICLE 2. MANAGEMENT OF CONTRACTOR BIDDING

*Article 2, consisting of Sections R17-3-201 through R17-3-204, adopted effective March 3, 1987.*



### ARTICLE 3. RELOCATION ASSISTANCE

*Article 3, consisting of Sections R17-3-301 through R17-3-304, repealed; new Article 3, consisting of Sections R17-3-301 through R17-3-306, made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1).*



### ARTICLE 4. REPEALED

*Article 4, consisting of Sections R17-3-406 through R17-3-408, repealed by final rulemaking at 8 A.A.R. 849, effective February 8, 2002 (Supp. 02-1).*



*Editor's Note: The Article 5 heading "Highway Encroachments and Permits" is published as submitted by the Department (Supp. 04-4).*

### ARTICLE 5. HIGHWAY ENCROACHMENTS AND PERMITS

*Article 5, consisting of Sections R17-3-501 through R17-3-509, made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).*



### ARTICLE 6. TELECOMMUNICATION FACILITIES

*Article 6, consisting of Sections R17-3-601 through R17-3-603, made by exempt rulemaking at 28 A.A.R. 3372 (October 21, 2022), effective January 1, 2023 (Supp. 22-3).*



### ARTICLE 7. HIGHWAY BEAUTIFICATION



### ARTICLE 8. EXPIRED

*Article 8 consisting of Sections R17-3-801 through R17-3-809 adopted effective May 30, 1984.*

**ARTICLE 9. HIGHWAY TRAFFIC CONTROL DEVICES**

## ARTICLE 1. REPEALED

**R17-3-101. Reserved**

**R17-3-102. Repealed**

**Historical Note**

Former Rule, ASHC Resolution. Former Section R17-3-10 renumbered without change as Section R17-3-102 (Supp. 88-4). Repealed effective May 31, 1991 (Supp. 91-2).

## ARTICLE 2. MANAGEMENT OF CONTRACTOR BIDDING

**R17-3-201. General**

**A.** Definitions.

1. "Application" means a request for contractor prequalification, consisting of an application booklet available from the Department's office of Contracts and Specifications, and a financial statement prepared according to the requirements of this subsection and R17-3-202.
2. "Board" means the Contractor Prequalification Board.
3. "Compiled financial statement" means a financial statement prepared for form, appropriateness, and arithmetic accuracy. It does not express an opinion or provide any assurance regarding the financial statement.
4. "Contractor" means the individual, partnership, firm, corporation, joint venture, or any combination acceptable to the Department, that seeks to contract with the Department for constructing or reconstructing state transportation facilities, unless the context requires otherwise.
5. "Contractor prequalification" means the Department's process of review and evaluation of a contractor's work history and current financial condition before a contractor is allowed to submit a proposal for constructing or reconstructing state transportation facilities.
6. "Department" means the Arizona Department of Transportation.
7. "Examined financial statement" means a financial statement that includes the amounts and disclosures in the firm's financial statement, an assessment of the accounting principles used and the significant estimates made by management, and an evaluation of the overall financial statement presentation.
8. "Financial statement" means a financial report prepared according to generally accepted accounting principles by an independent certified public accountant or an independent public accountant. The financial statement includes a cover letter on the accountant's letterhead, a balance sheet, a statement of cash flows, an income statement, and all notes and appropriate supporting schedules.
9. "Joint venture" means the combination of two or more contractors for the purpose of submitting a proposal to the Department and performing a contract for constructing or reconstructing state transportation facilities.
10. "Prequalification amount" means the dollar limitation of each contract, based on the Department's estimate of contract value, for which a contractor may submit a proposal to the Department for constructing or reconstructing state transportation facilities.
11. "Reviewed financial statement" means a financial statement that includes an inquiry of company personnel, and a review of the analytical procedures applied to the financial data. It does not express an opinion regarding the financial statement taken as a whole.
12. "State Engineer" has the meaning in A.R.S. § 28-6901(3).

**B.** Contractor Prequalification Board.

1. The State Engineer shall appoint the Board to consider and decide on applications for contractor prequalification.
2. The Board will be comprised of three Department employees, one of whom shall be a professional engineer, registered by the Arizona Board of Technical Registration, and one a certified or licensed public accountant.
3. The Board's authority to determine prequalification does not limit the Department's ability to establish additional criteria for contracts.

**Historical Note**

Adopted effective March 3, 1987 (Supp. 87-1). Amended by final rulemaking at 8 A.A.R. 79, effective December 10, 2001 (Supp. 01-4).

**R17-3-202. Contractor Prequalification**

**A.** Criteria. An applicant for contractor prequalification shall include on the application and the Board shall consider the following information in determining the prequalification amount for a contractor:

1. Key personnel and their work experience,
2. Organizational structure,
3. History of past or current projects and contracts,
4. Company affiliations,
5. Equipment owned or controlled,
6. Any applicable licenses,
7. Type of work requested,
8. Individuals authorized to act on behalf of the contractor,
9. Any prequalification or bidding disputes with a government agency, and
10. Financial condition.

**B.** Prequalification Expiration and Extension.

1. Prequalification expires 15 months after the end of a contractor's fiscal year, as reflected on the financial statement. Due to the time necessary to prepare an examined financial statement, the Board may grant up to a 60 day extension on the expiration of prequalification, if:
   a. The contractor submits a letter from its accountant stating the reasons for delay in preparing the examined financial statement,
   b. The letter from the accountant states the anticipated completion date of the examined financial statement, and
   c. The contractor submits an interim compiled or reviewed financial statement that was prepared within the previous six months.
2. The Board will notify each contractor in writing of its decision on the contractor's prequalification amount.

**C.** Joint Ventures.

1. Each contractor in a proposed joint venture shall be prequalified. The joint venture shall submit a joint venture statement of intent at least five calendar days before the applicable bid opening date.
2. If one or more of the parties to the joint venture are corporations, a copy of a resolution from the Board of Directors authorizing the corporation to enter into the joint venture and execute all contract documents shall be submitted with the statement of intent.
3. Contractors operating as a joint venture on a continuing basis may file for prequalification as a joint venture.
4. The Board may allow a contractor operating as a joint venture to prequalify for a pro rata share of the entire contract amount. The percentage share of work shall not

exceed each individual contractor's prequalification amount.

**D.** Classification of Contractors. The Board shall categorize contractors into the following classifications:
1. Inexperienced firms: Firms that have no experience as contractors in transportation facilities construction work;
2. New firms: Recently organized firms that have officers with experience with other contractors in positions of responsibility for transportation facilities construction;
3. Unknown firms: Firms that have experience as contractors but have not completed a transportation facilities construction contract as a contractor for the Department within the past five years or at any time;
4. Known firms: Firms that have successfully completed at least one transportation facilities construction contract within the past five years as a contractor for the Department.

**E.** Classification of Financial Statements.
1. All financial statements shall be examined, reviewed, or compiled according to generally accepted accounting principles, by either an independent certified public accountant or an independent public accountant, registered and licensed under the laws of any state. A contractor shall not submit a financial statement prepared by either a certified or public accountant who is directly or indirectly interested in or affiliated with the business of the contractor.
2. A contractor that desires a prequalification amount in excess of $1.5 million shall submit an examined financial statement.
3. A contractor that submits a reviewed financial statement will be limited to a maximum prequalification amount of $1.5 million.
4. A contractor that submits a compiled financial statement will be limited to a maximum prequalification amount of $300,000.

**F.** Prequalification Limits. In determining the prequalification amount for each contractor, the amount set by the Board may be less than the maximum amount set out in this subsection due to the Board's evaluation of the contractor's information under R17-3-202(A).
1. Inexperienced firms. An inexperienced firm will be limited to a maximum prequalification amount of $300,000 until the contractor has satisfactorily completed at least one transportation facilities construction contract for any public agency.
2. New firms. A new firm will be limited to a maximum prequalification amount of five times the firm's net worth.
3. Unknown firms. An unknown firm will be limited to a maximum prequalification amount of five times the firm's net worth or the amount of the largest transportation facilities construction contract it has successfully completed as a contractor for any other public agency, whichever is larger.
4. Known firms. A known firm will be limited to a maximum prequalification amount of ten times the firm's net worth. An unlimited prequalification amount may be granted if the product of ten times the firm's net worth exceeds $100 million.
5. All firms. Evidence of additional assets pledged in behalf of a contractor or letters from a contractor's surety company may be considered in establishing higher prequalification amounts than stated in subsections (F)(2) through (F)(4). A parent company that pledges assets in behalf of a contractor shall submit a financial statement.

**G.** Reconsideration of Prequalification Determination.
1. If a contractor is dissatisfied with the Board's decision, the contractor may request in writing a hearing, within 15 days of receiving the Board's decision. The hearing shall be conducted under A.R.S. § 41-1062. The letter shall indicate the basis for the request and shall provide supportive data. The Board shall review the request and accompanying information and decide on the request within 30 calendar days of its receipt.
2. If the contractor is still dissatisfied with the decision of the Board, the contractor may appeal to the State Engineer. The Board shall notify the contractor about the appeal procedures.

**H.** Issuance of Bidding Documents. A contractor shall not request bid documents for a contract for which it is not prequalified.

**I.** The Department may waive the prequalification requirement on an individual contract when it is in the best interest of the state. The advertisement for bids shall identify if prequalification is waived.

**Historical Note**
Adopted effective March 3, 1987 (Supp. 87-1). Amended by final rulemaking at 8 A.A.R. 79, effective December 10, 2001 (Supp. 01-4).

**R17-3-203. Reduced Prequalification Amounts or Disqualifications**

**A.** The Board may reduce the prequalification amount of a contractor already prequalified or disqualify a contractor from bidding if a contractor:
1. Falsifies any document or misrepresents any material fact in the information furnished to the Department;
2. Fails to enter into a contract with the Department;
3. Defaults on a previous contract with any public agency;
4. Has an unsatisfactory work performance record with the Department on the basis of workmanship, competent superintendence, adequate and proper equipment, timely completion, or failure to submit required documentation for closing out a contract; or
5. Fails to provide notification to the Board, within 30 calendar days of occurrence, of any change in ownership, corporate officers or general partners, bankruptcy, receivership, court supervised reorganization, or the entry of a judgment in a judicial or administrative proceeding adverse to the contractor.

**B.** The Board shall notify a contractor in writing of its intention to reduce the prequalification amount or to disqualify a contractor. The Board's notice to reduce prequalification or to disqualify a contractor shall become a final determination unless the contractor requests a hearing with the Board within 20 calendar days after receiving such notification. The Board shall notify the contractor about the hearing procedures.

**C.** The contractor may appeal the Board's decision to the State Engineer. The Board shall notify the contractor about the appeal procedures.

**Historical Note**
Adopted effective March 3, 1987 (Supp. 87-1). Amended by final rulemaking at 8 A.A.R. 79, effective December 10, 2001 (Supp. 01-4).

**R17-3-204. Access to Department Prequalification Files**

Prequalification files are considered to be strictly confidential. The files will be available only to:

1. Members of the Board,
2. The Director of the Department or any authorized agents of the Department,
3. Members of the Arizona State Transportation Board,
4. The division administrator of the Federal Highway Administration or any authorized representatives,
5. Agents of surety upon the filing of an application for bond duly signed by an authorizing party of the prequalified contractor,
6. Members of the Arizona State Board of Accountancy or their duly authorized representatives, and
7. The contractor that is the subject of the file.

**Historical Note**

Adopted effective March 3, 1987 (Supp. 87-1). Amended by final rulemaking at 8 A.A.R. 79, effective December 10, 2001 (Supp. 01-4).

## ARTICLE 3. RELOCATION ASSISTANCE

*Article 3, consisting of Sections R17-3-301 through R17-3-304, repealed; new Article 3, consisting of Sections R17-3-301 through R17-3-306, made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1).*

**R17-3-301. Relocation Assistance; Adoption of Federal Regulations**

**A.** The Department incorporates by reference 49 CFR 24.1 through 24.10, 49 CFR 24.201 through 24.209, 49 CFR 24.301 through 24.305, 49 CFR 24.401 through 24.404, 49 CFR 24.501 through 24.503, 49 CFR 24.601 through 24.603, and Appendix A to Part 24 as it relates to Subparts A, C, D, and E, revised as of October 1, 2010, and no later amendments or editions, as amended by this Article. These sections apply to relocation assistance activity provided by the Department. The incorporated material is on file with the Arizona Department of Transportation and is available from the U.S. Government Printing Office, P. O. Box 979050, St. Louis, MO 63197-9000. The incorporated material can be ordered online by visiting the U.S. Government Online Bookstore at http://bookstore.gpo.gov or is available free of charge at http://gpo.gov.

**B.** The following definition applies for the purpose of this Article unless indicated otherwise.

"Department" means the Arizona Department of Transportation.

**Historical Note**

Former Rule, Right of Way Resolution 70-60. Former Section R17-3-12 renumbered without change as Section R17-3-301 (Supp. 88-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1). Section amended by final rulemaking at 19 A.A.R. 141, effective March 10, 2013 (Supp. 13-1).

**R17-3-302. Relocation Assistance; 49 CFR 24, Subpart A - General**

**A.** 49 CFR 24.2, "Definitions and acronyms" is amended as follows:

"Agency" means the Arizona Department of Transportation."

"Contribute materially" in paragraph (a)(7) is amended to read:

The term "contribute materially" means that during the two taxable years before the taxable year in which displacement occurs, a business contributed at least 33 1/3% of the owner's or operator's average annual gross income from all sources.

"Decent, safe, and sanitary dwelling" in paragraph (a)(8) is amended to read:

The term decent, safe, and sanitary dwelling means a dwelling that meets applicable housing and occupancy codes. However, any of the following standards that are not met by an applicable code shall apply unless waived for good cause by the federal agency or state agency funding the project. The dwelling shall:

Be structurally sound, weathertight, and in good repair;

Contain a safe electrical wiring system adequate for lighting and other devices; and

Contain heating and cooling systems capable of sustaining a healthful temperature for a displaced person, except in those areas where local climatic conditions do not require such systems.

"Initiation of negotiations" has the same meaning as prescribed in A.R.S. § 28-7141.

"Notice of intent to acquire or notice of eligibility for relocation assistance" as described in 49 CFR 24.203(d) and 49 CFR 24.203(b) means:

Written notice furnished to a person to be displaced that establishes eligibility for relocation benefits before the initiation of negotiations.

"Persons not displaced" in paragraph (a)(9)(ii)(A) is amended to read:

A person who moves before the initiation of negotiations, unless this requirement is waived by the Department due to a move necessitated for reasons beyond the person's control.

"Program or project" in paragraph (a)(22) is amended to read:

The phrase "program" or "project" means any displacing activity or series of activities undertaken by the Department, related to construction or reconstruction of a transportation facility, or a facility necessary for maintaining a transportation facility.

"Salvage value" in paragraph (a)(23) is deleted.

"Uneconomic remnant" in paragraph (a)(27) is deleted.

"Uniform Act" in paragraph (a)(28) is amended to read:

The term "Uniform Act" means the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended (42 U.S.C. 4601 et seq.).

"Utility facility" in paragraph (a)(31) is deleted.

"Utility relocation" in paragraph (a)(32) is deleted.

**B.** 49 CFR 24.5 "Manner of notices" is amended to read:

Each notice which the agency is required to provide to a property owner or occupant under this part shall be personally served or sent by certified or registered first-class mail, return receipt requested, and documented in agency files. Each notice shall be written in plain, understandable language. Persons who are unable to read and understand the notice must be provided with appropriate translation and counseling. Each notice shall indicate the name and telephone number of a person to contact for answers to questions or other needed help.

**C.** 49 CFR 24.9 "Recordkeeping and reports" is amended to read:

Paragraph (a) Records. The agency shall maintain adequate records of its acquisition and displacement activi-

ties in sufficient detail to demonstrate compliance with this part. These records shall be retained for at least three years after each owner of a property and each person displaced from the property receives the final payment to which each owner of property is entitled under this part, or in accordance with the applicable regulations of the federal funding agency, whichever is later.

**D.** 49 CFR 24.10 "Appeals" is amended to read:

In addition to the provisions of A.R.S. §§ 41-1061 through 41-1067, the following provisions apply:

1. Actions that may be appealed. A person who believes the Department has failed to properly determine the person's eligibility for, or the amount of, a relocation payment may file a written appeal. A person shall include all contested issues in one appeal.
2. Process. To appeal, a person shall submit a letter stating name and address and the reasons for disagreeing with the Department's decision to the Right-of-Way Group, Arizona Department of Transportation, 205 S. 17th Ave., MD 612E, Phoenix, AZ 85007-3212.
3. Time limit. The person shall file the written appeal within 60 days after receiving notice of the Department's determination on the person's claim. The date the appeal request is received begins the official time limit constraints, as prescribed in subsections (D)(4) and (8) of this Section. Filing the appeal does not extend any eligibility periods or a required date to vacate a property.
4. Hearing date. Within 45 days of receipt of the appeal request, the Department shall set a mutually acceptable date for a hearing before a hearing officer.
5. Review of files. After making a written request to the Department at the address in subsection (D)(2) of this Section, the person may review and receive a copy of any non-confidential documentation contained in the Department's files regarding the person's appeal.
6. Scope of review. The Department shall consider and review the person's arguments, statements, and documents in support of the appeal, allowing reasonable latitude for the hearing of relevant material.
7. Right to representation. The person has a right to be represented by legal counsel or another representative in connection with the person's appeal, but solely at the person's own expense.
8. Determination. Within 30 days of the hearing, the hearing officer shall make a recommendation to the Chief Right-of-Way Agent. The Department shall promptly issue a written decision and provide a copy to the person by certified mail. The Department shall explain the basis on which its decision was made, and what relief, if any, is to be provided.
9. Judicial review. If the Department does not grant the relief requested, the Department shall advise the person of the right to seek judicial review.

**Historical Note**

Former Rule, Right of Way Resolution 71-42. Former Section R17-3-13 renumbered without change as Section R17-3-302 (Supp. 88-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1). Section amended by final rulemaking at 19 A.A.R. 141, effective March 10, 2013 (Supp. 13-1).

**R17-3-303. Relocation Assistance; 49 CFR 24, Subpart C - General Relocation Requirements**

49 CFR 24.206 "Eviction for cause" is amended to read:

1. Eviction for cause must conform to A.R.S. §§ 12-1171 through 12-1183. The Department may determine that a person who is an unlawful occupant (as defined in 49 CFR 24.2) is still eligible for advisory relocation assistance. Any person who occupies the real property and is not in unlawful occupancy on the date of the initiation of negotiations, is presumed to be entitled to relocation payments and other assistance set forth in this part unless the agency determines that the factors in subsections (1)(a) or (b) apply. The Department shall use the following factors to determine eligibility of an unlawful occupant for advisory relocation assistance:
   a. The person received an eviction notice before the initiation of negotiations and, as a result of that notice, is later evicted; or
   b. The person is evicted after the initiation of negotiations for serious or repeated violation of material terms of the lease or occupancy agreement; and
   c. The eviction was not undertaken for the purpose of evading the obligation to make available the payments and other assistance set forth in this part;
   d. The person occupying the property and the owner dispute the issue of lawful occupancy;
   e. The duration of prior legal occupancy of the person occupying the property;
   f. Financial or medical hardship of the person occupying the property; or
   g. The cost of the relocation assistance is less than the cost of an appeal.
2. For purposes of determining eligibility for relocation payments, the date of displacement is the date the person moves, or if later, the date a comparable replacement dwelling is made available.
3. The state may initiate eviction proceedings due to:
   a. Unlawful activities being conducted on state-owned property,
   b. Willful destruction of state-owned property,
   c. Refusal to vacate state-owned property after all required notices to vacate have been delivered and appropriate assistance provided, or
   d. Failure to pay rent when there is no hardship.

**Historical Note**

Former Rule, Right of Way Resolution 71-69. Former Section R17-3-14 renumbered without change as Section R17-3-303 (Supp. 88-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1). Section amended by final rulemaking at 19 A.A.R. 141, effective March 10, 2013 (Supp. 13-1). Subsections numbered 2 and 3 were inadvertently combined as one paragraph in Supp. 13-1; subsection 3 has been corrected as filed at 19 A.A.R. 141 (Supp. 19-2).

**R17-3-304. Repealed**

**Historical Note**

Former Rule, Right of Way Resolution 70-51. Former Section R17-3-11 renumbered without change as Section R17-3-304 (Supp. 88-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1). Section repealed by final rulemaking at 19 A.A.R. 141 effective March 10, 2013

(Supp. 13-1).

**R17-3-305. Relocation Assistance; 49 CFR 24, Subpart E - Replacement Housing Payments**

49 CFR 24.401 "Replacement housing payment for 180-day homeowner-occupants" in paragraph (d)(3) is amended to read:

The interest rate on the new mortgage used in determining the amount of the payment shall not exceed the prevailing fixed interest rate for conventional mortgages currently charged by mortgage lending institutions in the area in which the replacement dwelling is located. If a displaced person chooses to buy down the interest rate, the agency shall:

1. Require documents indicating the initial interest rate,
2. Require documents indicating the final interest rate, and
3. Limit reimbursement to the lower of the amount the displaced person actually paid to buy down the interest rate or the amount for which the person qualified under the established market interest rate.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1). Section amended by final rulemaking at 19 A.A.R. 141, effective March 10, 2013 (Supp. 13-1).

**R17-3-306. Repealed**

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1075, effective May 6, 2003 (Supp. 03-1). Section repealed by final rulemaking at 19 A.A.R. 141, effective March 10, 2013 (Supp. 13-1).

## ARTICLE 4. REPEALED

**R17-3-401. Repealed**

**Historical Note**

Former Rule, Traffic Engineering Resolution; Repealed effective June 18, 1979 (Supp. 79-3). New Section R17-3-05 adopted effective August 4, 1982 (Supp. 82-4). Former Section R17-3-05 renumbered without change as Section R17-3-401 (Supp. 88-4). Section repealed by final rulemaking at 7 A.A.R. 2750, effective June 7, 2001 (Supp. 01-2).

**R17-3-402. Repealed**

**Historical Note**

Former Rule, ASHC Resolution. Repealed effective January 3, 1977 (Supp. 77-1). New Section R17-3-08 adopted effective March 25, 1982 (Supp. 82-2). Former Section R17-3-08 renumbered without change as Section R17-3-402 (Supp. 88-4). Section repealed by final rulemaking at 7 A.A.R. 2748, effective June 7, 2001 (Supp. 01-2).

**R17-3-403. Recodified**

**Historical Note**

Former Rule, Right of Way Resolution 71-15. Former Section R17-3-09 renumbered without change as Section R17-3-403 (Supp. 88-4). Section recodified to A.A.C. R17-4-428 at 7 A.A.R. 1260, effective February 20, 2001 (Supp. 01-1).

**R17-3-404. Repealed**

**Historical Note**

Adopted as an emergency effective April 13, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-2). Former Section R17-3-20 renumbered without change as Section R17-3-404 (Supp. 88-4). Section repealed by final rulemaking at 7 A.A.R. 2750, effective June 7, 2001 (Supp. 01-2).

**R17-3-405. Reserved**

**R17-3-406. Repealed**

**Historical Note**

Former Rule, Traffic Engineering Report. Former Section R17-3-02 renumbered without change as Section R17-3-406 (Supp. 88-4). Section repealed by final rulemaking at 8 A.A.R. 849, effective February 8, 2002 (Supp. 02-1).

**R17-3-407. Repealed**

**Historical Note**

Former Rule, ASHC Resolution; Former Section R17-3-06 repealed, new Section R17-3-06 adopted effective April 25, 1978 (Supp. 78-2). Former Section R17-3-06 renumbered without change as Section R17-3-407 (Supp. 88-4). Section repealed by final rulemaking at 8 A.A.R. 849, effective February 8, 2002 (Supp. 02-1).

**R17-3-408. Repealed**

**Historical Note**

Former Rule, General Order 21. Former Section R17-3-08 renumbered without change as Section R17-3-408 (Supp. 88-4). Section repealed by final rulemaking at 8 A.A.R. 849, effective February 8, 2002 (Supp. 02-1).

## ARTICLE 5. HIGHWAY ENCROACHMENTS AND PERMITS

**R17-3-501. Definitions**

In this Article, unless otherwise defined, these terms have the following meanings:

"Abutting property" means real property or interest in real property bordering a state highway right-of-way.

"Adopt-a-highway" means a Department program that allows a group of persons access to a state highway right-of-way to conduct litter pickup on a designated portion of the state highway.

"Airspace" means the space above real property.

"Applicant" means a person or entity seeking to obtain an encroachment permit.

"Department" means the Arizona Department of Transportation.

"District Office" means one of the Department's Engineering and Maintenance district offices.

"Encroachment" means any use of, intrusion upon, or construction of improvement within a state highway right-of-way by any person or entity other than the Department for any purpose, temporary or fixed, other than public travel authorized by state statute.

"Encroachment owner" means the person or entity responsible for creating or maintaining an encroachment on a state highway right-of-way.

"Encroachment permit" means a written approval granted by the Department for construction of a fixed or temporary improvement within a state highway right-of-way, or for any activity requiring the temporary use of or intrusion upon a state highway right-of-way.

"Engineering stationing" means the Department identification system to identify the location of a state highway feature.

"Improvement" means any constructed facility or object, or alteration to any existing physical facility or object, or change in the elevation, slope, or drainage of a state highway right-of-way.

"Permittee" means a person or entity to whom the Department issues an encroachment permit, and who is responsible for meeting the obligations, responsibilities, and specifications stated in the encroachment permit.

"Right-of-way" means the real property or interest in real property on which state transportation facilities and appurtenances to the facilities are constructed or maintained.

"Special event" means any temporary organized or supervised activity that could affect the normal operation of a state highway.

"State highway" has the meaning prescribed in A.R.S. § 28-101(47).

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-502. Applicability**

**A.** A person or entity shall not encroach on a state highway right-of-way without obtaining an encroachment permit.

**B.** Only the following types of encroachments qualify for a Department encroachment permit:
1. Access improvements to abutting properties, consistent with subsection (C)(6);
2. Utility construction and maintenance, including underground and overhead;
3. Drainage improvements;
4. Airspace encroachments, such as overhanging signs, awnings, and banners;
5. Landscaping;
6. Special events;
7. Removing or improving an existing encroachment;
8. Rest area coffee breaks;
9. Change in the principal activity or function of an abutting property where an access or utility encroachment has been constructed;
10. Adopt-a-highway;
11. Activities, such as surveying, performed to compile information about physical features in the highway right-of-way;
12. Traffic control unrelated to the types of encroachments listed above for specific incidents, such as hazardous material removal, accident clean-up, or check points by government enforcement; and
13. For such uses as the Director specifies.

**C.** An encroachment not listed under subsection (B) is ineligible to qualify for an encroachment permit and is an unauthorized encroachment. An unauthorized encroachment also includes:
1. Outdoor advertising signs, except as an overhang in subsection (B)(4);
2. Parking areas;
3. Sales of any service or thing;
4. Bicycling, walking, horseback riding, or other activities prohibited under A.R.S. § 28-733;
5. Any commercial or industrial activity; or
6. Access to undeveloped property abutting a state highway, unless the applicant demonstrates a plan for:
   a. Immediate development of the property evidenced by construction plans or building permits, or
   b. Continuing maintenance of the undeveloped property.

**D.** A new owner of an existing permitted encroachment shall apply for an encroachment permit in the new owner's name within 30 days from the date of purchase of the abutting real property.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-503. Who Can Apply for an Encroachment Permit**

**A.** Any person or entity, other than the Department, seeking an encroachment upon a state highway right-of-way shall apply to the Department for an encroachment permit.

**B.** Any person or entity is eligible to apply for an encroachment permit, except for an encroachment involving:
1. Access, only an abutting property owner is eligible to apply.
2. Landscaping and aesthetic enhancements, only an abutting property owner or a political subdivision is eligible to apply.
3. Utility installation, only an ultimate owner who will be responsible for maintenance and liability of the utility after it is put into service is eligible to apply. An ultimate owner includes a utility company, improvement district, political subdivision, or abutting property owner. A contractor or developer may apply if the contractor or developer provides evidence that an ultimate owner has approved plans and agrees to obtain an encroachment permit as a new owner upon completion of the utility installation.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-504. General Application Procedures**

**A.** An applicant shall obtain an encroachment permit application form from the District Office serving the Department's district in which the proposed encroachment will be located.

**B.** An applicant shall include the following information on a District Office's encroachment permit application:
1. Name, address, city, state, zip code, telephone number, and signature of proposed encroachment owner;
2. Name, address, city, state, zip code, telephone number, and signature of applicant, if different from proposed encroachment owner;
3. Applicant's legal relationship to proposed encroachment owner;
4. City nearest to the proposed encroachment;
5. Location of proposed encroachment from the nearest milepost (in feet), including state highway route number, side of highway, and engineering stationing (if applicable); and
6. Purpose of proposed encroachment, as listed in R17-3-502(B), and a description of the proposed work or activity in the right-of-way.

**C.** By signing an application, an applicant or proposed encroachment owner, or both, agree to accept the following general obligations and responsibilities:
1. Assume all legal liability and financial responsibility for the encroachment activity for the duration of the permit;

2. Be responsible for any repair or maintenance work to the encroachment for the duration of the permit;
3. Comply with the Department's traffic control standards;
4. Obtain written approval from the abutting property owner if the encroachment encroaches on abutting property;
5. Upon notice from the Department, repair any aspect or condition of the encroachment that causes danger or hazard to the traveling public;
6. Remove the encroachment and restore the right-of-way to its original or better condition if the Department cancels the encroachment permit, and terminates all rights under the permit;
7. Reimburse the Department for costs incurred or deposit with the Department money necessary to cover all costs incurred for activities related to the encroachment, such as inspections, restoring the right-of-way to its original or better condition, or removing the encroachment;
8. Notify a new owner to apply for an encroachment permit, as required by R17-3-502(D);
9. Apply for a new encroachment permit if the use of the permitted encroachment changes;
10. Keep a copy of the encroachment permit at the work site or site of encroachment activity;
11. Construct the encroachment according to plans that the Department approves as part of the final permit;
12. Obtain required permits from other government agencies or political subdivisions;
13. Remove any defective materials, or materials that fail to pass the Department's final inspection, and replace with materials the Department specifies.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-505. Supporting Documentation**

An applicant for an encroachment permit shall provide supporting documentation relevant to the type of encroachment activity and necessary to allow the Department to analyze the proposed encroachment's impact on the state highway and right-of-way, using such criteria as:

1. Whether the proposed encroachment is for commercial or residential access;
2. The proposed encroachment's impact on roadway features within the right-of-way;
3. The amount of traffic the proposed encroachment will generate;
4. Duration of the proposed encroachment;
5. The proposed encroachment's potential to disrupt traffic or change traffic patterns;
6. The surrounding terrain and physical features of the right-of-way and the abutting property; and
7. The number, size, and intended use of any buildings that would be accessed via the proposed encroachment.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-506. Encroachment Permit Requirements**

**A.** An encroachment permit consists of the materials submitted by an applicant under R17-3-504 and R17-3-505, and additional requirements from the Department as described in subsection (B). An encroachment permit will list in detail the requirements with which the permittee shall comply in order to perform the requested encroaching activity. Some of the requirements are general and apply to every encroachment permit. Others are specific to a particular encroachment activity.

**B.** The Department shall set encroachment permit requirements to:

1. Maintain the integrity of the Department's right-of-way and transportation facilities;
2. Mitigate the risk to traffic safety;
3. Improve traffic movement, efficiency, and capacity;
4. Mitigate adverse drainage on state property or abutting property affecting state property;
5. Mitigate environmental impacts;
6. Mitigate maintenance costs to transportation facilities;
7. Mitigate potential liability for the Department or the state; and
8. Mitigate potential harms to national or state security.

**C.** By accepting an encroachment permit, a permittee agrees to the requirements described in the permit. If the permittee disagrees with the requirements, the permittee shall return the permit immediately to the District Office.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-507. Review Procedures**

**A.** The Department shall conduct an administrative completeness review and substantive review of an application for an encroachment permit under A.R.S. §§ 41-1072 through 41-1077 and A.A.C. R17-1-102.

**B.** The Department shall decide whether to grant an encroachment permit based solely on the documents and information before the Department.

**C.** Decision.

1. The Department shall approve an encroachment permit if:
   a. The proposed encroachment use is lawful,
   b. The applicant provides complete and accurate information,
   c. The proposed encroachment use qualifies under R17-3-502(B), and
   d. The applicant agrees to comply with the Department's requirements as set out in the permit.
2. The Department shall deny an encroachment permit application if:
   a. The proposed encroachment use is unlawful,
   b. The applicant provides incomplete or inaccurate information,
   c. The proposed encroachment use does not qualify under R17-3-502(B), or
   d. The permittee disagrees with the requirements in the permit.
3. An applicant may appeal the Department's denial decision on an encroachment permit application as prescribed in R17-3-509.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-508. Unauthorized Encroachments; Enforcement Actions**

**A.** An encroachment is unauthorized if:

1. A permittee fails to comply with the permit requirements,
2. A permittee provides false or inaccurate information on the encroachment permit application,

3. A person or entity fails to obtain an encroachment permit, or
4. The encroachment is unauthorized under R17-3-502(C).

**B.** An encroachment owner shall remove any unauthorized encroachment at the owner's own cost.

**C.** After considering the totality of the circumstances and in consultation with the Office of the Attorney General, the Department may refer a matter to the Office of the Attorney General according to A.R.S. §§ 28-7053 and 28-7054 for:
1. Enforcement against the owner of an unauthorized encroachment, or
2. Recovery of costs from the encroachment owner for the Department removing an unauthorized encroachment if the encroachment owner fails to remove the unauthorized encroachment.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-509. Hearings**
The Department shall inform an applicant or permittee of the hearing procedures when the Department:
1. Denies an application for an encroachment permit, or
2. Determines that an encroachment is unauthorized.

**Historical Note**
New Section made by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

## ARTICLE 6. TELECOMMUNICATION FACILITIES

**R17-3-601. Definitions**
In addition to the definitions provided under A.R.S. §28-7381, the following terms apply to this Article unless otherwise specified:

"At-grade" means roadways, intersections, or facilities at the same elevation or level.

"Clear zone" means a specific distance from the edge of a travel lane free of above ground obstacles as determined by the Department and in accordance with the American Association of State Highway and Transportation Officials (AASHTO) Roadside Design Guide.

"Controlled access" has the same meaning as a controlled access highway as defined in A.R.S. § 28-601.

"Department" has the same meaning as defined in A.R.S. § 28-101.

"Dig Once" means reducing the number and scale of excavations when installing telecommunication facilities in highway rights-of-way.

"Encroachment permit" has the same meaning as defined in R17-3-501.

"Guideline for Accommodating Utilities on Highway Rights-of-Way" means the guidelines and procedures adopted by the Department for the accommodation of utilities on highway rights-of-way.

"Interstate System" has the same meaning as defined in A.R.S. § 28-7901.

"Lease agreement" means the written agreement between the Department and the provider, which authorizes the provider to utilize spare conduit and related facilities of the Department subject to the terms and conditions outlined in the agreement and this Article.

"New installation" means an initial installation on a highway right-of-way except in the event of a relocation required by the Department.

"Right-of-way" has the same meaning as defined in A.R.S. § 28-101.

"Right-of-way occupancy rate" means the compensation from a provider for longitudinal access to the right-of-way of a state highway for the purpose of installing telecommunication facilities as authorized under A.R.S. § 28-7385.

"State" means the state of Arizona.

"State highway" has the same meaning as defined in A.R.S. § 28-101.

"State Milepost System" means the markers placed on the highway at one-mile intervals that indicate the distance through the state.

"Uncontrolled access" means a highway to which owners or occupants of abutting lands and other persons have a legal right of access.

"Telecommunication use and occupancy agreement" means the written agreement between the Department and the provider allowing the provider longitudinal access of highway right-of-way for its telecommunication facilities or private line subject to the terms and conditions outlined in the agreement and this Article.

**Historical Note**
New Section made by exempt rulemaking at 28 A.A.R. 3372 (October 21, 2022), effective January 1, 2023 (Supp. 22-3).

**R17-3-602. Telecommunication Use and Occupancy Agreement; Time-frames; Compensation for Longitudinal Access to the Right-of-Way**

**A.** A provider must enter into a telecommunication use and occupancy agreement with the Department and obtain an encroachment permit, as prescribed under Article 5 of this Chapter, before being granted longitudinal access for new installation of a telecommunication facility. This Section does not apply to a telecommunication facility with an encroachment permit approved before January 1, 2023.

**B.** A provider seeking to enter into a telecommunication use and occupancy agreement shall complete and provide the following information on a telecommunication use and occupancy agreement application provided by the Department at www.azdot.gov:
1. Name of provider;
2. The point of contact's information, which includes name, telephone number, and email address;
3. A description of the proposed work or activity in the right-of-way or facilities; and
4. A map, drawing, or geographical description of the proposed telecommunication facility installation, including the starting and ending milepost to the nearest tenth of a mile, state highway number, the cardinal direction of the highway, the number and size of conduits, and accompanying telecommunication facility locations.

**C.** The Department shall, within five calendar days of receiving an application under subsection (B), provide written notice to the provider acknowledging receipt of the application:
1. If the application is complete, the notice shall acknowledge receipt of a complete application and indicate the date the Department received the complete application; or

2. If the application is incomplete, the notice shall indicate the current date and include an itemized list of all additional information the provider must provide to the Department before the application can be considered complete and subsequently processed.

**D.** A provider with an incomplete application shall respond to the notice provided by the Department under subsection (C)(2) within 15 calendar days after the date indicated on the notice or the Department may deny the application.

**E.** The Department shall render a decision on the application within 15 calendar days after the date on the notice the Department gave to the provider under subsection (C)(1) acknowledging receipt of a complete application.

**F.** For the purpose of A.R.S. § 41-1073, the Department establishes the following time-frames:
1. Administrative completeness review time-frame: five calendar days.
2. Substantive review time-frame: 10 calendar days.
3. Overall time-frame: 15 calendar days.

**G.** A provider shall pay an annual right-of-way occupancy rate as compensation to the Department for longitudinal access to a highway right-of-way for new installations of telecommunication facilities, including overhead, surface, or underground, in accordance with A.R.S. § 28-7385.
1. The annual right-of-way occupancy rate schedule is as follows:
   a. Interstate System: $1.00 per linear foot of longitudinal access.
   b. Controlled Access Highways (non-interstate): $0.50 per linear foot of longitudinal access.
   c. Uncontrolled Access Highways: $0.25 per linear foot of longitudinal access.
2. At the beginning of each calendar year, starting January 1, 2024, the cost per linear foot as prescribed in subsection (G)(1), increases at a rate of 2% per calendar year. The new annual right-of-way occupancy rate applies to any new or renewed telecommunication use and occupancy agreements established within that given year.
3. The annual right-of-way occupancy rate, established at the time of signing the telecommunication use and occupancy agreement, shall be the rate for each year of a 20-year or 30-year agreement.
4. The distance is measured using the State Milepost System, rounded to the nearest tenth of a mile and converted to a linear foot value.
5. The total amount of the annual right-of-way occupancy rate is determined by using the following calculation: cost per linear feet x distance = total annual right-of-way occupancy rate.
6. The Department shall receive monetary compensation in the form of an annual or lump sum payment, unless an in-kind compensation or combination of in-kind and monetary compensation is agreed upon by the Department and the provider.
   a. Annual monetary compensation. The provider shall pay the total annual right-of-way occupancy rate established at the time of signing the telecommunication and occupancy use agreement and at the time of signing any renewals.
   b. Lump-sum monetary compensation. The provider shall pay in accordance with the following:
      i. The total annual right-of-way occupancy rate is multiplied by the number of years of the agreement.
      ii. A discounted rate of 10% is applied utilizing net present value calculation.
   c. In-kind compensation.
      i. Telecommunication facilities shall be valued on a present value basis at the estimated, reasonable cost to the provider for procuring and installing such telecommunication facilities. The in-kind value shall be agreed upon, between the Department and provider, in the telecommunication use and occupancy agreement.
      ii. The Department shall provide the provider with a list of the specific telecommunication facilities and services for consideration as in-kind compensation. The value of such in-kind compensation shall be subtracted from the total amount of monetary compensation due for occupancy of the right-of-way and the remaining balance, if any, shall be remitted as monetary compensation.
      iii. Any telecommunication facilities acquired as in-kind compensation shall be used exclusively for the further development of telecommunications that serve state purposes and may not be sold or leased in competition with providers.
      iv. The provider maintains ownership and is responsible for maintenance of the in-kind compensation provided, however, the associated costs will be agreed upon in the telecommunication use and occupancy agreement.
   d. Combination of monetary and in-kind compensation. The provider will pay the total annual right-of-way occupancy rate in accordance with subsections (G)(6)(a) through (c), as applicable, and as agreed upon by the Department and the provider.
7. The payment of the annual right-of-way occupancy rate will be made as follows:
   a. For monetary compensation, the provider shall pay the total annual right-of-way occupancy rate to the Department within 30 calendar days of signing the telecommunication use and occupancy agreement and any renewals.
   b. For in-kind compensation, the agreement shall set forth the timeline for the Department to receive agreed upon telecommunication facilities.

**H.** By signing a telecommunication use and occupancy agreement, a provider agrees to accept the following general obligations and responsibilities:
1. Complying with the encroachment permit rules in Article 5 of this Chapter;
2. Complying with the terms and conditions contained in the telecommunication use and occupancy agreement and encroachment permit documents for installation, operation, maintenance, and relocation of telecommunication facilities;
3. Not having exclusive access or rights to the right-of-way;
4. Having the term length of the telecommunication use and occupancy agreement to be for one year, 20 years, or 30 years with an option to renew the agreement at the current applicable starting rate for the first year of a new agreement or renewal; the rate will be increased annually if the renewal is for a one-year period, otherwise pursuant to the terms of a new 20-year or 30-year agreement; and

5. Terminating the telecommunication use and occupancy agreement due to removal of facilities from the right of way.
   a. For any monetary compensation, the provider shall receive a prorated refund based on the number of months remaining in the term agreement.
   b. For any in-kind compensation, the access to facilities or services provided will terminate at the time of the removal of the facilities.

**Historical Note**
New Section made by exempt rulemaking at 28 A.A.R. 3372 (October 21, 2022), effective January 1, 2023 (Supp. 22-3).

**R17-3-603. Installation, Maintenance, Operation, and Relocation of Telecommunication Facilities**

**A.** Installations of telecommunication facilities may be permitted under the following conditions:
1. The installation does not adversely affect the safety, design, construction, operation, maintenance or stability of the highway;
2. The installation does not interfere with or impair the planned future expansion of the highway;
3. The installation does not interfere with or impair planned future Department-owned telecommunication facilities projects;
4. In accordance with Dig Once, the Department may require providers to adhere to Dig Once when installing telecommunication facilities into the same general location on the highway system and providers shall coordinate their planning and work, install in a joint trench, and equitably share costs;
5. The Department does not incur any unreimbursed additional expense or maintenance costs associated with the telecommunication facility installation, relocation, or removal;
6. The Department and state are not liable for any claims, demands, costs or expenses, including all legal expenses, for loss, damages or injury to any person or property, including third-party persons or property, due to the telecommunication facilities' use of the rights-of-way excluding claims made pursuant to A.R.S. § 28-7382;
7. At-grade or underground telecommunication facility items requiring access, such as conduit, fiber, splice locations, vaults, manholes, and pull boxes may be allowed inside the control of access;
8. Above ground telecommunication facility items such as cabinets, node buildings, amplifiers, pedestals, and regeneration huts will be located where they do not need to be accessed from the travel lane such as traffic interchanges, frontage roads, and intersections;
9. Above ground telecommunication facilities will not be installed within the clear zone; and
10. The location of longitudinal telecommunication facilities are as close to the right-of-way line as practical or as determined by one of the Department's Engineering and Maintenance district offices.

**B.** Telecommunication facilities may be installed longitudinally within a controlled access highway when it meets the requirements as outlined in the ADOT Guideline for Accommodating Utilities on Highway Rights-of-Way.

**C.** Pursuant to A.R.S. § 28-7384, the Department requires the removal or relocation of telecommunication facilities located on the highway right-of-way to accommodate operations and highway projects at the provider's expense. The Department may require removal or relocation of such telecommunication facilities upon expiration or earlier termination of the telecommunication use and occupancy agreement, encroachment permit, or other agreements at the provider's expense.

**Historical Note**
New Section made by exempt rulemaking at 28 A.A.R. 3372 (October 21, 2022), effective January 1, 2023 (Supp. 22-3).

## ARTICLE 7. HIGHWAY BEAUTIFICATION

**R17-3-701. Outdoor Advertising Control**

**A.** Purpose. The purpose of this subsection is to present the definitions of specialized terms used in describing outdoor advertising signs and matters relating to outdoor advertising signs. Terms used in this rule are defined as follows:
1. "Abandoned sign" means a sign for which neither the sign owner nor the landowner claim any responsibility.
2. "Back-to-back sign" means a sign that carries faces attached on each side of the structure and is read from opposite directions.
3. "Directional" means signs containing directional information about public places owned or operated by federal, state, or local government or their agencies; publicly or privately owned natural phenomena, historic, cultural, scientific, educational, religious, and rural activity sites; and areas of natural scenic beauty or naturally suited for outdoor recreation, deemed to be in the interest of the traveling public.
4. "Directional and other official signs and notices" includes only official signs and notices, public utility signs, service club and religious notices, public service signs, and directional signs.
5. "Double-faced sign" means a sign that has two faces facing in the same direction.
6. "Erect" means to construct, build, raise, assemble, place, affix, attach, create, paint, draw, or in any way bring into being or establish.
7. "Face" means the surface of an outdoor advertising structure on which the design is posted or painted, usually made of galvanized metal sheets, fiberboard, plywood or plastic.
8. "Federal or state law" means a federal or state constitutional provision or statute, or an ordinance, rule, or regulation enacted or adopted by a state or federal agency or a political subdivision of a state pursuant to a federal or state constitution or statute.
9. "Illegal sign" means a sign that was erected or maintained, or both, in violation of the state law.
10. "Intended to be read from the main-traveled way" is defined by any of the following criteria:
    a. More than 80% of the average daily traffic (as determined by traffic counts) viewing the outdoor advertising is traveling in either or both directions along the main-traveled way.
    b. Message content is of such a nature that it would be only of interest for the traffic using the main-traveled way.
    c. The sales value of the outdoor advertising is directly attributable to advertising circulation generated by traffic along the main-traveled way.
11. "Interchange" means a junction of two or more highways by a system of separate levels that permit traffic to pass

from one to another without the crossing of traffic streams.

12. "Landmark sign" means a sign of historic or artistic significance that existed on October 22, 1965, which may be preserved or maintained as determined by the Director and approved by the Secretary of Transportation.
13. "Lease" means an agreement, oral or in writing, by which possession or use of land or interests in land is given by the owner to another person for a specified period of time.
14. "Maintain" means to allow to exist, including such activities necessary to keep the sign in good repair, safe condition, and change of copy.
15. "Nonconforming sign" means a sign that was lawfully erected but does not comply with the provisions of state law or state laws passed at a later date or later fails to comply with state law or state regulations due to changed conditions. Illegally erected or maintained signs are not nonconforming signs.
16. "Normal maintenance (nonconforming sign)" means the maintenance customary to keep a sign in ordinary repair, upkeep or refurbishing. The maintenance does not include:
    a. Maintenance that exceeds 50% of the appraised value using current appraisal schedules for a sign, or
    b. Repairs to a sign damaged to such an extent that 60% or more of the uprights require replacement for wood uprights, or 30% or more of the length of each upright support above ground requires replacement for metal uprights.
17. "Obsolete sign" means a directional or other official sign the purpose of which is no longer pertinent.
18. "Official signs and notices" means signs and notices, other than traffic regulatory signs and notices, erected and maintained by public officers or public agencies within their territorial or zoning jurisdiction and pursuant to direction or authorization contained in federal, state, or local law for the purposes of carrying out an official duty or responsibility. Historical markers authorized by state law and erected by state or local government agencies or nonprofit historical societies are official signs.
19. "Off-premise sign" means an outdoor advertising sign that advertises an activity, service or product and that is located on premises other than the premises at which the activity or service occurs or the product is sold or manufactured.
20. "On-premise sign" means any sign that meets the following requirements (such signs are not controlled by state statutes):
    a. Premises. The sign must be located on the same premises as the activity or property advertised.
    b. Purpose. The sign must have as its purpose:
        i. The identification of the activity, or its products or services, or
        ii. The sale or lease of the property on which the sign is located, rather than the purpose of general advertising.

c. In the case of an on-premise sign advertising an activity, the premises must include all actual land used or occupied for the activity, including its buildings, parking, storage and service areas, streets, driveways and established front, rear, and side yards constituting an integral part of such activity, provided the sign is located on property under the same ownership or lease as the activity. Uses of land that serve no reasonable or integrated purpose related to the activity other than to attempt to qualify the land for signing purposes are not premises. Generally these will be inexpensive facilities, such as picnic grounds, playgrounds, walking paths, or fences.

21. "Parkland" means any publicly owned land that is designated or used as a public park, recreation area, wildlife or waterfowl refuge or historic site.
22. "Public service signs" means signs that are located on school bus stop shelters and that:
    a. Identify the donor, sponsor, or contribution of the shelters;
    b. Contain safety slogans or messages, which must occupy not less than 60% of the area of the sign;
    c. Contain no other message;
    d. Are located on school bus shelters that are authorized or approved by city, county, or state law, regulation, or ordinance, and at places approved by the city, county, or state agency controlling the highway involved; and
    e. May not exceed 32 square feet in area. Not more than one sign on each shelter shall face in any one direction.
23. "Public utility signs" means warning markers that are customarily erected and maintained by publicly or privately owned public utilities to protect their facilities.
24. "Re-erection" means the placing of any sign in a vertical position subsequent to its initial erection. Re-erection shall only occur in the event the sign has been damaged by tortious acts, or in the course of normal maintenance.
25. "Scenic area" means any area of particular scenic beauty or historical significance as determined by the federal, state, or local officials having jurisdiction of the area, and includes interests in land that have been acquired for the restoration, preservation, and enhancement of scenic beauty.
26. "Scenic overlook or rest area" means an area or site established and maintained within or adjacent to the highway right-of-way by or under public supervision or control for the convenience of the traveling public.
27. "Service club and religious notices" means signs and notices, whose erection is authorized by law, relating to meetings of nonprofit service clubs or charitable associations, or religious service, that do not exceed eight square feet in area.
28. "V-type signs" means signs that are oriented at an angle to each other, the nearest points of which are not more than 10 feet apart.
29. "Within the view of and directed at the main-traveled way" means any sign that is readable from the main-traveled way for more than five seconds traveling at the posted speed limit or for such a time as the whole message can be read, whichever is less.

**B.** Outdoor advertising permit application procedure.

1. Purpose. The purpose of this subsection is to present the procedures to be followed by applicants in requesting permits for the erection of outdoor advertising facilities.
2. Permit form and fee required. Each application for a permit to erect an outdoor advertising facility must be made on the appropriate Arizona Department of Transportation form and shall be accompanied by a check or money order in the amount of $20.00 payable to the Arizona Department of Transportation.

a. The initial application fee shall be valid for a period of one year from date of issuance. It shall be renewable annually upon payment of a $5.00 fee.
b. Renewal fees will become delinquent 30 days after the annual renewal date. On becoming delinquent, such sign structures will be in violation and a new initial application fee of $20.00 will be required.

3. Applications mailed to maintenance permit engineer. Applications for outdoor advertising permits should be mailed to: Arizona Department of Transportation, Intermodal Transportation Division; 206 South 17th Avenue; Phoenix, Arizona 85007; Attention: Maintenance Permits Section. Assistance to applicants is available at District offices.
4. Separate application for each sign. Each outdoor advertising sign, display or device requires a separate application with fee. All required information describing the location of the sign, the sign qualification standards, and the permitted area identification shall be completely entered on the permit form.
5. Legal description of sign site required. Applicants shall be required to obtain a certification from the governing zoning authority certifying that the zoning is correct for the legal description of the proposed sign location. In cases where the legal description is listed incorrectly on the application, a new certification must be obtained for the correct legal description. Legal descriptions shall adequately describe the property for which the application is made.
6. Location diagram required. Applicants shall submit a location diagram indicating highway route number and such physical features as: buildings, bridges, culverts, poles, mileposts and other stationary land marks necessary to adequately describe the location. The sketch will also indicate the distance in feet the sign is to be erected from the nearest milepost or a street intersection and other off-premise signs in the same vicinity.
7. Applicants must mark site locations. Applicants are required to place an identifiable device or object bearing applicant's name at the proposed sign location to aid field inspectors in site evaluations.
8. Landowner's permission mandatory. Applicants shall be required to obtain a signed certification stating that the applicant has the permission of the landowner to erect the sign at the noted legal description, or in lieu of the signed certification, furnish a copy of an executed lease.
9. Each pending application field checked. Each pending application will be field checked for compliance with the state act and regulations by the district. The findings of the field check will be forwarded to the Maintenance Permit Engineer, Maintenance Section, for final examination and, if approved, permit issuance.
10. Noncompliance. Each application for a permit to erect an outdoor advertising facility which does not comply with all requirements of the law and the Arizona Department of Transportation regulations, will be denied and the application fee may be retained by the state. Exception will be made in cases where applicants did not have knowledge of previous applications or permits for the same site. An additional $20.00 fee shall be added to the regular permit fee for signs illegally erected prior to the issuance of a permit.
11. Permit decals on sign structures. Applicants shall affix permit decals on a permanent surface near the portion of the sign structure closest to the main-traveled way and clearly visible from the roadway. Permit decals to replace any which have been issued and were improperly affixed, lost or destroyed, whether before or after attaching to the sign structure, may be purchased at a cost of $5.00. Signs bearing permit decals for signs other than the sign for which they were issued shall be in violation.
12. Forfeiture of permit fee. Outdoor advertising facilities for which permits have been issued shall be erected within 120 days and shall bear the official permit identification issued for the specific facility. If the applicant mails a written request for extension of time prior to expiration of the 120 days, an additional 60-day extension may be granted. Any permit canceled because no sign was erected within the prescribed time will result in forfeiture of the $20.00 fee.
13. Denial of permit renewals. An existing permit will not be renewed for an approved location on which no sign structure exists.
14. Removal and re-erection time limits. If an outdoor advertising sign is removed from a permitted location for any reason, the permit shall expire within 30 days from date of removal, except that the permittee may notify the Arizona Department of Transportation, Intermodal Transportation Division; Maintenance Permits Section, of intent to re-erect which will allow 120 days for re-erection. Failure to re-erect which will allow 120 days for re-erection. Failure to re-erect within the 120 days allowed will cancel the existing permit.
15. Transfer of permits. Permits are transferable upon sale of sign provided a new owner furnishes the Arizona Department of Transportation with notification of sale within 30 days after date of sale.
16. Calendar days. All references to days made in this permit application procedure, as well as those references in all rules and regulations applying to outdoor advertising control, shall mean calendar days.

**C.** Administrative rules.

1. Purpose. The purpose of this subsection is to present administrative rules developed by the Arizona Department of Transportation for control of outdoor advertising.
2. Restrictions on rights-of-way use. No sign shall be erected or maintained from or by use of interstate highway rights-of-way. Any observed action of this type will result in cancellation of the permit. Signs may be erected and maintained from primary and secondary highways only if no other access is available and an encroachment permit is issued.
3. Nonconforming signs shall be in violation if:
   a. A sign is enlarged (increased in any dimensions of the sign face or structural support),
   b. A sign is replaced (an existing sign is removed and replaced with a completely different sign),
   c. A sign is rebuilt to a different configuration or material composition beyond normal maintenance,
   d. A sign is relocated (moved to a new position or location without being lawfully permitted), or
   e. A sign which was previously non-illuminated has lighting added.
4. Commercial or industrial activities. Commercial or industrial activities which define a business area, or an unzoned commercial or industrial area must be in operation at the time the permit application is made. Should any commercial or industrial activity, which has been

used in defining or delineating a business area, or an unzoned commercial or industrial area, cease to operate for a period of six continuous months, any signs qualified by such activity shall become nonconforming.

5. On premise. Should any activity which has been used in defining an on-premise sign cease to operate for a period of six continuous months any signs qualified by that activity shall be considered as off premise and will require appropriate permits. If the signs are then not permitable they will be in violation.
6. Municipal limit between signs. When a municipal limit falls between signs the spacing requirement shall be 300 feet between signs on primary or secondary highways.
7. Proposed interstate alignment locations. Signs existing or to be erected on primary or secondary highway systems which have been declared by the Director of Transportation as an interstate freeway alignment prior to construction of such interstate or freeway shall be classified as though the Interstate or Freeway already exists, requiring spacing criteria for Interstate or other freeways.
8. Double-faced, back-to-back, and V-type signs. Double-faced, back-to-back and V-type sign structure permits will be limited to a single sign ownership for each site. No more than two faces will be allowed facing each direction of travel. Double-faced signs shall not exceed 350 square feet per face. V-type signs will be limited to a 10’ spacing between faces at the apex. V-type sign spacing from other signs shall be measured from the middle of the apex.
9. Multifaced community signs. Local chambers of commerce may obtain permits to erect signs with more than two faces. These signs shall not exceed 1,200 square feet in area with a maximum overall vertical facing of 25 feet and a maximum overall horizontal facing of 60 feet, including border and trim, and excluding base or apron supports and other structural members. All other laws, rules and regulations will apply to multifaced community signs as to other off premise signs.
10. New sign making existing sign nonconforming. If a new sign which would otherwise be conforming will make an existing sign nonconforming, the new sign shall not be allowed.
11. Hearing requests. The land owner or sign owner may request a hearing in connection with a permit application denied or other action taken by the Arizona Department of Transportation in connection with the rules prescribed in this Section. Within seven days after notice of the action is mailed or posted, the land owner or sign owner may make written request for a hearing on the action. The Director of the Department of Transportation shall designate a hearing officer, who shall be an administrative employee of the Department of Transportation, to conduct and preside at the hearings. When a hearing is requested, the hearing shall be held within 30 days after the request, and the party requesting the hearing shall be given at least five days notice of the time of the hearing. All hearings shall be conducted at Department of Transportation administrative offices. A full and complete record and transcript of the hearing shall be taken. The presiding officer shall within 10 days after the hearing make a written determination of the presiding officer’s findings of fact, conclusions and decision and shall mail a copy of the same, by certified mail, to the owner or the party who requested the hearing.
12. Landmark signs. The Director will submit a one-time declaration listing all landmark signs to the Secretary of Transportation. The preservation of these signs would be consistent with the purposes of state highway beautification laws.
13. Blanked out or discontinued nonconforming signs. When an existing nonconforming sign ceases to display advertising matter for a period of one year the use of the structure as a nonconforming outdoor advertising sign is terminated.
14. Vandalized signs. Legal nonconforming signs may be rebuilt to their original configuration and size when they are destroyed due to vandalism and other criminal or tortious acts.

**D.** Standards for directional and other official signs.

1. Purpose. The purpose of this subsection is to present standards applicable to directional and other official signs.
2. Scope and application. The standards presented in this Chapter apply to directional and other official signs and notices which are erected and maintained within 660 feet of the nearest edge of the right-of-way of the interstate, federal-aid primary and secondary highway systems and which are visible from the main-traveled way of the systems. These types of signs must conform to national standards, promulgated by the Secretary of Transportation under authority set forth in 23 U.S.C. 131(c). These standards do not apply, however, to directional and other official signs erected on the highway right-of-way.
3. Standards for directional signs. The following apply only to directional signs:
    a. General. The following signs are prohibited:
        i. Signs advertising activities that are illegal under federal or state laws or regulations in effect at the location of those signs or at the location of those activities.
        ii. Signs located in such a manner as to obscure or otherwise interfere with the effectiveness of an official traffic sign, signal, or device or obstruct or interfere with the driver’s view of approaching, merging, or intersecting traffic.
        iii. Signs which are erected or maintained upon trees or painted or drawn upon rocks or other natural features.
        iv. Obsolete signs.
        v. Signs which are structurally unsafe or in disrepair.
        vi. Signs which move or have any animated or moving parts.
        vii. Signs located in rest areas, parklands or scenic areas.
    b. Size. No sign shall exceed the following limits, which include border and trim, but exclude supports.
        i. Maximum area -- 150 square feet.
        ii. Maximum height -- 20 feet.
        iii. Maximum length -- 20 feet.
    c. Lighting. Signs may be illuminated, subject to the following:
        i. Signs which contain, include, or are illuminated by any flashing, intermittent or moving light or lights are prohibited.
        ii. Signs which are not effectively shielded so as to prevent beams or rays of light from being directed at any portion of the traveled way of an Interstate or primary highway or which are of

such intensity or brilliance as to cause glare or to impair the vision of the driver of any motor vehicle, or which otherwise interfere with any driver's operation of a motor vehicle are prohibited.

iii. No sign may be so illuminated as to interfere with the effectiveness of or obscure an official traffic sign, device, or signal.

d. Spacing.

i. Each location of a directional sign must be approved by the Arizona Department of Transportation.

ii. No directional sign may be located within 2,000 feet of an interstate, or intersection at grade along the interstate system or other freeways (measured along the interstate of freeway from the nearest point of the beginning or ending of pavement widening at the exit from or entrance to the main traveled way).

iii. No directional sign may be located within 2,000 feet of a rest area, parkland, or scenic area.

(1) No two directional signs facing the same direction of travel shall be spaced less than one mile apart;

(2) Not more than three directional signs pertaining to the same activity and facing the same direction of travel may be erected along a single route approaching the activity;

(3) Directional signs located adjacent to the Interstate System shall be within 75 air miles of the activity; and

(4) Directional signs located adjacent to the Primary System shall be within 50 air miles of the activity.

(5) No directional signs shall be located within 500 feet of an off-premise outdoor advertising sign on any state highway.

e. Message content. The message on directional signs shall be limited to the identification of the attraction or activity and directional information useful to the traveler in locating the attraction, such as mileage, route numbers, or exit number. Descriptive words or phrases, and pictorial or photographic representations of the activity or its environs are prohibited.

f. Selection methods and criteria for privately owned activities or attractions to obtain directional sign approval.

i. Privately owned activities are attractions eligible for directional signing are limited to the following categories:

(1) Natural phenomena,
(2) Scenic attractions,
(3) Historic sites,
(4) Educational sites,
(5) Cultural sites,
(6) Scientific sites,
(7) Religious sites, and
(8) Outdoor recreational areas.

ii. To be eligible, privately owned attractions or activities must be nationally or regionally known, and of outstanding interest to the traveling public.

iii. The Director, Arizona Department of Transportation, will appoint a Selection Board for Directional Signing Qualifications consisting of three administrative or professional employees of the Department of Transportation, one of whom shall be designated as chairperson, to judge and approve the qualifications for directional signing of privately owned activities or attractions as limited to the categories in subsection (D)(3)(f)(i) and the qualification in subsection (D)(3)(f)(ii).

iv. Applicants for directional signs involving privately owned activities or attractions, shall first qualify the activity or attraction by submitting an official qualification form to the attention of the maintenance permit engineer, highways division, Arizona Department of Transportation. The maintenance permit engineer will forward the application for qualification, along with any technical data which may assist the selection board in making the selection board's determination, to the selection board.

v. Applicant shall indicate one or more categories (as listed in subsection (D)(3)(f)(i) that is applicable to the activity or attraction for which qualification is sought. Applicants shall submit a statement and supporting evidence that the activity or attraction is nationally or regionally known and is of outstanding interest to the traveling public.

vi. The selection board will, upon approval or rejection of an application, give notification of the selection board's determination in writing, to the applicant and to the maintenance permit engineer.

vii. The maintenance permit engineer will not issue any permits for directional signs for any privately owned activity or attraction until receipt of qualification approval by the selection board. All directional sign permits issued for the Department of Transportation by the maintenance permit engineer will meet the standards for directional and other official signs as incorporated in the "Rules and Regulations for Outdoor Advertising along Arizona Highways" approved and issued by the Director, Arizona Department of Transportation.

g. Rural activity signs are intended to give directions to rural activity sites located along rural roads connecting to state highways. The signs must be located in areas primarily rural in nature. Rural activities that may qualify include ranches, recreational areas and mines. Signs for private residences, subdivisions, and commercial activities are not permitted. Industrial activities that are located in primarily rural areas such as mines or material pits may be allowed. The signs shall not be located in business areas, unzoned commercial or industrial areas, or within municipal limits. The selection board may make final determination of eligibility for those signs when necessary. Not more than one sign pertaining to a rural activity facing the same direction of travel may be erected along a single route approaching the rural connecting road. Signs will be limited to 10

square feet in area. All other standards for directional signs shall apply.

h. No application fee is required for official signs and notices, public utility signs, service club and religious notices, public service signs or directional signs erected by federal, state or local governments. Other directional signs require a permit application and $20.00 fee.

**Historical Note**

Adopted effective January 3, 1977 (Supp. 77-1). Former Section R17-3-711 renumbered without change as Section R17-3-701 (Supp. 88-4). Amended by final rulemaking at 18 A.A.R. 2347, effective November 10, 2012 (Supp. 12-3).

**Exhibit 1. Expired**

**Historical Note**

Exhibit 1 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 2. Expired**

**Historical Note**

Exhibit 2 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 3. Expired**

**Historical Note**

Exhibit 3 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 4. Expired**

**Historical Note**

Exhibit 4 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 5. Expired**

**Historical Note**

Exhibit 5 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 6. Expired**

**Historical Note**

Exhibit 6 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 7. Expired**

**Historical Note**

Exhibit 7 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 8. Expired**

**Historical Note**

Exhibit 8 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**Exhibit 9. Expired**

**Historical Note**

Exhibit 9 expired under A.R.S. § 41-1056(E) at 15 A.A.R. 2104, effective October 1, 2009 (Supp. 09-4).

**R17-3-701.01. Outdoor Advertising Control: Restrictions on the Erection of Billboards and Signs and Restrictions on the Issuance of Permits**

**A.** Outdoor advertising shall not be erected under A.R.S. § 28-2102(A)(4) or (5) in a zoned area:

1. Which is not part of a comprehensive zoning plan and which is created primarily to permit outdoor advertising structures, or
2. In which limited commercial or industrial activities are permitted as an incident to other primary land uses.

**B.** A permit for outdoor advertising shall not be issued under A.R.S. § 28-2106(4) in a zoned area:

1. Which is not part of a comprehensive zoning plan and which is created primarily to permit outdoor advertising structures, or
2. In which limited commercial or industrial activities are permitted as an incident to other primary land uses.

**Historical Note**

Emergency rule adopted effective May 17, 1994, pursuant to A.R.S. § 41-1026, valid for 90 days (Supp. 94-2). Permanently adopted without change effective August 12, 1994 (Supp. 94-3).

**R17-3-702. Repealed**

**Historical Note**

Adopted effective September 9, 1977 (Supp. 77-5). Amended effective May 11, 1981 (Supp. 81-3). Former Section R17-3-712 renumbered without change as Section R17-3-702 (Supp. 88-4). Section R17-3-702 and Exhibits 1-9 repealed by final rulemaking at 10 A.A.R. 5202, effective February 5, 2005 (Supp. 04-4).

**R17-3-703. Arizona Junkyard Control**

**A.** Purpose. The purpose of this Section is to describe the Arizona Department of Transportation's responsibility to effectively control junkyards within 1000 feet of the right-of-way on interstate highways under A.R.S. §§ 28-7941 through 28-7946.

**B.** Definitions. For purposes of this Section:

1. "Department" means the Arizona Department of Transportation.
2. "Director" means the Director, Arizona Department of Transportation or the Director's designated representative.
3. "Screening" means the use of vegetative planting, fencing, masonry wall or other constructed structure, earthen embankment, or a combination of any of these that effectively hides from view a deposit of junk from the main-traveled way.
4 "Screening license" means a license issued by the Director as required by A.R.S. § 28-7943 and as described in this Section.
5. "Unzoned industrial area" means the same as in A.R.S. § 28-7901(11).

**C.** Screening license application procedure.

1. Screening license required. The Department requires a screening license for a junkyard that:
   a. Was established or expanded after July 1, 1974;
   b. Is located within 1000 feet of the nearest edge of the right-of-way of the interstate highway system;
   c. Is within view of the main-traveled way of the interstate highway system; and
   d. Is not located in a zoned or unzoned industrial area.

2. Screening license form. An applicant shall use the Department "junkyard permit application" form to apply for a screening license, and provide the following information:
   a. Name, address, and telephone number of the owner;
   b. Legal description of the land where the junkyard to be screened is located;
   c. Name and address of the junkyard business;
   d. Location of the junkyard, including:
      i. The highway route number,
      ii. Distance, in feet, to nearest highway milepost,
      iii. Distance, in feet, from the highway right-of-way to the junkyard boundaries.
   e. Zoning classification of the land where the junkyard is located; and,
   f. Type, size, and date of establishment of the junkyard.
3. Application mailed to Permits Manager. An applicant shall mail the completed junkyard permit application, required documentation and the $25.00 fee, in the form of a check or money order payable to the Arizona Department of Transportation, to:
   Arizona Department of Transportation
   Intermodal Transportation Division
   206 South 17th Avenue, MD 004R
   Phoenix, AZ 85007
   Attention: Maintenance Permits Manager, Maintenance Section
4. Required documentation. Along with the junkyard permit application, an applicant shall submit the following documentation:
   a. A location diagram or plat of the junkyard area that indicates:
      i. The highway route number;
      ii. Distance, in feet, to nearest highway milepost;
      iii. Physical features such as buildings, bridges, culverts, utility poles, and other stationary improvements or site features that adequately describe the location; and
      iv. Distance, in feet, from the highway right-of-way to the junkyard boundaries.
   b. A drawing or plan, drawn to scale, of the junkyard screening design to be used, that includes:
      i. Plan view;
      ii. Elevation;
      iii. Construction details of fencing, berms, and plantings used alone or in combination;
      iv. If applicable, plant pit size, backfill material to be used, planting and staking details, botanical names of plant materials, plant size at the time of planting, and the spacing between plants; and
      v. Any details necessary to show design and construction materials to be used.
5. Extensions. A request for an extension shall be in writing. The Department shall grant a 60 day extension in the following circumstances:
   a. If an applicant requests an extension for completion of screening within 90 days after the Department approves a screening license; and
   b. If the Department gives a junkyard owner a violation notice and the junkyard owner requests an extension to submit the screening application within 60 days of receiving the violation notice.
6. License issuance or denial.
   a. The Department shall grant an application for a screening license only if the application complies with all requirements of A.R.S. §§ 28-7941 through 28-7946 and this Section.
      i. A junkyard owner has 180 days from the date of approval to screen the junkyard.
      ii. The Department shall field check each approved license to ensure compliance with the screening requirements of A.R.S. §§ 28-7941 through 28-7946, and this Section.
   b. If the Department denies an application because the screening plan does not comply with A.R.S. §§ 28-7942 through 28-7946 or this Section, an applicant may, within 10 days of the denial, request permission in writing to submit an amended application and amended screening plan without paying an additional fee.
   c. A junkyard owner who fails to complete the junkyard screening within 180 days from approval of the screening license, or other prescribed period, may be found guilty under subsection (D)(9).
7. Invalidation of screening license. An existing screening license shall become invalid at a previously approved location when the junkyard is enlarged or substantially changed in use so that the screening no longer adequately screens the junk. An owner shall apply for a new and separate screening license.
8. Transfer of screening license. To transfer a screening license upon sale of a junkyard, a new owner shall submit to the Department written notification of sale within 30 days after date of sale. Upon sale of a junkyard, the new owner shall continue all screening maintenance.

**D.** Screening.
1. Purpose. This subsection describes the requirements governing the location, planting, construction, and maintenance, of materials used in screening junkyards as required in A.R.S. § 28-7942(D).
2. Junkyard expansions. A junkyard owner shall be responsible for any expense to expand an existing junkyard screen. Screening expansions shall be aesthetically compatible, as the Director determines, with existing screens.
3. Screening location. Fences and screens shall be located so as not to be hazardous to the traveling public. New junkyards and expansions shall have screens in place before any junk is deposited.
4. Acceptable screening. When fencing is used alone or in combination with plant material, the fencing shall be capable of screening the junk entirely from view. When planting is used alone or in combination with an earthen berm, the number, type, size, and spacing of the plants shall be capable of screening the junk entirely from view, as determined by the Department.
5. Acceptable fencing materials. Acceptable fencing includes: steel or other metals; durable woods such as heart cypress, redwood, or other wood treated with a preservative; and walls of concrete block, brick, stone, or other masonry. Metal fencing shall be stained, colored, coated, or painted to blend into surroundings and be aesthetically unobtrusive.
6. Acceptable plant materials. Plant materials used shall be predominantly evergreen. In general, the minimum size of plant materials used shall be equal to five-gallon con-

tainers. An applicant may obtain a list of acceptable plant materials from the Department.

7. Screening maintenance. A junkyard owner shall ensure that screening does not enter the right-of-way. A junkyard owner shall maintain all screening in good condition by:
   a. Maintaining fences, walls, or other structural material in good appearance by timely painting and repair.
   b. Adequately watering, cultivating, mulching, or giving other maintenance to plant material, including spraying for insect control, to keep the planting in healthy condition; and
   c. Removing all dead plant material immediately and replacing it promptly during the following planting season. Replacement plants shall be at least as large as the initial planting as approved on the screening license.
8. Abandoned, destroyed, or voluntarily discontinued junkyards. A junkyard that ceases to operate for a period of one year or longer, shall comply with A.R.S. § 28-7943 and obtain a screening license to be reopened.
9. Violation.
   a. The Department shall issue a violation notice to a junkyard owner for failing to comply with A.R.S. §§ 28-7941 through 28-7946. A junkyard owner shall have 60 days from the date the violation notice is issued to apply for a screening license and submit a screening plan for the Department's review and approval.
   b. A person who violates any provision of A.R.S. §§ 28-7941 through 28-7946 or this Section for junkyard control can be found guilty of a misdemeanor under A.R.S. § 28-7946.

**Historical Note**

Adopted effective September 7, 1979 (Supp. 79-5). Amended effective June 13, 1980 (Supp. 80-3). Former Section R17-3-713 renumbered without change as Section R17-3-703 (Supp. 88-4). Amended by final rulemaking at 8 A.A.R. 844, effective February 8, 2002 (Supp. 02-1).

## ARTICLE 8. EXPIRED

**R17-3-801. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Amended by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-1).

**R17-3-802. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Amended by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-1).

**R17-3-803. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-1).

**R17-3-804. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-1).

**R17-3-805. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Correction to subsection (C) (Supp. 88-4). Amended effective August 3, 1994 (Supp. 94-3). Amended by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-1).

**R17-3-806. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Amended by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-w1).

**R17-3-807. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Amended by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 1589, effective February 4, 2020 (Supp. 20-3).

**R17-3-808. Expired**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 382, effective February 4, 2020 (Supp. 20-1).

**R17-3-809. Repealed**

**Historical Note**

Adopted effective May 30, 1984 (Supp. 84-3). Amended effective August 3, 1994 (Supp. 94-3). Section repealed by final rulemaking at 10 A.A.R. 2073, effective July 6, 2004 (Supp. 04-2).

## ARTICLE 9. HIGHWAY TRAFFIC CONTROL DEVICES

**R17-3-901. Signing for Colleges and Universities**

**A.** Definitions.

"Community College" has the meaning as prescribed in A.R.S. § 15-1401.

"Department" means the Arizona Department of Transportation.

"FHWA" means the Federal Highway Administration of the U.S. DOT.

"Major metro area" means an urban area with a population of at least 50,000.

"Municipality" means an incorporated city or town.

"MUTCD" means the Manual on Uniform Traffic Control Devices, a national standard for the design and application of traffic control devices that is published by the U.S. DOT/FHWA and that is the standard for traffic control devices on the streets and highways of this state as required by A.R.S. § 28-641.

"Nonconforming sign" means an erected sign that does not comply with this Section or A.R.S. § 28-642(D) due to changes in the statutes, rules, or changed conditions. Examples of changed conditions include the reconstruction of a highway or physical deterioration of a sign.

"Regionally accredited college or university" means a college or university accredited by a regional institutional accrediting association recognized by the Arizona State Board for Private Postsecondary Education.

"Rural area" means all areas other than a major metro area or an urban area.

"Signing" means standard highway supplemental guide signs as specified in the MUTCD.

"State highway" has the same meaning as prescribed in A.R.S. § 28-101.

"State University" means a university established and maintained by the Arizona Board of Regents under A.R.S. § 15-1601.

"Trailblazing sign" means a sign installed by a local governmental agency, off the state highway, to guide traffic to a college or university.

"Trip" means a one-way commute to or from a college or university, calculated by the Department based on the number of students or dorm beds, using the following equivalents:

One student = 1 1/2 trips
One dorm bed = three trips.

"Urban area" means a municipality having a population of at least 10,000 but less than 50,000.

"U.S. DOT" means the United States Department of Transportation.

**B.** Application for signing. A college or university referenced in A.R.S. § 28-642(D) may request signing by submitting a letter on its letterhead to the Department's State Traffic Engineer. The letter shall contain the following information:

1. Name of college or university;
2. Complete street address;
3. Names of agencies granting accreditation;
4. Number of students;
5. Number of dormitory beds, if applicable; and
6. Signature of a person authorized to sign for the college or university.

**C.** Requirements. To be considered for signing, a college or university referenced in A.R.S. § 28-642(D) shall satisfy the following:

1. Is on a road that intersects a state highway. If a college or university is on a road that does not intersect a state highway, it still may qualify if:
   a. The governing political subdivision submits to the Department, within 30 days from the Department's receipt of the request for signing, written confirmation stating that the governing political subdivision will install and maintain trailblazing signs; and
   b. The governing political subdivision installs trailblazing signs before the Department places signing on the state highway.
2. Meets all the requirements under subsection (C)(2)(a), (b), or (c) of this Section.
   a. If in a major metro area:
      i. Generates at least 4000 trips per weekday.
      ii. Is three miles or less from a state highway, except the distance may be increased 1/4 mile for each 10% increase in the required number of trips per weekday to a maximum of five miles.
   b. If in an urban area:
      i. Generates at least 2000 trips per weekday.
      ii. Is four miles or less from a state highway, except the distance may be increased 1/4 mile for each 10% increase in the required number of trips per weekday to a maximum of five miles.
   c. If in a rural area:
      i. Generates at least 1000 trips per weekday.
      ii. Is five miles or less from the state highway, except the distance may be increased 1/4 mile for each 10% increase in the required number of trips per weekday to a maximum of 15 miles.

**D.** Exceptions to standards. The Department may place supplemental guide signs on state highways to direct traffic to colleges and universities. The Department shall determine whether to place supplemental guide signs for a college or university based on the specific criteria and the guidelines in the MUTCD.

**E.** Nonconforming signs. The Department may remove a nonconforming sign if:

1. Other signs have greater priority under the criteria in the MUTCD,
2. Physical spacing of signs is limited for an upcoming interchange or intersection, or
3. A greater number of trips are generated by the subject of other guide signs.

**F.** College or university. Only the initial, main campus of a college or university referenced in A.R.S. § 28-642(D) may qualify for signing, unless otherwise permitted by statute.

**Historical Note**
Adopted effective May 7, 1991 (Supp. 91-2). Amended by final rulemaking at 8 A.A.R. 3838, effective August 12, 2002 (Supp. 02-3). Amended by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 1324, effective July 6, 2013 (Supp. 13-2).

**R17-3-902. Logo Sign Programs**

**A.** Definitions.

"Attraction" means any of the following:

"Arena" means a facility that has a capacity of at least 5000 seats, and is a:

Stadium or auditorium;

Track for automobile, boat, or animal racing; or

Fairground that has a tract of land where fairs or exhibitions are held and permanent buildings that include bandstands, exhibition halls, and livestock exhibition pens.

"Cultural" means an organized and permanent facility that is open to all ages of the public, and is a:

Facility for the performing arts, exhibits, or concerts; or

Museum with professional staff, and an artistic, historical, or educational purpose, that owns or uses tangible objects, cares for them, and exhibits them to the public.

"Domestic farm winery" means a site licensed by the Arizona Department of Liquor Licenses and Control under A.R.S. § 4-205.04 that produces at least 200 gallons and not more than 40,000 gallons of wine annually that is commercially packaged for off-premises sale, and is open to the public for tours to provide an educational format for informing visitors about wine.

"Domestic microbrewery" means a site licensed by the Arizona Department of Liquor Licenses and Control under A.R.S. § 4-205.08 that produces not less than 5000 gallons of beer in each calendar year following the first year of operation and not more than 1.24 million gallons of beer in a calendar year, and is open to the public for tours to provide an educational format for informing visitors about beer.

"Dude ranch" means a facility offering overnight lodging, meals, horseback riding, and activities related to cattle ranching;

"Farm-related" means an established area or facility where consumers can purchase directly from Arizona producers locally-grown, consumer-picked or pre-picked produce, or local products produced from locally-grown produce.

"Golf course" means a facility offering at least 18 holes of play. Golf course excludes a miniature golf course, driving range, chip-and-putt course, and indoor golf.

"Historic" means a structure, district, or site that is listed on the National or Arizona Register of Historic Places as being of historical significance, and includes an informational device to educate the public about the facility's historic features.

"Mall" means a shopping area with at least 1 million square feet of retail shopping space.

"Recreational" means a facility for physical exercise or enjoyment of nature that includes at least one of the following activities: walking, hiking, skiing, boating, swimming, picnicking, camping, fishing, playing tennis, horseback riding, skating, hang-gliding, and climbing;

"Scenic tours" means a business that offers guided tours of scenic areas in Arizona through various means, including air, motorized vehicle, animal, walking, or biking;

"Average annual daily traffic" means the total volume of traffic passing a point or segment of an interstate or other state highway in both directions for one year, divided by the number of days in the year, adjusted for hours of the day counted, days of the week, and seasons of the year.

"Business" means an entity that provides a specific service open for the general public and is located on a roadway within the required distance of an interstate or other state highway.

"Contract" means a written agreement between a contractor and the Department to operate a logo sign program or any aspect of a logo sign program that describes the obligations and rights of both parties.

"Contractor" means a person or entity that enters into an agreement with the Department to operate a logo sign program or any aspect of a logo sign program, and that is responsible for those aspects of a logo sign program as provided in the contract.

"Department" means the Arizona Department of Transportation.

"Exit ramp" means a roadway by which traffic may leave a controlled access highway.

"FHWA" means the Federal Highway Administration of the U.S. DOT.

"Food court" means a collective food facility that exists in one contiguous area and contains a minimum of three separate food service businesses.

"Highway" has the same meaning as prescribed in A.R.S. § 28-101.

"Interchange" means the point at which traffic on a system of interconnecting roadways that have one or more grade separations, moves from one roadway to another at a different level.

"Intersection" has the same meaning as prescribed in A.R.S. § 28-601.

"Interstate system" has the same meaning as prescribed in A.R.S. § 28-7901.

"Lease agreement" means a written contract between a contractor and a responsible operator, or between the Department and a responsible operator, to lease space for a responsible operator's logo on a contractor's or the Department's specific service information sign.

"Logo" means an identification brand, symbol, trademark, name, or a combination of these, for a responsible operator.

"Logo sign" means a specific service information sign consisting of a lettered board attached to a separate rectangular panel that displays an identification brand, symbol, trademark, name, or a combination of these, for a responsible operator.

"Logo sign panel" means a separate rectangular panel on which a logo is placed.

"Municipality" means an incorporated city or town.

"MUTCD" means the Manual on Uniform Traffic Control Devices, a national standard for the design and application of traffic control devices that is published by the U.S. DOT/FHWA and that is the standard for traffic control devices on the streets and highways of this state as required by A.R.S. § 28-641.

"Primary business" means:

A gas service business that is within three miles of an intersection or exit ramp; is in continuous operation to provide services at least 16 hours per day, seven days per

week for the interstate system; and 12 hours per day, seven days per week, for other highways;

A food service business that is within three miles of an intersection or exit ramp terminal and is in continuous operation to serve at least two meals per day at least six days per week;

A lodging service business that is within three miles of an intersection or exit ramp terminal;

A camping service business that is within five miles of an intersection or exit ramp terminal;

An attraction service business, or staging area of that business, that is within three miles of an intersection or exit ramp terminal; or

A 24-hour pharmacy that is within three miles in any direction of an interchange or exit ramp terminal on the interstate system.

"Ramp terminal" means the area where an exit ramp intersects with a roadway.

"Responsible operator" means a person or entity that:

Owns or operates an eligible business, pursuant to subsection (C) of this Section,

Has authority to enter into a lease,

Enters into a lease for a logo sign through the rural or urban logo sign program, and

Has not become ineligible to participate.

"Rural logo sign program" means a system to install and maintain specific service information signs on a rural state highway outside of an urbanized area, as provided in A.R.S. § 28-7311(E)(2).

"Rural state highway" means any class of state highway, located outside of an urbanized area as provided in A.R.S. § 28-7311 (E)(2).

"Secondary business" means a business as follows:

A gas service business that is within three to 15 miles of an intersection or exit ramp terminal, and is in continuous operation to provide services at least eight hours per day, five consecutive days per week;

A food service business that is within three to 15 miles of an intersection or exit ramp terminal, and is in continuous operation to serve at least two meals per day (either breakfast and lunch, or lunch and dinner) for a minimum of five consecutive days per week;

A lodging service business that is within three to 15 miles of an intersection or exit ramp terminal;

A camping service business that is within five to 15 miles of an intersection or exit ramp terminal; or

An attraction service business, or staging area of that business, that is within three to 15 miles of an intersection or exit ramp terminal.

"Specific service" means gas, food, lodging, camping, attractions, or 24-hour pharmacies.

"Specific service information sign" means a rectangular sign panel that contains directional information, one or more logos, and the following words:

"GAS," "FOOD," "LODGING," "CAMPING," "ATTRACTION," OR "24-HOUR PHARMACY."

"Staging area" means a regular, designated site where a scenic tour begins.

"State highway" has the same meaning as prescribed in A.R.S. § 28-101.

"Trailblazing sign" means a specific service information sign that provides additional directional guidance to a location, route, or building from another highway or roadway.

"Urbanized area" has the same meaning as prescribed in A.R.S. § 28-7311(E)(2).

"Urban logo sign program" means a system to install and maintain specific service information signs on an interstate system or other state highway within an urbanized area, as provided in A.R.S. § 28-7311.

"U.S. DOT" means the United States Department of Transportation.

**B.** Administration.

1. The Department may operate an urban and a rural logo sign program, or may select a contractor to administer an urban and a rural logo sign program. An urban logo sign program may be implemented on state highways in any urbanized areas in the state. A rural logo sign program may be implemented on state highways located outside of urbanized areas in the state. If the Department utilizes a contractor to administer an urban and a rural logo sign program, the Department shall solicit offers, as provided in A.R.S. §§ 41-2501 through 41-2673, to select a contractor.
2. The Department may contract separately for an urban and a rural logo sign program.
3. A contract shall specify the standards that a contractor shall use, which are contained in the MUTCD, U.S. DOT/FHWA current edition as adopted by the Department under A.R.S. § 28-641 and any other requirements and standards prescribed by the Department.
4. The Department may propose its own form of a written lease agreement with a responsible operator. The Department shall prescribe the form of any written lease agreement between a contractor and a responsible operator. A contractor's lease agreement with a responsible operator shall include, by reference, the terms and conditions of the Department's contract with a contractor under A.R.S. §§ 41-2501 through 41-2673. A contractor or the Department may terminate program participation of any responsible operator under subsection (C)(1) of this Section.

**C.** Eligibility criteria for primary and secondary businesses.

1. Any business is ineligible to place a logo on a logo sign panel on a particular state highway if it already has a highway guide sign installed on that state highway by a contractor or the Department. Any business is ineligible for program participation if:
   a. Thirty calendar days have elapsed since a contractor or the Department issued a notice of default to a business, during which time a business failed to cure the default, or
   b. A business has defaulted on a lease.
2. Gas service business. To be eligible to place a logo on a logo sign panel, a gas service business shall:
   a. Provide gasoline, diesel fuel, oil, and water for public purchase or use;

b. Provide sanitary restroom facilities and drinking water;
c. Provide a telephone available for public use; and
d. Meet the additional requirements for a primary or secondary gas service business in the definition of a primary or secondary business in subsection (A) of this Section.

3. Food service business. To be eligible to place a logo on a logo sign panel, a food service business shall:
   a. Provide sanitary restroom facilities for customers;
   b. Provide a telephone available for public use;
   c. If a food service business is part of a food court located within a shopping mall, the shopping mall may qualify as the responsible operator if the food court:
      i. Complies with this Section, and
      ii. Has clearly identifiable, on-premise signing consistent with the logo sign that is sufficient to guide motorists directly to the entrance to the food court.
   d. Have a license where required; and
   e. Meet the additional requirements for a primary or secondary food service business in the definition of a primary or secondary business in subsection (A) of this Section.
4. Lodging service business. To be eligible to place a logo on a logo sign panel, a lodging service business shall:
   a. Provide five or more units of sleeping accommodations;
   b. Provide a telephone available for public use;
   c. Have a license, where required;
   d. Provide sanitary restroom facilities for customers; and
   e. Meet the additional requirements for a primary or secondary lodging service business in the definition of a primary or secondary business in subsection (A) of this Section.
5. Camping service business. To be eligible to place a logo on a logo sign panel, a camping service business shall:
   a. Be able to accommodate all common types of travel trailers and recreational vehicles;
   b. Have a license, where required;
   c. Provide sanitary restroom facilities and drinking water;
   d. Be available on a year-round basis unless camping in the community is of a seasonal nature in which case, the facilities in question shall be open to the public 24 hours per day, seven days per week during the entire season; and
   e. Meet the additional requirements for a primary or secondary camping service business in the definition of a primary or secondary business in subsection (A) of this Section.
6. Attraction service business. To be eligible to place a logo on a logo sign panel, an attraction service business shall meet the following requirements, if applicable:
   a. Derive less than 50% of its sales from:
      i. The sale of alcohol consumed on the premises, or
      ii. Gambling.
   b. Derive more than 50% of its sales or visitors during the normal business season from motorists who do not reside within a 25-mile radius of the business.
   c. Provide at least 10 parking spaces.
   d. Provide historical, cultural, amusement, or leisure activities to the public.
   e. Be in continuous operation at least six hours per day, six days per week, except:
      i. An arena attraction shall hold events at least 28 days annually;
      ii. A cultural attraction shall be open at least 180 days annually;
      iii. A domestic farm winery or domestic microbrewery shall be open for tours at least 40 days annually;
      iv. A farm-related attraction shall be open at least 120 days annually; or
      v. A dude ranch shall be open at least 150 days annually.
   f. Meet the additional requirements for a primary or secondary attraction service business in the definition of a primary or secondary business in subsection (A) of this Section.
7. Twenty-four hour pharmacy business. To be eligible to place a logo on a logo sign panel, a 24-hour pharmacy business shall:
   a. Operate continuously 24 hours per day, seven days per week;
   b. Have a state-licensed pharmacist present and on duty at all times; and
   c. Meet the additional requirements for a primary 24-four hour pharmacy business in the definition of a primary business in subsection (A) of this Section.

**D.** Responsible operator pricing and lease procedures.
1. In the rural and urban logo sign programs, a contractor or the Department may use:
   a. Rate schedules that are established and periodically adjusted by the Department; or
   b. Competitive pricing established by one or more offers from potential or current responsible operators.
2. A contractor or the Department may use competitive pricing or rate schedules to determine the ranking order of potential or current responsible operators who may be awarded a logo sign lease at each appropriate highway interchange or location.
3. Along with the amount of available signage, competitive pricing or rate schedules may be based on any one or a combination of the following additional factors:
   a. The average, annual, daily traffic at, or adjacent to, the highway location of the specific service information sign;
   b. The population mix and relative distribution between primary and secondary businesses that appear to meet all the program requirements;
   c. The ranking order determined by a contractor or the Department as established by competitive pricing proposed or offered by potential or current responsible operators, or rate schedules, at each appropriate highway interchange or location; or
   d. The competitive market conditions, as well as economic, regulatory, logistical, and other related factors as determined by the Department.
4. If any of the factors in subsection (D)(3) of this Section are used in competitive pricing or rate schedules, a contractor or the Department shall make information relevant to these factors available to businesses on the contractor's or the Department's website.

5. If the factors in subsection (D)(3) of this Section do not resolve the business rankings at a location, a contractor or the Department shall prioritize the remaining requests for placement of a logo on a specific service information sign panel based on the following additional factors in the order listed below:
   a. The responsible operator situated closest to the highway intersection or exit ramp terminal;
   b. A gas service business or a food service business that provides the most days and hours of service to the public; and
   c. The first-in-time, eligible responsible operator to request placement of a logo on a logo sign panel.
6. If a potential responsible operator requests placement of a logo on a specific service information sign panel at a highway intersection or interchange where there are no available placements, and does so no later than 90 calendar days before the first expiration of an existing lease with a lower-ranked responsible operator at that location, a contractor or the Department may award a lease to the highest-ranked responsible operator at that location. A contractor or the Department may establish a waiting list of requesting businesses and potential responsible operators.
7. A contractor or the Department may choose not to renew an existing lease or a lease expiring within the next 90 calendar days, if another eligible business with higher priority requests placement of a logo on a specific service information sign panel at the same location.

**E.** Secondary businesses.

1. Lease limitations. For a secondary business, a contractor or the Department may enter into a lease for up to five years or renew a lease for up to five years, with the following terms:
   a. A contractor or the Department shall review the lease of a responsible operator at the beginning of the 24th month of the lease term to determine if the responsible operator complies with all other terms of the lease;
   b. After the 24-month review, a contractor or the Department may terminate the lease and remove the appropriate logo from the logo sign panel if another eligible business with higher priority requests lease space for a logo on a logo sign panel; and
   c. A contractor or the Department shall notify a responsible operator at least 90 calendar days before terminating the lease and removing a logo from the logo sign panel.
2. A contractor or the Department may display the following additional information on a specific service information sign for a secondary business, as space allows, based on the following ranking order:
   a. Distance,
   b. Days and hours of operation, and
   c. Seasonal operation.

**F.** Contractor or Department responsibility.

1. A contractor shall follow all Department design standards and specifications for all sign panels, supports, and materials, as provided in the contract and the MUTCD.
2. A contractor or the Department shall ensure that a business complies with all criteria established in this Section. A contractor or the Department may choose not to enter into a lease agreement or renew a lease agreement if the eligibility criteria in subsection (C) of this Section are not met. If a responsible operator becomes ineligible to place a logo on a logo sign panel, a contractor or the Department shall remove a logo from a logo sign panel after notifying a responsible operator as provided in the lease.
3. A contractor or the Department shall require that a responsible operator certify in writing as directed that a responsible operator will comply with all applicable federal, state, and local laws, ordinances, rules, regulations, and contractual requirements of the rural or urban logo sign program.
4. Nothing in these rules shall require a contractor or the Department to place or maintain a specific service information sign at any particular interchange or intersection. A contractor or the Department shall not place a specific service information sign that obstructs or interferes with a traffic control device.
5. A contractor shall not remove or relocate an existing official traffic control device, as defined in A.R.S. § 28-601, to accommodate a specific service information sign without prior written approval by the Department, or a local authority under A.R.S. § 28-643.
6. A contractor or the Department shall provide a copy of the signed lease agreement to a responsible operator. A responsible operator shall deliver a logo for the logo sign panel to a contractor or the Department for installation, or contract with a contractor to fabricate a logo for a logo sign panel to a responsible operator's, and the Department's, specifications.
7. Within 30 calendar days after receipt of a written request from a responsible operator, a contractor or the Department shall return any pre-paid lease payments to a responsible operator if a responsible operator's logo is not installed on a logo sign panel within 90 calendar days of tendering the payments, for reasons solely caused by the Department or a contractor.
8. A contractor shall obtain an encroachment permit under R17-3-501 through R17-3-509 before erecting or modifying a specific service information sign along a state highway.
9. If a contractor requests an encroachment permit under R17-3-501 through R17-3-509, the Department's staff shall decide the best placement of a specific service information sign and shall cooperate with a contractor to provide information to the motoring public as prescribed in subsection (E)(2) of this Section.
10. If an urban or rural logo sign program is terminated, a contractor or the Department shall:
    a. Notify a responsible operator by certified mail, or a mutually agreed upon electronic communication method, of the program termination and the location where a responsible operator may claim its logo;
    b. Remove all sign panels and supports, as directed by the Department; and
    c. Refund any unused lease payments on a prorated basis to each responsible operator.
11. A contractor or the Department shall solely determine the position and location of new or additional logos on logo sign panels or specific service information signs when logo sign vacancies occur on a logo sign panel or a specific service information sign panel, and a new responsible operator wishes to lease space on that panel, or a waiting list exists.
12. In a lease agreement with a responsible operator, a contractor or the Department may collect all applicable taxes.

**G.** Urbanized or rural boundary changes. If the boundaries of an urbanized area, as identified in a subsequent decennial census, are relocated or adjusted, a contractor or the Department shall allow:
1. The logo signs within the urbanized area boundaries and outside of those boundaries to remain in place until the minimum lease obligations between a contractor or the Department and a responsible operator have been fulfilled; or
2. Until lease termination, whichever occurs first.

**H.** Signage transition. Logo signage in place at the end of a lease term following boundary changes in subsection (G) of this Section may be transitioned from the urban to the rural logo sign program or from the rural to the urban logo sign program as appropriate.

**I.** Elimination of exit ramp or interchange. When the Department eliminates an exit ramp or interchange from the state highway system, a contractor or the Department may install and maintain a specific service information sign at an exit ramp or interchange directly preceding the exit ramp or interchange that the Department eliminates in each direction, as follows:
1. On request of a responsible operator, the Department may relocate a logo sign panel or a specific service information sign, as deemed appropriate by the Department.
2. A business affected by exit ramp or interchange elimination shall meet all eligibility criteria for continued program participation as prescribed in Subsection C of this Section and the following:
   a. Be located directly off the interstate or other state highway, and
   b. Had previous routine access from the eliminated exit ramp or interchange with direct access from:
      i. The crossroad at the eliminated exit ramp or interchange;
      ii. The frontage road of the interstate or other state highway at the eliminated exit ramp or interchange, within 1000 feet of the crossroad; or
      iii. The frontage road of the interstate or other state highway at the eliminated exit ramp or interchange, within 1000 feet of the crossroad, as the frontage road existed before the exit ramp or interchange was eliminated.

**Historical Note**

Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Former Section R17-3-911 renumbered without change as Section R17-3-909 (Supp. 88-4). Former Sections R17-3-902 through R17-3-909 renumbered without change as Section R17-3-902 (Supp. 89-1). Amended effective May 3, 1993 (Supp. 93-2). Amended by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 5047, effective November 4, 2003 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 3856, effective September 15, 2005 (Supp. 05-3). Amended by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 1324, effective July 6, 2013 (Supp. 13-2).

**R17-3-903. Repealed**

**Historical Note**

Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1). New Section made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Amended by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2). Repealed by final rulemaking at 19 A.A.R. 1324, effective July 6, 2013 (Supp. 13-2).

**R17-3-904. MUTCD Requirements for Logo Signs**

**A.** Number of sign panels and services allowed. No more than four specific service information sign panels are allowed on an interstate or other state highway at the approach to an intersection, interchange, or exit ramp.
1. Each specific service information sign panel shall contain a maximum of six logos as provided in Chapter 2J of the current version of the MUTCD.
2. No more than two specific service information sign panels for each type of specific service are allowed on an interstate or other state highway at the approach to an intersection, interchange, or exit ramp. A contractor or the Department may combine types of specific services as prescribed in subsection (A)(3) of this Section.
3. Except for existing logo signs displayed or approved for display as of July 6, 2012, no more than three types of services shall be represented on any specific service information sign panel. If three types of services are displayed on one specific service information sign panel, the panel shall have two logo sign panels for each service, or a total of six logo sign panels. If two types of services are displayed on one sign, the logo sign panels shall be limited to either three for each type, for a total of six logo sign panels, or four for one type and two for the other type, for a total of six logo sign panels.
4. One service type shall appear on no more than two specific service information sign panels.
5. When logos for more than six businesses of a specific service type are displayed at the same interchange or intersection approach, no more than 12 logos of a specific service type shall be displayed on no more than two specific service information sign panels.

**B.** Sign sequence. A contractor or the Department shall install successive specific service information signs for participating responsible operators in the direction of travel for the following as specified in the MUTCD:
1. Twenty-four hour pharmacies,
2. Attractions,
3. Camping,
4. Lodging,
5. Food, and
6. Gas services.

**C.** Seasonal requirements. If a responsible operator operates on a seasonal basis, a contractor or the Department shall:
1. Remove or cover a logo on a logo sign panel during the off-season; or
2. Display the dates of operation, if additional information is not required on the sign under R17-3-902(E)(2).

**D.** Sign standards. If the Department decides to move a specific service information sign because of construction or reconstruction of transportation facilities, or the placement of other signs or traffic control devices, the standards of the MUTCD apply regarding the new placement.

**E.** Trailblazing signs.
1. A contractor or the Department shall install a trailblazing sign for a responsible operator along a highway if a responsible operator's business is not located on, and is

not visible from, an intersection with a highway as directed from the specific service information sign.
2. A contractor or the Department may locate a trailblazing sign near all intersections where the direction of the route changes or where a motorist may be uncertain which road to follow.
3. A trailblazing sign is limited to four or fewer logo sign panels.
4. A contractor or the Department shall obtain written approval from a local governing authority to install and maintain a trailblazing sign along a highway that is not under the Department's maintenance jurisdiction.
5. A contractor or the Department shall not install a logo on a specific service information sign panel until all necessary trailblazing signs have been installed.
6. A trailblazing sign shall indicate by arrow the direction to a responsible operator's business.
7. A trailblazing sign may:
   a. Duplicate the logo sign or specific service information sign, or both;
   b. Consist of two lines of text; or
   c. Include the type of specific service and distance to a responsible operator's business.

**F.** Sign requirements. A logo sign shall comply with A.R.S. § 28-648. Descriptive advertising words, phrases, or slogans are prohibited on a logo sign, except:
1. If a responsible operator does not have an official trademark or logo, a responsible operator may display as its logo, on a logo sign panel, the name indicated in its partnership agreement, incorporation documents, or other documentation.
2. A contractor or the Department may place supplemental wording on logo sign panels in accordance with the MUTCD.

**Historical Note**
Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1). New Section made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 4132, effective September 9, 2003 (Supp. 03-3). Amended by final rulemaking at 9 A.A.R. 5047, effective November 4, 2003 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 1324, effective July 6, 2013 (Supp. 13-2).

**Appendix A. Repealed**

**Historical Note**
Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Appendix A repealed by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1).

**Appendix B. Repealed**

**Historical Note**
Adopted effective May 3, 1993 (Supp. 93-2). Appendix B repealed by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1).

**R17-3-905. Rural Logo Sign Requirements**

**A.** In addition to R17-3-902 through R17-3-904 and R17-3-906, the spacing between specific service information signs on a rural state highway shall be in accordance with the MUTCD based on engineering judgment.

**B.** Agreement. A community official designated by a municipality or town organized under Arizona law may sign a written agreement with a contractor or the Department to prohibit installation of logos on logo sign panels or specific service information sign panels on rural state highways within the recognized boundaries of the community.

**Historical Note**
Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1). New Section made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Amended by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 1324, effective July 6, 2013 (Supp. 13-2).

**R17-3-906. Existing Leases**

Any change to R17-3-902 through R17-3-905 does not affect a responsible operator's lease before the current lease expires.

**Historical Note**
Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1). New Section made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 5047, effective November 4, 2003 (Supp. 03-4). Amended by final rulemaking at 19 A.A.R. 1324, effective July 6, 2013 (Supp. 13-2).

**Illustration A. Repealed**

**Historical Note**
New Illustration made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Illustration repealed by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2).

**Illustration B. Repealed**

**Historical Note**
New Illustration made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Illustration repealed by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2).

**Illustration C. Repealed**

**Historical Note**
New Illustration made by final rulemaking at 9 A.A.R. 624, effective February 7, 2003 (Supp. 03-1). Illustration repealed by final rulemaking at 18 A.A.R. 1263, effective July 6, 2012 (Supp. 12-2).

**R17-3-907. Repealed**

**Historical Note**
Adopted effective March 22, 1985 (Supp. 85-2). Former Section R17-3-907 repealed and a new Section R17-3-907 adopted effective June 18, 1987 (Supp. 87-2). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1).

**R17-3-908. Repealed**

**Historical Note**

Adopted effective March 22, 1985 (Supp. 85-2). Former Section R17-3-908 repealed and a new Section R17-3-908 adopted effective April 10, 1987 (Supp. 87-2). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1).

**R17-3-909. Repealed**

**Historical Note**

Adopted effective March 22, 1985 (Supp. 85-2). Amended effective April 10, 1987 (Supp. 87-2). Former Section R17-3-911 renumbered without change as Section R17-3-909 (Supp. 88-4). Section repealed by final rulemaking at 7 A.A.R. 1021, effective February 8, 2001 (Supp. 01-1).

**NOTICE OF FINAL RULEMAKING**

**TITLE 17. TRANSPORTATION**

**CHAPTER 3. DEPARTMENT OF TRANSPORTATION**

**HIGHWAYS**

## Statutory Authority Including Relevant Statutory Definitions

### General Authority for Rulemaking

**A.R.S. § 28-366. Director; rules**

The director shall adopt rules pursuant to title 41, chapter 6 as the director deems necessary for:

1. Collection of taxes and license fees.
2. Public safety and convenience.
3. Enforcement of the provisions of the laws the director administers or enforces.
4. The use of state highways and routes to prevent the abuse and unauthorized use of state highways and routes.

### Specific Statutes

**A.R.S. § 28-7384. Longitudinal telecommunication access in the highway system; agreements; restrictions; rulemaking**

A. Except as provided in subsection E of this section, the department may allow a provider longitudinal access to the right-of-way of a highway for the installation, operation and maintenance of a telecommunication facility.

B. The department shall enter into an agreement with a provider and issue a permit before granting the provider any longitudinal access under this section.

C. Except as specifically provided by the agreement, a property interest in a right-of-way may not be granted under this section.

D. An agreement entered into by the department under this section shall:

1. Specify the terms and conditions for renegotiating the agreement.
2. Specify maintenance responsibilities for each telecommunication facility.
3. Be nonexclusive.
4. Be limited to a maximum term of thirty years.

E. The department may not grant any longitudinal access under this section that results in a significant compromise of the safe, efficient and convenient use of the highway for the traveling public.

F. The director shall adopt rules that:

1. Govern the installation, operation and maintenance of a telecommunication facility granted longitudinal access under this section.
2. Specify the procedures for establishing an agreement for longitudinal access for a provider.
3. Provide for the relocation or removal of a telecommunication facility for any of the following:

(a) Needed changes to a highway.

(b) Expiration of an agreement.

(c) Breach of an agreement.

**A.R.S. § 28-7385. Longitudinal telecommunication access to highway system right-of-way; compensation**

A. The department shall require compensation from a provider for longitudinal access to the right-of-way of a state highway. The compensation shall be all of the following:

1. Fair and reasonable.

2. Competitively neutral.

3. Nondiscriminatory.

4. Open to public inspection.

5. Established to promote access by multiple providers.

6. Established for zones of this state.

7. Established to encourage the deployment of digital infrastructure within this state.

8. A lump sum payment or annual installment, at the option of the provider.

9. Set pursuant to subsection I of this section.

B. The compensation may be cash, in-kind compensation or a combination of cash and in-kind compensation.

C. In-kind compensation requires the agreement of both the provider and the department.

D. The department shall determine the present value of any in-kind compensation based on the incremental cost to the provider.

E. The value of in-kind compensation or a combination of cash and in-kind compensation shall be equal to or greater than the amount of cash compensation that would be charged if the compensation is cash only.

F. The department shall provide for the proportionate sharing of costs among the department and providers for joint trenching or trench sharing based on the amount of conduit innerduct space that is authorized in the agreement for the trench.

G. If two or more providers are required to share a single trench, each provider in the trench shall share the cost and benefits of the trench pursuant to subsection F of this section on a fair, reasonable, competitively neutral and nondiscriminatory basis.

H. The department, by rule, shall establish a schedule of rates of compensation for any longitudinal access granted under this section.

I. The department may not pay any cost of relocation of a private telecommunication facility granted longitudinal access to the right-of-way of a highway on the interstate system under this section.

J. The department shall deposit, pursuant to sections 35-146 and 35-147, monies collected pursuant to this section in the smart highway corridor trust fund established by section 28-7387.

K. Any telecommunications capacity acquired as in-kind compensation shall be used exclusively for the further development of telecommunications that serve state agencies and enhance connectivity for higher and public education and may not be sold or leased in competition with telecommunication or internet service providers.

L. A person may not use compensation paid to the department pursuant to this section as evidence of the market or other value of the access for any other purpose, including condemnation proceedings, other litigation, the application of rates of taxation or the establishment of franchise fees relating to longitudinal access rights.

**D-5.**

**DEPARTMENT OF HEALTH SERVICES**
Title 9, Chapter 10, Articles 1-4, 6, 9-11, 13-15, 17, 19 & 22

**Amend:** R9-10-101; R9-10-102; R9-10-103; R9-10-104; R9-10-104.01; R9-10-105; R9-10-107; R9-10-108; Table 1.1; R9-10-109; R9-10-110; R9-10-112; R9-10-113; R9-10-118; R9-10-120; R9-10-121; R9-10-201; R9-10-202; R9-10-203; R9-10-209; R9-10-212; R9-10-215; R9-10-218; R9-10-234; R9-10-303; R9-10-307; R9-10-320; R9-10-321; R9-10-402; R9-10-403; R9-10-406; R9-10-410; R9-10-411; R9-10-413; R9-10-414; R9-10-421; R9-10-423; R9-10-426; R9-10-606; R9-10-613; R9-10-901; R9-10-902; R9-10-905; R9-10-911; R9-10-914; R9-10-918; R9-10-1003; R9-10-1008; R9-10-1010; R9-10-1011; R9-10-1012; R9-10-1017; R9-10-1018; R9-10-1022; R9-10-1027; R9-10-1031; R9-10-1106; R9-10-1107; R9-10-1114; R9-10-1117; R9-10-1302; R9-10-1305; R9-10-1306; R9-10-1313; R9-10-1314; R9-10-1315; R9-10-1317; R9-10-1405; R9-10-1406; R9-10-1412; R9-10-1413; R9-10-1515; R9-10-1702; R9-10-1704; R9-10-1705; R9-10-1706; R9-10-1709; R9-10-1712; R9-10-1903; R9-10-1909; R9-10-2203; R9-10-2206; R9-10-2221

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** **June 17, 2025**

**SUBJECT:** **DEPARTMENT OF HEALTH SERVICES**
Title 9, Chapter 10, Articles 1-4, 6, 9-11, 13-15, 17, 19, & 22

**Amend:** **R9-10-101; R9-10-102; R9-10-103; R9-10-104; R9-10-104.01; R9-10-105; R9-10-107; R9-10-108; Table 1.1; R9-10-109; R9-10-110; R9-10-112; R9-10-113; R9-10-118; R9-10-120; R9-10-121; R9-10-201; R9-10-202; R9-10-203; R9-10-209; R9-10-212; R9-10-215; R9-10-218; R9-10-234; R9-10-303; R9-10-307; R9-10-320; R9-10-321; R9-10-402; R9-10-403; R9-10-406; R9-10-410; R9-10-411; R9-10-413; R9-10-414; R9-10-421; R9-10-423; R9-10-426; R9-10-606; R9-10-613; R9-10-901; R9-10-902; R9-10-905; R9-10-911; R9-10-914; R9-10-918; R9-10-1003; R9-10-1008; R9-10-1010; R9-10-1011; R9-10-1012; R9-10-1017; R9-10-1018; R9-10-1022; R9-10-1027; R9-10-1031; R9-10-1106; R9-10-1107; R9-10-1114; R9-10-1117; R9-10-1302; R9-10-1305; R9-10-1306; R9-10-1313; R9-10-1314; R9-10-1315; R9-10-1317; R9-10-1405; R9-10-1406; R9-10-1412; R9-10-1413; R9-10-1515; R9-10-1702; R9-10-1704; R9-10-1705; R9-10-1706; R9-10-1709; R9-10-1712; R9-10-1903; R9-10-1909; R9-10-2203; R9-10-2206; R9-10-2221**

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**Summary:**

This regular rulemaking from the Department of Health Services (Department) seeks to amend eighty-three (83) rules and one (1) table in Title 9, Chapter 5 regarding Health Care Institutions Licensing. The amendments are across the following fourteen articles 1, 2, 3, 4, 6, 9, 10, 11, 13, 14, 15, 17, 19, and 22. Excluding Articles 6, 15, 19, and 22, the amendments all relate to Five-year Review Reports approved by the Council. The goals of the amendments are to incorporate statutory changes from several law changes since 2021, which the Department indicates will increase public health and safety, and will make the rules more concise and understandable. The amendments to the rules and accompanying session law, if applicable, address:

- The presence of specific medical personnel for a surgical discharge (Laws 2021, Ch 363)
- Remove the requirement for submission of architecture plans for Health Care Institution (HCI) applicants, and replacing it with signed attestation from a licensed architect. (Laws 2022, Ch. 34)
- Prevent exposure to surgical smoke and evacuation systems/procedures (Laws 2022, Ch. 57).
- Outpatient treatment centers who share governing authority with a licensed hospital no longer require separate licenses (Laws 2022, Ch. 128).
- Clarify the requirements for visitation procedures at HCI's including procedures if a visitor is denied (Laws 2022, Ch. 179).
- HCI employers must have a workplace violence prevention policy in place (Laws 2022, Ch. 190).
- Amend rules to align with the Board of Pharmacy's Prescription Medication Donation Program ( Laws 2021, Ch. 137).
- Update terminology from telemedicine to telehealth (Laws 2021, Ch. 320).
- Require administrators of behavioral health inpatient facilities to create policies that prevent abuse and neglect of patients
- Require administrators to develop and implement a fall prevention program
- Clarify definitions across articles including, certified nurse anesthetist, surgical suites, outpatient treatment centers vs counseling facilities, and tuberculosis testing requirements, trai
- Follow state law, the Department will allow additional individuals to become qualified to administer anesthesia in outpatient settings.
- Clarify dietary requirements in accordance with the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Department cites both general and specific statutory authority for these rules.

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Department indicates it did not review any study relevant to this rulemaking.

**4. Summary of the agency's economic impact analysis:**

The Department states that it engages in this rulemaking to align with statutory law changes, address issues identified in recent five-year reports, and to make rules clearer and more concise. This rulemaking consists of several rule amendments to the Arizona Administrative Code Title 9, Chapter 10. The Department anticipates these rules may increase the regulatory burden or cost on some affected persons, but believes the benefits far outweigh any potential costs.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department has determined that that there are no less intrusive or less costly alternatives for achieving the purpose of the rulemaking. It does expect minimal costs to the Department for implementation of, educating/training for, and compliance to the rules; to HCIs (Health Care Institutions) for implementing some of these changes; and potentially to the public for implementation, with a specific highlight on raised concerns about privacy, consent, infection control and logistical challenges regarding rules implementing statutes on patient visitation. However, it believes expected benefits to the HCIs and the general public from these rulemakings outweigh these costs.

**6. What are the economic impacts on stakeholders?**

The Department identified itself, HCIs, and the general public as those directly affected by the rules and stand to bear the costs or benefits from them. The Department believes the overall economic impact will be positive. The Department states that amendments will streamline administrative processes, reduce unnecessary regulatory burdens, and promote better compliance with updated standards, thereby enhancing patient care, safety, and outcomes. The Department further states clear and concise rules will benefit HCIs by facilitating a more efficient and effective regulatory environment. It further states that the general public stands to benefit from improved healthcare standards and enhanced safety measures, resulting in better overall health outcomes. Regarding state revenues, the Department states that this rulemaking does not amend a fee and no additional licensing fees would be incurred from this rulemaking.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

Between the Notice of Proposed Rulemaking published in the Administrative Register on November 29, 2024 and the Notice of Supplemental Proposed Rulemaking published in the Administrative Register on February 21, 2025, the Department implemented the following changes:

- R9-10-103(B)(4) and (5) was updated to include the placement of or in accordance with rule writing standards and to improve clarity
- R9-10-101 was amended to reflect an added definition as a result of a rulemaking approved by the Council on June 3, 2025. No text was altered as part of the rulemaking now before the Council.

Council staff believes these changes to be non-substantive in accordance with A.R.S. § 41-1025.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Department received a total of five written comments related to this rule. One comment is from the Nelson Law Group, on behalf of the Arizona Society of Anesthesiologist. Four comments are from the Chief Compliance Officer at the Arizona State Hospital. A brief summary of the comments and responses are below:

- **Comment 1 from Arizona Society of Anesthesiologist**

The group asked for explicit recognition that the revisions do not alter the scope of practice for certified registered nurse anesthetists (CRNAs) as defined in ARS 32-1634.04(A).

  - **Department Response**

The Department indicated that the rules do not change the existing scope of practice and are only intended to align with A.R.S. § 36-405.

- **Comment 1 from Arizona State Hospital**

The Hospital indicates concern over R9-10-1315, which requires evacuation drills every three months. The Hospital indicated that the frequency was excessive

  - **Department Response**

The Department indicated that patients with certain medical conditions are exempt from participation, something that does not exist in the current rules. The Department also declined to substitute evacuation with fire drills because evacuations could be necessary for reasons other than fires.

- **Comment 2 from Arizona State Hospital**

The Hospital recommends that the discharge process in R9-10-1307 should be more aligned with the process for Arizona Community Protection and Treatment Centers (ACPTC).

- **Department Response**

The Department indicated that those sorts of changes to the discharge requirements would exceed the scope of the rulemaking and would require further discussion and analysis.

- **Comment 3 from Arizona State Hospital**

The Hospital recommends updating R9-10-1310 to better align with the treatment plan for ACPTC residents since some of the existing requirements were duplicative.

- **Department Response**

The Department indicated that those sorts of changes would result in the rules becoming inconsistent with other rules in Chapter 10 and would not be consistent with national standard practices.

- **Comment 4 from Arizona State Hospital**

The Hospital recommends that individuals receiving treatment should be referred to as residents and not patients.

- **Department Response**

The Department declined the request because resident is used elsewhere and in a different capacity in Chapter 10 and would result in inconsistency and confusion.

Additionally, the Department received oral comments during the oral proceeding that took place on February 18, 2025. The comments were from representatives of the Arizona Hospital and Healthcare Association and Community Bridges. The Arizona Hospital and Healthcare Association issued a comment in support of the rules and thanked the Department for being responsive during the rulemaking process. A brief summary of the comments and responses are below:

- **Comment 1 from Community Bridges**

The Association raised concern over whether it was appropriate for a registered nurse to serve as a behavioral health technician.

- **Department Response**

The Department responded that change does not significantly impact registered nurses duties, stating that registered nurses maintain their RN designation without needing to be classified as BHTs.

- **Comment 2 from Community Bridges**

The Association raised concern with R9-10-103 and whether outpatient treatment centers (OTCs) would no longer be eligible for a licensing exception.

  - **Department Response**

The Department responded by saying that the rule only applies to off-site services providing medical services at an assisted living facility or another health care institution, which do not require a dual license. The rule does require that an OTC cannot provide service with another licensed healthcare institution unless expressly authorized by rule or permit.

Full Department summaries of the comments and the Department's responses are found in Section 12 of the Preamble to the Notice of Final Rulemaking. Copies of the comments and the Department's responses are also included in the final materials for the Council's reference.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The amendments to the rules do not require the issuance of a regulatory permit or license.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates that there is no corresponding federal law.

**11. Conclusion**

This regular rulemaking from the Department of Health Services (Department) seeks to amend eighty-three (83) rules and one (1) table in Title 9, Chapter 5 regarding Health Care Institutions Licensing. The amendments are across the following fourteen articles 1, 2, 3, 4, 6, 9, 10, 11, 13, 14, 15, 17, 19, and 22. With the exceptions of Articles 6, 15, 19, and 22, the amendments all relate to Five-year Review Reports approved by the Council. The goals of the amendments are to incorporate statutory changes from several law changes since 2021, which the Department indicates will increase public health and safety, and will make the rules more concise and understandable. The amendments will primarily cover the following areas: telehealth, outpatient treatment centers, healthcare visitation policies, workplace violence prevention, fall prevention programs, preventing abuse and neglect, and surgical smoke evacuation systems.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A).

Council staff recommends approval of this rulemaking.

ARIZONA
DEPARTMENT OF
HEALTH SERVICES

April 24, 2025

**VIA EMAIL: grrc@azdoa.gov**
Jessica Klein, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Department of Health Services, 9 A.A.C. 10, Articles 1, 2, 3, 4, 6, 9, 10, 11, 13, 14, 15, 17, 19, and 22

Dear Ms. Klein:

Enclosed are the administrative rules identified above which I am submitting, as the Designee of the Director of the Department of Health Services, for approval by the Governor's Regulatory Review Council (Council). The following information is provided for your use in reviewing the enclosed rule package pursuant to A.R.S. § 41-1052 and A.A.C. R1-6-202:

1. The close of record date: February 18, 2025

2. Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:
The rulemaking for 9 A.A.C. 10 relates to the following five-year review reports:
   - Article 1. General, approved by the Council on August 1, 2023,
   - Article 2. Hospitals, approved by the Council on January 4, 2023,
   - Article 3. Behavioral Health Inpatient Facilities, approved by the Council on July 5, 2023,
   - Article 4. Nursing Care Institutions, approved by the Council on July 5, 2023,
   - Article 9. Outpatient Surgical Centers, approved by the Council on May 2, 2023,
   - Article 10. Outpatient Treatment Centers, approved by the Council on October 3, 2023,
   - Article 11. Adult Day Health Care Facilities, approved by the Council on January 4, 2023,
   - Article 13. Behavioral Health Specialized Transitional Facility, approved by the Council on January 4, 2023,

- Article 14. Substance Abuse Transitional Facilities, approved by the Council on July 5, 2023, and
- Article 17. Unclassified Health Care Institutions, approved by the Council on May 2, 2023.

3. Whether the rulemaking establishes a new fee and, if so, the statutes authorizing the fee:
   The rulemaking does not establish a fee.

4. Whether the rulemaking contains a fee increase:
   The rulemaking does not contain a fee increase.

5. Whether an immediate effective date is requested pursuant to A.R.S. § 41-1032:
   The Department is not requesting an immediate effective date for the rules.

The Department certifies that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on its evaluation of or justification for the rule.

The Department certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee there are no new full-time employees necessary to implement and enforce the rule.

The following documents are enclosed:

1. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of each rule;
2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055; and
3. General and specific statutes authorizing the rules, including relevant statutory definitions.

The Department's point of contact for questions about the rulemaking documents is Lucinda Sallaway at Lucinda.Sallaway@azdhs.gov.

Sincerely,

Stacie Gravito
Director's Designee

SG: ls

Enclosures

**NOTICE OF FINAL RULEMAKING**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES –**

**HEALTH CARE INSTITUTIONS: LICENSING**

## PREAMBLE

**1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039(B) by the governor on:**

April 21, 2025

| **2. Article, Part, or Section Affected (as applicable)** | **Rulemaking Action** |
|---|---|
| R9-10-101 | Amend |
| R9-10-102 | Amend |
| R9-10-103 | Amend |
| R9-10-104 | Amend |
| R9-10-104.01 | Amend |
| R9-10-105 | Amend |
| R9-10-107 | Amend |
| R9-10-108 | Amend |
| Table 1.1 | Amend |
| R9-10-109 | Amend |
| R9-10-110 | Amend |
| R9-10-112 | Amend |
| R9-10-113 | Amend |
| R9-10-118 | Amend |
| R9-10-120 | Amend |
| R9-10-121 | Amend |
| R9-10-201 | Amend |
| R9-10-202 | Amend |
| R9-10-203 | Amend |
| R9-10-209 | Amend |
| R9-10-212 | Amend |
| R9-10-215 | Amend |
| R9-10-218 | Amend |
| R9-10-234 | Amend |
| R9-10-303 | Amend |
| R9-10-307 | Amend |

| | |
|---|---|
| R9-10-320 | Amend |
| R9-10-321 | Amend |
| R9-10-402 | Amend |
| R9-10-403 | Amend |
| R9-10-406 | Amend |
| R9-10-410 | Amend |
| R9-10-411 | Amend |
| R9-10-413 | Amend |
| R9-10-414 | Amend |
| R9-10-421 | Amend |
| R9-10-423 | Amend |
| R9-10-426 | Amend |
| R9-10-606 | Amend |
| R9-10-613 | Amend |
| R9-10-901 | Amend |
| R9-10-902 | Amend |
| R9-10-905 | Amend |
| R9-10-911 | Amend |
| R9-10-914 | Amend |
| R9-10-918 | Amend |
| R9-10-1003 | Amend |
| R9-10-1008 | Amend |
| R9-10-1010 | Amend |
| R9-10-1011 | Amend |
| R9-10-1012 | Amend |
| R9-10-1017 | Amend |
| R9-10-1018 | Amend |
| R9-10-1022 | Amend |
| R9-10-1027 | Amend |
| R9-10-1031 | Amend |
| R9-10-1106 | Amend |
| R9-10-1107 | Amend |
| R9-10-1114 | Amend |
| R9-10-1117 | Amend |
| R9-10-1302 | Amend |
| R9-10-1305 | Amend |
| R9-10-1306 | Amend |

| | |
|---|---|
| R9-10-1313 | Amend |
| R9-10-1314 | Amend |
| R9-10-1315 | Amend |
| R9-10-1317 | Amend |
| R9-10-1405 | Amend |
| R9-10-1406 | Amend |
| R9-10-1412 | Amend |
| R9-10-1413 | Amend |
| R9-10-1515 | Amend |
| R9-10-1702 | Amend |
| R9-10-1704 | Amend |
| R9-10-1705 | Amend |
| R9-10-1706 | Amend |
| R9-10-1709 | Amend |
| R9-10-1712 | Amend |
| R9-10-1903 | Amend |
| R9-10-1909 | Amend |
| R9-10-2203 | Amend |
| R9-10-2206 | Amend |
| R9-10-2221 | Amend |

**3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. §§ 36-132(A)(1) and (A)(17) and 36-136(G)

Implementing statute: A.R.S. §§ 11-593, 32-1909, 36-405, 36-406, 36-407.02, 46-407.03, 36-420, 36-420.01, 36-420.03, 36-421, 36-422, 36-434.01, 36-402, 36-422, 36-439.01, 36-439.04, 36-439.05

**4. The effective date of the rule:**

This rule shall become effective 60 days after a certified original and preamble are filed in the Office of the Secretary of State pursuant to A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

**a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable

**b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable

**5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:**

Notice of Rulemaking Docket Opening: 30 A.A.R. 3014, October 11, 2024, 41, [R24-195]

Notice of Proposed Rulemaking: 31 A.A.R. 152, January 17, 2025, 3, [R24-305]

**6. The agency's contact person who can answer questions about the rulemaking:**


Name: Thomas Salow

Title: Assistant Director

Division: Public Health Licensing

Address: 150 N. 18th Ave., Suite 500, Phoenix, AZ 85007

Telephone: (602) 542-6383

Email: thomas.salow@azdhs.gov

or

Name: Stacie Gravito

Title: Office Chief, Administrative Counsel and Rules

Division: Director's Office

Address: 150 N. 18th Ave., Suite 200, Phoenix, AZ 85007

Telephone: (602) 542-1020

Email: stacie.gravito@azdhs.gov


**7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions (HCIs). In order to ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 require the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions. The Department has adopted rules to implement these statutes in Arizona Administrative Code Title 9, Chapter 10. The Department plans to amend the rules to align with the following statutory changes: Laws 2021, Ch. 320, related to definitions regarding telehealth; Laws 2022, Ch. 128, requires the Department to make exemptions of certain outpatient treatment centers from licensing requirements; Laws 2022, Ch. 179, requires the Department to ensure a healthcare institution's visitation policy allows a clergy member to visit a resident; Laws 2022, Ch. 296, requires the Department to ensure a hospital develops a visitation policy, especially during end-of-life care; Laws 2022, Ch. 34, amends the requirements for architectural plans and specifications for health care institutions construction or modifications; Laws 2022, Ch. 190, requires the Department to ensure a health care institution develops a written workplace violence prevention plan to assist in the decrease of assaults on health care workers; Laws 2022, Ch. 57, requires the Department to adopt rules that relate to outpatient surgical centers requiring policies related to surgical smoke evacuation; and Laws 2021, Ch. 363, related to staffing and approvals of surgical discharges from facility premises. The Department also plans to address policies and procedures for the use of naloxone; be consistent with other statutory provisions or legislation including: A.R.S. § 32-1909 regarding donated medicine; A.R.S. § 36-420 regarding CPR and first aid; A.R.S. § 11-593 regarding reporting a death; and A.R.S. § 46-454 regarding reporting abuse, neglect, or exploitation; and making other changes necessary for the proper administration

and enforcement of the laws relating to public health to promote continuity and improve patient outcomes. The Department anticipates that the rules may increase the regulatory burden or cost on some affected persons. After receiving rulemaking approval pursuant to A.R.S. § 41-1039, the Department began a rulemaking to adhere to the statutory changes identified above, address issues identified in recent five-year review reports approved by the Governor's Regulatory Review Council (GRRC), and make the rules clearer and more concise and understandable.

**8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

The Department did not review or rely on any study for this rulemaking.

**9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**10. A summary of the economic, small business, and consumer impact:**

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions (HCIs). To ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 requires the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions, the Department has adopted rules in Arizona Administrative Code Title 9, Chapter 10. In this rulemaking, the Department is amending rules to align with recent statutory changes, including updates related to telehealth, outpatient treatment centers, healthcare visitation policies, workplace violence prevention, and surgical smoke evacuation systems. The Department estimates that the proposed amendments in this rulemaking will improve patient outcomes by complying with new statutes related to health and safety, and address issues identified in recent five-year review reports. Some of the changes may increase regulatory burdens or costs for affected individuals. This analysis covers the costs and benefits associated with the rule changes related to implementing new legislation, updating rules, and making other changes necessary for the proper administration and enforcement of the laws pertaining to public health to promote continuity and improve patient outcomes. The annual cost and revenue changes are designated as minimal when $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. Costs are listed as significant when meaningful or important, but not readily subject to quantification.

As stated, the Department is amending several rules in Chapter 10 to comply with the following recent legislative changes:

1. **Surgical Discharges (Laws 2021, Ch. 363, amending A.R.S. § 36-405)**: Outpatient surgical centers must require the presence of specified physicians or licensed anesthesia providers until all patients are discharged from the recovery room. These physicians must medically discharge patients from surgery. Due to this, the Department is updating the language in R9-10-911. The Department does not expect costs to increase due to the statutory change since a physician is already to be on the premises until all patients are discharged from the recovery room. Rather, the rule change expands this to an individual authorized under A.R.S. Title 32, Chapter 13, 15, or 17 to administer anesthesia. The Department expects that outpatient surgical centers will receive a significant benefit from ensuring patient care and safety with the presence of a

licensed physician or anesthesia providers during post-surgery periods, potentially reducing medical complications.

2. **Architectural Plans and Specifications (Laws 2022, Ch. 34, amending A.R.S. §§ 36-405, 36-421, 36-422)**: HCI license applications no longer need architectural plans. Instead, a notarized attestation from a licensed architect verifying that plans meet or exceed Department standards is required. In addition, the Department is removing the fees for reviewing architectural plans in several Sections throughout Chapter 10, including Table 1.1. The Department anticipates these changes will benefit HCIs by reducing administrative burdens, and overtime, it is estimated that these changes would reduce costs imposed on HCIs.
3. **Surgical Smoke Evacuation (Laws 2022, Ch. 57, amending A.R.S. § 36-434.01)**: Outpatient surgical centers and hospitals must implement policies to prevent exposure to surgical smoke using smoke evacuation systems for relevant procedures. The Department will ensure compliance through inspections and in response to complaints. This necessitates changes to R9-10-902. The Department expects that HCIs may incur minimal costs to implement the new statute and rules, but receive a significant benefit for increasing health and safety.
4. **Outpatient Treatment Centers Exemption (Laws 2022, Ch. 128, amending A.R.S. §§ 32-1651, 36-401, 36-402, 36-422, 36-439, 36-439.01, 36-439.04, 36-439.05)**: Outpatient treatment centers that share the same governing authority as a licensed hospital are now exempt from licensure, regulation, and control by the Department. However, outpatient treatment centers are subject to inspection by the Department if the Department has reasonable cause to believe that patient harm is or may be occurring at the facility. Rule R9-10-203 is being amended to reflect this change. The Department estimates that outpatient treatment centers may receive a significant benefit and cost savings from being exempt from licensure.
5. **Visitation Policies (Laws 2022, Ch. 179 and Laws 2022, Ch. 296, adding A.R.S. § 36-407.02)**: Hospitals must develop policies allowing patients to have daily in-person visitation by a designated visitor, such as a spouse, friend, or family member. Additionally, healthcare institutions must allow clergy visits if in-person visitation is permitted or during end-of-life care. If visitation is denied, patients or their representatives can request a review with hospital officials within 24 hours. The Department is updating R9-10-403 to incorporate these requirements in compliance with the new statute. The Department estimates that some HCIs may incur minimal one-time administrative costs to amend or develop policies and procedures related to the visitation policy.
6. **Workplace Violence Prevention (Laws 2022, Ch. 190, amending A.R.S. § 36-420.03)**: Health care employers must create and maintain a written workplace violence prevention plan, tailored to site-specific risks and including procedures for reporting and responding to violent incidents. Employers must post signs warning of felony prosecution for assaults on healthcare workers and assist workers in reporting incidents to law enforcement. This change impacts R9-10-1027. The Department anticipates that HCIs may incur minimal costs to implement this training but are expected to receive a significant benefit by having personnel members trained on workplace violence prevention.
7. **Prescription Medication Donation Program (Laws 2021, Ch. 137, amending A.R.S. § 32-1909)**: The Arizona State Board of Pharmacy's Prescription Medication Donation Program allows HCIs to accept and dispense donated prescription medications that meet strict criteria, including original sealed packaging and expiration dates. The Department is amending rules in R9-10-320, R9-10-218, R9-10-421, R9-10-613, R9-10-914, R9-10-1010, R9-10-1412, and R9-10-1709 to align with these guidelines.

The new legislation is expected to have both cost increases and savings for HCIs in Arizona. Compliance costs may impose minimal costs for HCIs to update policies, train staff, and implement new procedures, such as ensuring the presence of physicians or anesthesia providers during surgical discharges (Laws 2021, Ch. 363) and adopting smoke evacuation systems (Laws 2022, Ch. 57). Additionally, healthcare employers are required to develop and implement workplace violence prevention plans (Laws 2022, Ch. 190), which may involve minimal costs for training, signage, and compliance monitoring. However, there are also areas where administrative costs may be lower. For example, the removal of architectural plan submission requirements (Laws 2022, Ch. 34) will reduce administrative burdens and fees associated with construction or modifications. Furthermore, certain outpatient treatment centers will be exempt from licensure and regulation, which would save those facilities costs related to licensure. The Department may incur minimal costs related to rulemaking, training staff, public awareness campaigns, and compliance monitoring, especially for new visitation policies and other regulatory updates. Overall, while the legislation may impose minimal costs on health care institutions for compliance, the Department believes that HCIs, patients, and their families will receive a significant benefit due to the new rules.

In addition to aligning rules with new statutory changes, the Department is making other updates to improve clarity, address issues mentioned in recent five-year review reports, and improve public health and safety requirements. One of the new changes includes updating terminology from "telemedicine" to "telehealth" in several sections to reflect Laws 2021, Ch. 320, and revising meal and snack guidelines to align with the latest U.S. dietary standards to make the rules more effective, clear, and concise. In Article 2, the Department is amending eight sections related to hospitals. Key updates include removing four obsolete terms in R9-10-201 and redefining “nurse anesthetist” to match the definition of “certified registered nurse anesthetist” in A.R.S. § 32-1601. The term “specialty” is now defined in R9-10-202, where it is used. Changes in R9-10-203, R9-10-212, R9-10-215, and R9-10-234 reflect new statutory requirements. Additionally, the amendments in R9-10-209 ensure discharge or transfer information complies with A.R.S. § 36-420.04.

The Department is implementing several amendments to rules for Behavioral Health Inpatient Facilities, Nursing Care Institutions, and Outpatient Surgical Centers. In Article 3. Behavioral Health Inpatient Facilities, a new subsection is being added to R9-10-303 (Administration) requiring administrators to ensure that policies and procedures effectively prevent abuse or neglect of patients. In Article 4. Nursing Care Institutions, ten sections are being amended for clarification, the correction of grammatical errors, and cross-references. Specifically, R9-10-402 (Supplemental Application Requirements) will include a reference to proper documentation, and R9-10-403 (Administration) will incorporate training references according to A.R.S. § 36-420.01, along with a new subsection for procedures to prevent abuse or neglect of residents. These rule amendments will also include the first aid and CPR training requirements, consistent with A.R.S. § 36-420(B).

In Article 9. Outpatient Surgical Centers, the Department is making amendments to the definition of a “surgical suite” in R9-10-901 to encompass one or more procedure rooms. In R9-10-911, the Department is amending the rules to allow individuals authorized under specific state laws (A.R.S. Title 32, Chapters 13, 15, or 17) to administer anesthesia, thus broadening the scope for anesthesia administration in outpatient settings. The Department expects these changes will significantly benefit outpatient surgical centers by complying and more consistent with current statutes. Furthermore, these rule changes are expected to have a

positive impact by improving patient safety through stronger protocols against abuse or neglect, which may help decrease liability and legal costs for facilities. Therefore, the Department estimates that the costs of imposing the new rules may be minimal and that HCIs may receive a significant benefit from the new rules. Moreover, the clarifications and corrections in the regulations could reduce administrative burdens, allowing for more efficient operations. By enabling a broader range of qualified personnel to administer anesthesia, outpatient surgical centers may experience increased operational capacity, resulting in reduced wait times and improved service delivery.

In Article 10. Outpatient Treatment Centers, the Department is amending ten sections to comply with statutory requirements and make the rules more clear, concise, and understandable. R9-10-1011 is being amended to clarify the distinction between outpatient treatment centers and counseling facilities by incorporating a medication component into the behavioral health assessment, allowing for the prescribing of medication to treat mental health or substance abuse conditions. In R9-10-1017, the language is adjusted to replace "a copy of a certificate documenting" with "written documentation of," streamlining requirements for compliance with A.R.S. Title 30, Chapter 4. The amendments also update the terminology from "physician" to "medical staff member" to broaden service eligibility. R9-10-1022 further adjusts references to physician oversight and aligns with state statute. R9-10-1031 includes an exemption clarification under A.R.S. § 36-402, and other sections are revised to align with new statutory changes. The Department anticipates that these updates will provide significant benefits to outpatient treatment centers without imposing additional costs.

In Article 11. Adult Day Health Care Facilities, the Department is amending four sections to improve compliance with tuberculosis testing requirements. Specifically, R9-10-1107 removes the seven-day testing requirement for TB, aligning with updated CDC guidelines that mandate evidence of freedom from infectious tuberculosis before participant enrollment. Language updates are also made in R9-10-1114 while R9-10-1117 is revised to reflect statutory changes. The Department estimates that there could be a minimal cost for requiring TB testing to be done before participation, but estimates that this change would provide a significant benefit for ensuring the health and safety of a facility.

In Article 13, Behavioral Health Specialized Transitional Facilities, the Department is amending seven sections. R9-10-1302 is being revised to correct a cross-reference and mandates annual training for personnel on recognizing signs of abuse or neglect. R9-10-1305 requires an administrator to ensure that each personnel member, employee, volunteer, or student is in compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training. R9-10-1306 clarifies that medical history must be obtained from patients during admission. In R9-10-1313, the phrase "or" is changed to "and" for clarification. Additional language updates are made in R9-10-1314 and R9-10-1317 for consistency with the latest dietary guidelines according to the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. The Department estimates the costs to implement the new rules may be minimal, but Behavioral Health Specialized Transitional Facilities are expected to receive a significant benefit from having updated rules.

For Article 14, Substance Abuse Transitional Facilities, the Department is amending one section, R9-10-1413, to align meal and snack guidelines with the latest dietary standards. In Article 15. Abortion Clinics, R9-10-1515 is updated for physical plant

standards to correct a statutory cross-reference. Amendments in Articles 17, 19, and 22 also focus on similar changes to correct grammatical errors, simplifying language, and complying with new statutory changes. The Department does not foresee costs being incurred by these amendments; instead, the Department expects that these updates will provide a significant benefit by aligning rules with current statutes.

The proposed amendments to the Department's rules are significant updates aimed at enhancing public health and safety within healthcare institutions. These changes align with recent statutory modifications and address concerns raised in five-year review reports. Key amendments include the establishment of new standards for behavioral health residential facilities and outpatient surgical centers, as well as updated policies regarding workplace violence prevention and visitation in hospitals. New statutes mandating clergy visitation and visitor access for patients aim to alleviate isolation and provide emotional support, recognizing diverse cultural and spiritual needs. The amendments are also expected to improve patient care through better compliance with safety standards, including those related to surgical discharges and architectural requirements for facilities. The inclusion of workplace violence prevention measures is particularly important for safeguarding healthcare workers, thereby enhancing overall safety within these institutions. Although compliance may incur minimal costs—such as staff training and facility upgrades—the Department believes that aligning with these rules will significantly benefit small businesses by enhancing public health and safety. While initial implementation costs may arise, the Department expects that those affected by the rules will receive a significant benefit. The proposed rules are expected to streamline administrative processes, reduce regulatory burdens, and promote compliance with updated standards, ultimately benefiting HCIs and the public by improving patient care and safety outcomes. For the general public, these rule changes are expected to provide a significant benefit for having updated rules that align with statutes and increase public health and safety.

The rule amendments may involve minimal costs for the Department, including training staff, updating safety protocols, and revising administrative processes. These costs cover implementing smoke evacuation systems, workplace violence prevention plans, and compliance monitoring. Additional minimal expenses arise from updating records, public awareness efforts, and the rulemaking process itself. Despite these potential minimal costs, the Department believes the new rule changes may provide a significant benefit for maintaining public health, ensuring patient safety, and complying with new statutory provisions. Overall, the proposed amendments to the Department's rules are comprehensive updates designed to ensure alignment with recent statutory changes and address issues identified in recent five-year review reports. These changes are anticipated to improve the effectiveness and clarity of regulations, enhance public health and safety, and align with Arizona statutes. Economically, while there may be initial costs associated with implementing some of these changes, the overall impact is expected to provide a significant benefit.

**11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

After the proposed rulemaking, in the final rulemaking, the Department amended R9-10-103(B)(4) and (5) to update the placement of "or" to correctly follow rule writing standards according to the Secretary of State's Office. In addition, the "base rules" in R9-10-101 were amended to reflect a recent rulemaking that the Department submitted to GRRC on April 22, 2025, which

amends 9 A.A.C. 10 Articles 1 and 8.

**12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

The Department received two formal written comments. One comment was from Joel Wakefield with the Nelson Law Group representing Ying Tian, MD, president of the Arizona Society of Anesthesiologists (AzSA). Another comment was received from Katrina Trinchera, Chief Compliance Officer at the Arizona State Hospital (ASH).

The comment on behalf of AzSA acknowledged the Department's proposed revisions to A.A.C. R9-10-911, as required by legislative changes to ARS 36-405. However, AzSA urges the Department to explicitly recognize that these revisions do not alter the established scope of practice for certified registered nurse anesthetists (CRNAs) as defined in ARS 32-1634.04(A). AzSA emphasizes that no health care professional in Arizona may exceed their legislatively defined scope of practice and that the Department does not have the authority to modify professional licensure restrictions through facility licensure rules. Therefore, AzSA requested that the Department acknowledge these statutory limitations in the final rule. The Department thanked Joel Wakefield for the comments and assured them that the changes in R9-10-911 are intended to align with the statutory revisions to A.R.S 36-405 while maintaining consistency with existing scope of practice requirements.

ASH provided feedback on the proposed changes to A.A.C. R9-10-1315, which require evacuation drills every three months for all individuals at the Arizona Community Protection and Treatment Center (ACPTC), except those with medical exemptions. Given ACPTC's unique population and lengthy average stay, ASH finds this frequency excessive and disruptive to the therapeutic environment. While recognizing the importance of staff training for emergencies, ASH suggests aligning the requirements with hospital disaster management rules in A.A.C. R9-10-232 by changing the term "evacuation drill" to "fire drill." In response, the Department clarified that the proposed changes are intended to reduce the burden of evacuation drills by exempting patients whose medical records indicate that evacuation would cause harm. Currently, all patients are required to participate, as no exemption exists under A.A.C. Title 9, Chapter 10, Article 13. Additionally, the term "evacuation drill" aligns with A.A.C. Title 9, Chapter 10 and accounts for various emergency scenarios beyond fire.

ASH also recommended the Department revise A.A.C. R9-10-1302(H)(2)(b), R9-10-1305(E), and R9-10-1305(G)(3) and remove reference to behavioral health technicians (BHTs) because ACPTC does not employ BHTs for resident care. Instead, residential program specialists provide supervision, security, assistance with daily living activities, and recreational support without performing duties requiring licensure under Title 32. Since these staff do not meet the definition of a BHT under A.A.C. R9-10-101(39), ASH suggested removing references to BHTs from certain sections of Article 13 for clarity. In response, the Department stated that the requested changes fall outside the scope of this rulemaking. While ACPTC does not currently employ behavioral health technicians (BHTs), the Department questioned whether this could be a possibility in the future. Since the rules set minimum standards, they would remain applicable if ACPTC were to hire BHTs later.

ASH also recommended updating A.A.C. R9-10-1307 to align with the discharge process for ACPTC residents. They noted that

residents could be conditionally released to a less restrictive alternative through the privileges process but remained under ACPTC's care until discharge. Additionally, ASH highlighted that it was rare for ACPTC residents to be determined to have a Serious Mental Illness (SMI) and, therefore, to have an outpatient treatment team or Regional Behavioral Health Authority (RHBA) involved in their transition. As a result, many residents were discharged to the community without a designated health care provider or behavioral health professional to receive the discharge summary. To address this, ASH suggested revising the language in A.A.C. R9-10-1307(D). In response, the Department stated that amending discharge process rules is beyond the scope of this rulemaking. The Department acknowledged that ACPTC residents are rarely determined to have a SMI and that some may be discharged without an identified health care provider or behavioral health professional. However, any changes to discharge requirements would require further discussion and analysis, as the language in this Section is consistent with statute.

ASH recommended updating A.A.C. R9-10-1310 to better align with the treatment planning process for ACPTC residents. They explained that a resident's treatment plan was developed by a multidisciplinary team under the ultimate responsibility of the clinical director. Since treatment orders could come from various providers and be stored in locations other than the resident's master treatment plan, ASH stated that listing each provider's name on the treatment plan was duplicative and impractical. Therefore, they recommended removing this requirement from the rule. In response, the Department explained that the requirement of documenting the name of each individual who ordered medication, counseling, or other treatment for the patient would be inconsistent with other rules in Chapter 10 as well as national standard practices.

Lastly, ASH recommended the individuals receiving care at ACPTC be termed "residents." It is recommended that the Article refer to "residents" rather than "patients." In response, the Department explained that the use of the term "patient" with "resident" when referring to individuals receiving care at ACPTC would create inconsistency and would not align with the defined terms in R9-10-101(164) and (195).

At the Oral Proceeding on February 18, 2025, six stakeholders attended. Comments were made by Debbie Johnston from the Arizona Hospital and Healthcare Association and Susan Russo from Community Bridges. Debbie Johnston expressed her gratitude, thanking the Department for being responsive to their concerns during the rulemaking process. Susan Russo raised a concern about whether it is appropriate for a registered nurse (RN) to serve in a behavioral health technician (BHT) role. The Department clarified that RNs are not required to be classified as BHTs. They can serve as standalone staff and do not require clinical oversight if they are not providing behavioral health services. For example, if an RN is conducting clinical rounds related to nursing or medication services, they would not need oversight from a behavioral health professional. The Department ensured that this change does not significantly impact their duties, emphasizing that registered nurses maintain their RN designation without needing to be classified as BHTs. Susan Russo also expressed concerns regarding the licensing exceptions in R9-10-103 and whether outpatient treatment centers (OTCs) would no longer be eligible for a licensing exception. The Department explained that the rule applies to off-site services, such as home health or hospice agencies providing medical services at an assisted living facility or another health care institution, which do not require dual licensure. The changes to the exception do not impact an OTC's ability to provide services in the community. However, the rule clarifies that OTCs cannot provide services within another licensed health care institution unless a specific rule or agreement permits them to do so. This change does not

limit an OTC from operating in the community but ensures that services provided within other licensed institutions comply with applicable regulations.

**13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

There are no other matters prescribed by statutes applicable specifically to the Department or this specific rulemaking.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

The rule does not require the issuance of a regulatory permit. Therefore, a general permit is not applicable.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

There are no federal rules applicable to the subject of the rule.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

**14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Not applicable

**15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**16. The full text of the rules follows:**

# TITLE 9. HEALTH SERVICES
# CHAPTER 10. DEPARTMENT OF HEALTH SERVICES – HEALTH CARE INSTITUTIONS: LICENSING

## ARTICLE 1. GENERAL



## ARTICLE 2. HOSPITALS



## ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES



## ARTICLE 4. NURSING CARE INSTITUTIONS

Section



**ARTICLE 6. HOSPICES**



**ARTICLE 9. OUTPATIENT SURGICAL CENTERS**

Section



**ARTICLE 10. OUTPATIENT TREATMENT CENTERS**

Section



**ARTICLE 11. ADULT DAY HEALTH CARE FACILITIES**

Section

## ARTICLE 13. BEHAVIORAL HEALTH SPECIALIZED TRANSITIONAL FACILITY



## ARTICLE 14. SUBSTANCE ABUSE TRANSITIONAL FACILITIES



## ARTICLE 15. ABORTION CLINICS



## ARTICLE 17. UNCLASSIFIED HEALTH CARE INSTITUTIONS



## ARTICLE 19. COUNSELING FACILITIES



## ARTICLE 22. NURSING-SUPPORTED GROUP HOMES

## ARTICLE 1. GENERAL

**R9-10-101. Definitions**

In addition to the definitions in A.R.S. §§ 36-401(A) and 36-439, the following definitions apply in this Chapter unless otherwise specified:

1. "Abortion clinic" No change
2. "Abuse" No change
    a. No change
        i. No change
        ii. No change
    b. No change
    c. No change
    d. No change
3. "Accredited" No change
4. "Active malignancy" No change
    a. No change
        i. No change
        ii. No change
        iii. No change
    b. No change
    c. No change
5. "Activities of daily living" No change
6. "Acuity" No change
7. "Acuity plan" No change
8. "Adjacent" No change
    a. No change
    b. No change
9. "Administrative completeness review time-frame" No change
10. "Administrative office" No change
11. "Admission" or "admitted" No change
12. "Adult" No change
13. "Adult behavioral health therapeutic home" No change
14. "Adult residential care institution" No change
15. "Adverse reaction" No change
16. "Affiliated counseling facility" No change
17. "Affiliated outpatient treatment center" No change
18. "Alternate licensing fee due date" No change
19. "Ancillary services" No change
20. "Anesthesiologist" No change
    a. No change
    b. No change
    c. No change
    d. No change

21. "Applicant" No change
    a. No change
    b. No change
    c. No change
    d. No change
22. "Application packet" No change
    a. No change
    b. No change
    c. No change
    d. No change
23. "Assessment" No change
24. "Assistance in the self-administration of medication" No change
25. "Attending physician" No change
26. "Authenticate" No change
    a. No change
    b. No change
    c. No change
    d. No change
27. "Authorized service" No change
28. "Available" No change
    a. No change
    b. No change
    c. No change
29. "Behavioral care" No change
    a. No change
        i. No change
            (1) No change
            (2) No change
        ii. No change
    b. No change
30. "Behavioral health facility" No change
31. "Behavioral health inpatient facility" means a health care institution <u>other than a general hospital, rural general hospital, or special hospital</u> that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
    a. Have a limited or reduced ability to meet the individual's basic physical needs; b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
    c. Be a danger to self;
    d. Be a danger to others;
    e. Be persistently or acutely disabled, as defined in A.R.S. § 36-501; or
    f. Be gravely disabled.
32. "Behavioral health issue" No change
33. "Behavioral health observation/stabilization services" No change
    a. No change

b. No change

c. No change

34. "Behavioral health paraprofessional" No change

a. No change

b. No change

35. "Behavioral health professional" means the following licensed professionals that provide services specifically within the scope of practices defined by their profession:

a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

i. Independently engage in the practice of behavioral health, as defined in A.R.S. § 32-3251; or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health, as defined in A.R.S. § 32-3251, under direct supervision as defined in A.A.C. R4-6-101;

b. A psychiatrist as defined in A.R.S. § 36-501;

c. A psychologist as defined in A.R.S. § 32-2061;

d. A physician;

e. A behavior analyst as defined in A.R.S. § 32-2091; or

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; ~~or~~

g. A ~~registered~~ clinical nurse specialist as described in A.R.S. § 32-1601 or ~~with:~~

~~i. A psychiatric-mental health nursing certification, or~~

~~ii. One year of experience providing behavioral health services.~~

h. Psychiatric physician assistant.

36. "Behavioral health residential facility" No change

a. No change

b. No change

37. "Behavioral health respite home" No change

38. "Behavioral health specialized transitional facility" means a health care institution that provides inpatient behavioral health services and physical health services to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37 and 9 A.A.C. 10 Article 13.

39. "Behavioral health technician" No change

a. No change

b. No change

40. "Benzodiazepine" No change

41. "Biohazardous medical waste" No change

42. "Calendar day" No change

43. "Case manager" No change

44. "Certification" No change

45. "Certified health physicist" No change

46. "Change in ownership" No change

47. "Chief administrative officer" or "administrator" No change

48. "Clinical laboratory services" No change

49. "Clinical oversight" No change

a. No change

b. No change

c. No change

d. No change

50. “Clinical privileges” No change

51. “Collaborating health care institution” No change

a. No change

b. No change

52. “Common area” No change

a. No change

b. No change

c. No change

53. “Communicable disease” No change

54. “Conspicuously posted” No change

a. No change

b. No change

55. “Consultation” No change

56. “Contracted services” No change

57. “Contractor” No change

58. “Controlled substance” No change

59. “Counseling” No change

60. “Counseling facility” No change

a. No change

b. No change

61. “Court-ordered evaluation” No change

62. “Court-ordered treatment” No change

63. “Crisis services” No change

64. “Current” No change

65. “Daily living skills” No change

66. “Danger to others” No change

67. “Danger to self” No change

68. “Detoxification services” No change

a. No change

b. No change

69. “Diagnostic procedure” No change

70. “Dialysis” No change

71. “Dialysis services” No change

72. “Dialysis station” No change

73. “Dialyzer” No change

74. “Disaster” No change

75. “Discharge” No change

76. “Discharge instructions” No change

77. “Discharge planning” No change

78. “Discharge summary” No change

79. “Disinfect” No change

80. “Documentation” or “documented” No change

81. “Drill” No change

82. “Drug” No change

83. “Electronic” No change

84. “Electronic signature” No change

85. “Emergency” No change

86. “Emergency medical services provider” No change

87. “Emergency services” No change

88. “End-of-life” No change

89. “Environmental services” No change

90. “Equipment” No change

91. “Exploitation” No change

92. “Factory-built building” No change

93. “Family” or “family member” No change

94. “Follow-up instructions” No change

95. “Food services” No change

96. “Full-time” No change

97. “Garbage” No change

98. “General consent” No change

99. “General hospital” No change

100. “Gravely disabled” No change

101. “Habilitation services” No change

102. “Hazard” or “hazardous” No change

103. “Health care directive” No change

104. “Hemodialysis” No change

105. “Home health agency” No change

106. “Home health aide” No change

107. “Home health aide services” No change

108. “Home health services” No change

109. “Hospice inpatient facility” No change

110. “Hospital” No change

111. “Immediate” No change

112. “Immediate jeopardy” No change

~~112.~~113. “Incident” means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:

a. On the premises of a health care institution, or

b. Not on the premises of a health care institution but directly receiving physical health services or behavioral health ser-vices from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.

~~113.~~114. “Infection control” means to identify, prevent, monitor, and minimize infections.

~~114.~~115. “Infectious tuberculosis” has the same meaning as “infectious active tuberculosis” in A.A.C. R9-6-101.

~~115.~~116. “Informed consent” means:

a. Advising a patient of a proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic proce-dure; alternatives to the treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; and associated risks and possible complications; and

b. Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure from the patient or the patient's representative.

~~116.~~117. "In-service education" means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.

~~117.~~118. "Interdisciplinary team" means a group of individuals consisting of a resident's attending physician, a registered nurse responsible for the resident, and other individuals as determined in the resident's comprehensive assessment or, if applicable, placement evaluation.

~~118.~~119. "Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" has the same meaning as in A.R.S. § 36-551.

~~119.~~120. "Interval note" means documentation updating a patient's:

a. Medical condition after a medical history and physical examination is performed, or

b. Behavioral health issue after an assessment is performed.

~~120.~~121. "Isolation" means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.

~~121.~~122. "Leased facility" means a facility occupied or used during a set time period in exchange for compensation.

~~122.~~123. "License" means:

a. Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or

b. Written approval issued to an individual to practice a profession in this state.

~~123.~~124. "Licensed occupancy" means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.

~~124.~~125. "Licensee" means an owner approved by the Department to operate a health care institution.

~~125.~~126. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.

~~126.~~127. "Medical condition" means the state of a patient's physical or mental health, including the patient's illness, injury, or disease.

~~127.~~128. "Medical director" means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.

~~128.~~129. "Medical history" means an account of a patient's health, including past and present illnesses, diseases, or medical conditions.

~~129.~~130. "Medical practitioner" means a physician, physician assistant, or registered nurse practitioner.

~~130.~~131. "Medical record" has the same meaning as "medical records" in A.R.S. § 12-2291.

~~131.~~132. "Medical staff" means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.

~~132.~~133. "Medical staff bylaws" means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.

~~133~~134. "Medical staff member" means an individual who is part of the medical staff of a health care institution.

~~134.~~135. "Medication" means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:

a. Biologicals as defined in A.A.C. R18-13-1401,

b. Prescription medication as defined in A.R.S. § 32-1901, or

c. Nonprescription drug as defined in A.R.S. § 32-1901.

~~135.~~136. "Medication administration" means restricting a patient's access to the patient's medication and providing the medication to the patient or applying the medication to the patient's body, as ordered by a medical practitioner.

~~136.~~137. "Medication error" means:

a. The failure to administer an ordered medication;

b. The administration of a medication not ordered; or

c. The administration of a medication:

i. In an incorrect dosage,

ii. More than 60 minutes before or after the ordered time of administration unless ordered to do so, or

iii. By an incorrect route of administration.

~~137.~~138. "Mental disorder" means the same as in A.R.S. § 36-501.

~~138.~~139. "Mobile clinic" means a movable structure that:

a. Is not physically attached to a health care institution's facility;

b. Provides medical services, nursing services, behavioral health services, or health related service to an outpatient under the direction of the health care institution's personnel; and

c. Is not intended to remain in one location indefinitely.

~~139.~~140. "Monitor" or "monitoring" means to check systematically on a specific condition or situation.

~~140.~~141. "Neglect" has the same meaning:

a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and

b. For an individual 18 years of age or older, as in A.R.S. § 46-451.

~~141.~~142. "Nephrologist" means a physician who is board eligible or board certified in nephrology by a professional credentialing board.

~~142.~~143. "Nurse" has the same meaning as "registered nurse" or "practical nurse" as defined in A.R.S. § 32-1601.

~~143.~~144. "Nursing care institution administrator" means an individual licensed according to A.R.S. Title 36, Chapter 4, Article 6.

~~144.~~145. "Nursing personnel" means individuals authorized according to A.R.S. Title 32, Chapter 15 to provide nursing services.

~~145.~~146. "Observation chair" means a physical piece of equipment that:

a. Is located in a designated area where behavioral health observation/stabilization services are provided,

b. Allows an individual to fully recline, and

c. Is used by the individual while receiving crisis services.

~~146.~~147. "Occupational therapist" has the same meaning as in A.R.S. § 32-3401.

~~147.~~148. "Occupational therapy assistant" has the same meaning as in A.R.S. § 32-3401.

~~148.~~149. "Ombudsman" means a resident advocate who performs the duties described in A.R.S. § 46-452.02.

~~149.~~150. "On-call" means a time during which an individual is available and required to come to a health care institution when requested by the health care institution.

~~150.~~151. "Opioid" means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of "opiate" in A.R.S. § 36-2501.

~~151.~~152. "Opioid agonist treatment medication" means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of ~~premises~~ opioid-related substance use disorder.

~~152.~~153. "Opioid antagonist" means a prescription medication, as defined in A.R.S. § 32-1901, that:

a. Is approved by the U.S. Department of Health and Human Services, Food and Drug Administration; and

b. When administered, reverses, in whole or in part, the pharmacological effects of an opioid in the body.

~~153.~~154. "Opioid treatment" means providing medical services, nursing services, behavioral health services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opioid-related substance use disorder.

~~154.~~155. "Order" means instructions to provide:

a. Physical health services to a patient from a medical practitioner or as otherwise provided by law; or

b. Behavioral health services to a patient from a behavioral health professional.

~~155.~~156. "Orientation" means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.

~~156.~~157. "Outing" means a social or recreational activity that:

a. Occurs away from the premises,

b. Is not part of a behavioral health inpatient facility's or behavioral health residential facility's daily routine, and

c. Lasts longer than ~~four~~ two hours.

~~157.~~158. "Outpatient surgical center" means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia ser-vices to a patient whose recovery, in the opinions of the patient's surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.

~~158.~~159. "Outpatient treatment center" means a class of health care institution without inpatient beds that provides physical health services, or physical health services and behavioral health services, including medication services for the diagnosis and treatment of patients.

~~159.~~160. "Overall time-frame" means the same as in A.R.S. § 41-1072.

~~161.~~161. "Owner" means a person who appoints, elects, or designates a health care institution's governing authority.

~~161.~~162. "Pain management clinic" has the same meaning as in A.R.S. § 36-448.01.

~~162.~~163. "Participant" means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.

~~163.~~164. "Participant's representative" means the same as "patient's representative" for a participant.

~~164.~~165. "Patient" means an individual receiving physical health services or behavioral health services from a health care institution.

~~165.~~166. "Patient's representative" means:

a. A patient's legal guardian;

b. If a patient is less than 18 years of age and not an emancipated minor, the patient's parent;

c. If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient's legal guardian; or

d. A surrogate as defined in A.R.S. § 36-3201.

~~166.~~167. "Person" means the same as in A.R.S. § 1-215 and includes a governmental agency.

~~167.~~168. "Personnel member" means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.

~~168.~~169. "Pest control program" means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient's health and safety is not at risk.

~~169.~~170. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.

~~170.~~171. "Physical examination" means to observe, test, or inspect an individual's body to evaluate health or determine the cause of illness, injury, or disease.

~~171.~~172. “Physical health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s medical condition.

~~172.~~173. “Physical therapist” has the same meaning as in A.R.S. § 32-2001.

~~173.~~174. “Physical therapist assistant” has the same meaning as in A.R.S. § 32-2001.

~~174.~~175. “Physician assistant” has the same meaning as in A.R.S. § 32-2501.

~~175.~~176. “Placement evaluation” means the same as in A.R.S. § 36-551.

~~176.~~177. “Pre-petition screening” has the same meaning as “prepetition screening” in A.R.S. § 36-501.

~~177.~~178. “Premises” means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a resident or patient.

~~178.~~179. “Prescribe” means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user’s behalf, a specific dose of a specific medication in a specific quantity and route of administration.

~~179.~~180. “Professional credentialing board” means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.

~~180.~~181. “Progress note” means documentation by a medical staff member, nurse, or personnel member of:

a. An observed patient response to a physical health service or behavioral health service provided to the patient,

b. A patient’s significant change in condition, or

c. Observed behavior of a patient related to the patient’s medical condition or behavioral health issue.

~~181.~~182. “PRN” means pro re nata or given as needed.

~~182.~~183. “Project” means specific construction or modification of a facility stated on an architectural plans and specifications approval application.

~~183.~~184. “Provider” means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual’s place of residence.

~~184.~~185. “Provisional license” means the Department’s written approval to operate a health care institution issued to an applicant or licensee that is not in substantial compliance with the applicable laws and rules for the health care institution.

186. “Psychiatric services” means the diagnosis, treatment, and management of a mental disorder under the direction of a licensed psychiatrist or licensed nurse practitioner.

~~185.~~187. “Psychotropic medication” means a chemical substance that:

a. Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and

b. Is provided to a patient to address the patient’s behavioral health issue.

~~186.~~188. “Quality management program” means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.

~~187.~~189. “Recovery care center” has the same meaning as in A.R.S. § 36-448.51.

~~188.~~190. “Referral” means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.

~~189.~~191. "Registered dietitian" means an individual approved to work as a dietitian by the American Dietetic Association's Commission on Dietetic Registration.

~~190.~~192. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.

~~191.~~193. "Registered nurse practitioner" has the same meaning as A.R.S. § 32-1601.

~~192.~~194. "Regular basis" means at recurring, fixed, or uniform intervals.

~~193.~~195. "Rehabilitation services" means medical services provided to a patient to restore or to optimize functional capability.

~~194.~~196. "Research" means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.

~~195.~~197. "Resident" means an individual living in and receiving physical health services or behavioral health services, including rehabilitation services or habilitation services if applicable, from a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.

~~196.~~198. "Resident's representative" means the same as "patient's representative" for a resident.

~~197.~~199. "Respiratory care services" has the same meaning as "practice of respiratory care" as defined in A.R.S. § 32-3501.

~~198.~~200. "Respiratory therapist" has the same meaning as in A.R.S. § 32-3501.

~~199.~~201. "Respite capacity" means the total number of children who do not stay overnight for whom an outpatient treatment center or a behavioral health residential facility is authorized by the Department to provide respite services on the premises of the outpatient treatment center or behavioral health residential facility.

~~200.~~202. "Respite services" means respite care services provided to an individual who is receiving behavioral health services.

~~201.~~203. "Restraint" means any physical or chemical method of restricting a patient's freedom of movement, physical activity, or access to the patient's own body.

~~202.~~204. "Risk" means potential for an adverse outcome.

~~203.~~205. "Room" means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.

~~204.~~206. "Rural general hospital" means a subclass of hospital:

a. Having 50 or fewer inpatient beds,

b. Located more than 20 surface miles from a general hospital or another rural general hospital, and

c. Requesting to be and being licensed as a rural general hospital rather than a general hospital.

~~205.~~207. "Satellite facility" has the same meaning as in A.R.S. § 36-422.

~~206.~~208. "Scope of services" means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.

~~207.~~209. "Seclusion" means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.

210. "Secure behavioral health residential facility" has the same meaning as in A.R.S. § 36.425.06.

211. "Self-injury" means any intentional act of causing harm or injury to oneself and may include, but is not limited to, actions such as cutting, burning, hitting, scratching, or other forms of physical harm which as a result may require care from a health care provider.

~~208.~~212. "Sedative-hypnotic medication" means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.

~~209.~~213. "Self-administration of medication" means a patient having access to and control of the patient's medication and may include the patient receiving limited support while taking the medication.

~~210.~~214. "Sexual abuse" means the same as in A.R.S. § 13-1404(A).

~~211.~~215. "Sexual assault" means the same as in A.R.S. § 13-1406(A).

~~212.~~216. "Shift" means the beginning and ending time of a continuous work period established by a health care institution's policies and procedures.

~~213.~~217. "Short-acting opioid antagonist" means an opioid antagonist that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.

~~214.~~218. "Signature" means:

a. A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or

b. An electronic signature.

~~215.~~219. "Significant change" means an observable deterioration or improvement in a patient's physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.

220. "Single dwelling unit" has the same meaning as "single family residence" in A.R.S. § 33-1310.

~~216.~~221. "Single group license" means a license that includes authorization to operate health care institutions according to A.R.S. § 36-422(F) or (G).

~~217.~~222. "Speech-language pathologist" means an individual licensed according to A.R.S. Title 36, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.

~~218.~~223. "Special hospital" means a subclass of hospital that:

a. Is licensed to provide hospital services within a specific branch of medicine; or

b. Limits admission according to age, gender, type of disease, or medical condition.

~~219.~~224. "Student" means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.

~~220.~~225. "Substance abuse" means an individual's misuse of alcohol or other drug or chemical that:

a. Alters the individual's behavior or mental functioning;

b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and

c. Impairs, reduces, or destroys the individual's social or economic functioning.

~~221.~~226. "Substance abuse transitional facility" means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.

~~222.~~227. "Substance use disorder" means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.

~~223.~~228. "Substance use risk" means an individual's unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.

~~224.~~229. "Substantial" when used in connection with a modification means:

a. An addition or removal of an authorized service;

b. The addition or removal of a colocator;

c. A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;

d. A change in the physical plant, including facilities or equipment, that costs more than $300,000; or

e. A change in the building where a health care institution is located that affects compliance with:

i. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or

ii. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.

~~225.~~230. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.

~~226.~~231. "Supportive services" has the same meaning as in A.R.S. § 36-151.

~~227.~~232. "Surgical procedure" means the excision of or incision in a patient's body for the:

a. Correction of a deformity or defect;

b. Repair of an injury; or

c. Diagnosis, amelioration, or cure of disease.

~~228.~~233. "Swimming pool" has the same meaning as "semipublic swimming pool" in A.A.C. R18-5-201.

~~229.~~234. "System" means interrelated, interacting, or interdependent elements that form a whole.

~~230.~~235. "Tapering" means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.

~~231.~~236. "Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.

~~232.~~237. ~~"Telemedicine"~~ "Telehealth" has the same meaning as in A.R.S. § 36-3601.

~~233.~~238. "Therapeutic diet" means foods or the manner in which food is to be prepared that are ordered for a patient.

~~234.~~239. "Therapist" means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.

~~235.~~240. "Time-out" means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.

~~236.~~241. "Transfer" means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending health care institution.

~~237.~~242. "Transport" means a licensed health care institution:

a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or

b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.

~~238.~~243. "Treatment" means a procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.

~~239.~~244. "Treatment plan" means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.

~~240.~~245. "Unclassified health care institution" means a health care institution not classified or subclassified in statute or in rule.

~~241.~~246. "Vascular access" means the point on a patient's body where blood lines are connected for hemodialysis.

~~242.~~247. "Volunteer" means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.

~~243.~~248. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.

**R9-10-102. Health Care Institution Classes and Subclasses; Requirements**

**A.** A person may apply for a license as one of the following classes or subclasses of health care institution:

1. General hospital~~,~~;
2. Rural general hospital~~,~~;
3. Special hospital~~,~~;
4. Behavioral health inpatient facility~~,~~;

5. Nursing care institution~~,~~;
6. Intermediate care facility for individuals with intellectual disabilities~~,~~;
7. Recovery care center~~,~~;
8. Hospice inpatient facility~~,~~;
9. Hospice service agency~~,~~;
10. Behavioral health residential facility~~,~~;
11. Adult residential care institution~~,~~;
12. Assisted living center~~,~~;
13. Assisted living home~~,~~;
14. Adult foster care home~~,~~;
15. Outpatient surgical center~~,~~;
16. Outpatient treatment center~~,~~; unless exempt pursuant to A.R.S. § 36-402,
17. Abortion clinic~~,~~;
18. Adult day health care facility~~,~~;
19. Home health agency~~,~~;
20. Substance abuse transitional facility~~,~~;
21. Behavioral health specialized transitional facility~~,~~;
22. Counseling facility~~,~~;
23. Adult behavioral health therapeutic home~~,~~;
24. Behavioral health respite home~~,~~;
25. Unclassified health care institution~~,~~; ~~or~~
26. Pain management clinic~~,~~; or
27. Secure behavioral health residential facility.

**B.** No change

**C.** No change

**D.** No change

1. No change
2. No change

**E.** No change

**R9-10-103. Licensing Exceptions**

**A.** No change

1. No change
2. No change

**B.** Unless required by another Article in this Chapter, the ~~The~~ Department does not require a separate health care institution license for:

1. A satellite facility of a hospital under A.R.S. § 36-422(F);
2. An accredited facility of an accredited hospital under A.R.S. § 36-422(G);
3. A facility operated by a licensed health care institution that is:
   a. Adjacent to and contiguous with the licensed health care institution premises; or
   b. Not adjacent to or contiguous with the licensed health care institution but connected to the licensed health care institution facility by an all-weather enclosure and:
      i. Owned by the health care institution, or
      ii. Leased by the health care institution with exclusive rights of possession;

4. A mobile clinic operated by a licensed health care institution; or

5. A facility located on grounds that are not adjacent to or contiguous with the health care institution premises where only ancillary services are provided to a patient of the health care institution.; or

6. A home health agency or hospice agency that provides off-site services, as specified as medical services, nursing services, behavioral health services, health-screening services, or health-related services provided by a licensed health care institution in an area that is:

   a. Not located on the health care institution's premises;

   b. Used to provide medical services, nursing services, behavioral health services, health-screening services, or health-related services of a limited duration; and

   c. Used for purposes other than providing medical services, nursing services, behavioral health services, health-screening services, or health-related services when not used by the health care institution.

**C.** A health care institution shall maintain at the health care institution, a current and valid documentation of any certificate or permit issued by a local jurisdiction related to the operation of the health care institution and provide copies to the Department for review upon request.

**R9-10-104. ~~Approval of~~ Architectural Plans and Specifications**

**A.** ~~For approval of architectural plans and specifications for~~ For the construction or modification of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01, an applicant shall submit as part of the health care institution license application to the Department an application packet including:

1. An application in a Department-provided format that contains:

   a. For construction of a new health care institution:

      i. The health care institution's name, street address, city, state, zip code, telephone number, and e-mail address;

      ii. The name and mailing address of the health care institution's governing authority;

      iii. The requested health care institution class or subclass; and

      iv. If applicable, the requested licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations for the health care institution;

   b. For modification of a licensed health care institution that requires approval of architectural plans and specifications:

      i. The health care institution's license number,

      ii. The name and mailing address of the licensee,

      iii. The health care institution's class or subclass, and

      iv. The health care institution's existing licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations; and the requested licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations for the health care institution;

   c. The health care institution's contact person's name, street mailing address, city, state, zip code, telephone number, and e-mail address;

   ~~d. The name, street mailing address, city, state, zip code, telephone number, and e-mail address of:~~

      ~~i. The project architect; or~~

      ~~ii. If the construction or modification of the health care institution does not require a project architect, the project engineer or other individual responsible for the completion of the construction or modification;~~

d. A notarized attestation from an architect registered pursuant to A.R.S. Title 32, Chapter 1 that verifies the architectural plans and specifications meet or exceed standards adopted by the Department;

i. For a modification of a health care institution, authorities having jurisdiction may grant approval to renovate portions of a structure, space, or system if the facility operations and patient safety in renovated and existing areas are not jeopardized by existing features of areas retained without complete corrective measures which minimize restriction on those improvements where total compliance would create an unreasonable hardship and would not substantially improve safety;

e. A narrative description of the project;

f. The estimated total project cost including the costs of:

i. Site acquisition,

ii. General construction,

iii. Architect fees,

iv. Fixed equipment, and

v. Movable equipment;

g. If providing or planning to provide medical services, nursing services, or health-related services that require compliance with specific physical plant codes and standards incorporated by reference in R9-10-104.01, the number of rooms or inpatient beds designated for providing the medical services, nursing services, or health-related services;

h. If providing or planning to provide behavioral health observation/stabilization services, the number of behavioral health observation/stabilization observation chairs designated for providing the behavioral health observation/stabilization services;

~~i. For construction of a new health care institution and if modification of a health care institution requires a project architect, a statement signed and sealed by the project architect, according to the requirements in 4 A.A.C. 30, Article 3, that the:~~

~~i. Project architect has complied with A.A.C. R4-30-301; and~~

~~ii. Architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;~~

~~j.~~i. If construction or modification of a health care institution requires a project engineer, a statement signed and sealed by the project engineer, according to the requirements in 4 A.A.C. 30, Article 3, that the project engineer has complied with A.A.C. R4-30-301; and

~~k.~~j. A statement signed by the governing authority or the licensee that the architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;

2. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following:

a. A building permit for the construction or modification issued by the local governmental agency; or

b. If a building permit issued by the local governmental agency is not required, zoning clearance issued by the local governmental agency that includes:

i. The health care institution's name, street address, city, state, zip code, and county;

ii. The health care institution's class or subclass and each type of medical services, nursing services, or health-related services to be provided; and

iii. A statement signed by a representative of the local governmental agency stating that the address listed is zoned for the health care institution's class or subclass;

3. The following information that is as necessary to demonstrate that the project described on the application complies with applicable codes and standards incorporated by reference in R9-10-104.01:

~~a.~~ ~~A table of contents containing:~~

~~i.~~ ~~The architectural plans and specifications submitted;~~

~~ii.~~ ~~The physical plant codes and standards incorporated by reference in R9-10-104.01 that apply to the project;~~

~~iii.~~ ~~The physical plant codes and standards that are required by a local governmental agency, if applicable;~~

~~iv.~~ ~~An index of the abbreviations and symbols used in the architectural plans and specifications; and~~

~~v.~~ ~~The facility's specific International Building Code construction type and International Building Code occupancy type;~~

~~b.~~ ~~If the facility is larger than 3,000 square feet and is or will be occupied by more than 20 individuals, the seal of an architect on the architectural plans and specifications according to the requirements in A.R.S. Title 32, Chapter 1 and 4 A.A.C. 30, Article 3;~~

~~c.~~a. A site plan, drawn to scale, of the entire premises showing streets, property lines, facilities, parking areas, outdoor areas, fences, swimming pools, fire access roads, fire hydrants, and access to water mains;

~~d.~~b. For each facility, on architectural plans and specifications~~:~~.,

~~i.~~ ~~A~~ a floor plan, drawn to scale, for each level of the facility, showing the layout and dimensions of each room, the name and function of each room, means of egress, and natural and artificial lighting sources;

~~ii.~~ ~~A diagram of a section of the facility, drawn to scale, showing the vertical cross-section view from foundation to roof and specifying construction materials;~~

~~iii.~~ ~~Building elevations, drawn to scale, showing the outside appearance of each facility;~~

~~iv.~~ ~~The materials used for ceilings, walls, and floors;~~

~~v.~~ ~~The location, size, and fire rating of each door and each window and the materials and hardware used, including safety features such as fire exit door hardware and fireproofing materials;~~

~~vi.~~ ~~A ceiling plan, drawn to scale, showing the layout of each light fixture, each fire protection device, and each element of the mechanical ventilation system;~~

~~vii.~~ ~~An electrical floor plan, drawn to scale, showing the wiring diagram and the layout of each lighting fixture, each outlet, each switch, each electrical panel, and electrical equipment;~~

~~viii.~~ ~~A mechanical floor plan, drawn to scale, showing the layout of heating, ventilation, and air conditioning systems;~~

~~ix.~~ ~~A plumbing floor plan, drawn to scale, showing the layout and materials used for water, sewer, and medical gas systems, including the water supply and plumbing fixtures;~~

~~x.~~ ~~A floor plan, drawn to scale, showing the communication system within the health care institution including the nurse call system, if applicable;~~

~~xi.~~ ~~A floor plan, drawn to scale, showing the automatic fire extinguishing, fire detection, and fire alarm systems; and~~

~~xii.~~ ~~Technical specifications or drawings describing installation of equipment or medical gas and the materials used for installation in the health care institution;~~

4. The estimated total project cost including the costs of:

a. Site acquisition,

b. General construction,

c. Architect fees,

d. Fixed equipment, and

e. Movable equipment;

5. ~~The following, as applicable:~~

~~a.~~ If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following provided by the local governmental agency:

~~i.~~a. A copy of the certificate of occupancy for the facility,

~~ii.~~b. Documentation that the facility was approved for occupancy, or

~~iii.~~c. Documentation that a certificate of occupancy for the facility is not available~~;~~.

~~b. A certification and a statement that the construction or modification of the facility is in substantial compliance with applicable licensing requirements in A.R.S. Title 36, Article 4 and this Chapter signed by the project architect, the contractor, and the owner;~~

~~c. A written description of any work necessary to complete the construction or modification submitted by the project architect;~~

~~d. If the construction or modification affects the health care institution's fire alarm system, a contractor certification and description of the fire alarm system in a Department-provided format provided by the Department;~~

~~e. If the construction or modification affects the health care institution's automatic fire extinguishing system, a contractor certification of the automatic fire extinguishing system in a Department-provided format provided by the Department;~~

~~f. If the construction or modification affects the health care institution's heating, ventilation, or air conditioning system, a copy of the heating, ventilation, air conditioning, and air balance tests and a contractor certification of the heating, ventilation, or air conditioning system;~~

~~g. If draperies, cubicle curtains, or floor coverings are installed or replaced, a copy of the manufacturer's certification of flame spread for the draperies, cubicle curtains, or floor coverings;~~

~~h. For a health care institution using inhalation anesthetics or nonflammable medical gas, a copy of the Compliance Certification for Inhalation Anesthetics or Nonflammable Medical Gas System required in the National Fire Codes incorporated by reference in R9-10-104.01;~~

~~i. If a generator is installed, a copy of the installation acceptance required in the National Fire Codes incorporated by reference in R9-10-104.01;~~

~~j. If equipment is installed, a certification from an engineer or from a technical representative of the equipment's manufacturer that the equipment has been installed according to the manufacturer's recommendations and, if applicable, calibrated;~~

~~k. For a health care institution providing radiology, a written report from a certified health physicist of the location, type, and amount of radiation protection; and~~

~~l. If a factory-built building is used by a health care institution:~~

~~i. A copy of the installation permit and the copy of a certificate of occupancy for the factory-built building from the Office of Manufactured Housing; or~~

~~ii. A written report from an individual registered as an architect or a professional structural engineer under 4 A.A.C. 30, Article 2, stating that the factory-built building complies with applicable design standards;~~

~~6. For construction of a new health care institution and for a modification of a health care institution that requires a project architect, a statement signed by the project architect that final architectural plans and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution;~~

~~7. For modification of a health care institution that does not require a project architect, a statement signed by the project engineer or other individual responsible for the completion of the modification that final architectural plans and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution; and~~

~~8. The applicable fee required by R9-10-106.~~

~~**B.** Before an applicant submits an application for approval of architectural plans and specifications for the construction or modification of a health care institution, an applicant may request an architectural evaluation by providing the documents in subsection (A)(3) to the Department.~~

~~**C.**~~**B.** The Department may conduct on-site facility reviews during the construction or modification of a health care institution.

~~**D.** The Department shall approve or deny an application for approval of architectural plans and specifications of a health care institution in this Section according to R9-10-108.~~

~~**E.** In addition to obtaining an approval of a health care institution's architectural plans and specifications, a person shall obtain a health care institution license before operating the health care institution.~~

**R9-10-104.01. Codes and Standards**

**A.** No change

1. No change
2. No change

**B.** The following physical plant health and safety codes and standards are incorporated by reference as modified, are on file with the Department, and include no future editions or amendments:

1. Guidelines for Design and Construction of Health Care Facilities (2018 ed.), published by the American Society for Healthcare Engineering and available from The Facility Guidelines Institute at www.fgiguidelines.org;
2. The following National Fire Codes (2012), published by and available from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269, and at www.nfpa.org/catalog:
   a. NFPA70 National Electrical Code,
   b. NFPA101 Life Safety Code, and
   c. 2012 Supplements;
3. ICC/A117.1-2017, American National Standard: Accessible and Usable Buildings and Facilities (2017), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org;
4. International Building Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]";
   b. Section 101.2 is modified by deleting the "Exception";
   c. Section 101.4.7 is deleted;
   d. Sections 103.1 through 103.3 are deleted;
   e. Sections 104.1 through 104.11.2 are deleted;
   f. Sections 105.1 through 105.7 are deleted;
   g. Sections 106.1 through 106.3 are deleted;
   h. Sections 107.1 through 107.5 are deleted;

i. Sections 108.1 through 108.4 are deleted;

j. Sections 109.1 through 109.6 are deleted;

k. Sections 110.1 through 110.6 are deleted;

l. Sections 111.1 through 111.4 are deleted;

m. Sections 112.1 through 112.3 are deleted;

n. Sections 113.1 through 113.3 are deleted;

o. Sections 114.1 through 114.4 are deleted;

p. Sections 115.1 through 115.3 are deleted;

q. Sections 116.1 through 116.5 are deleted; and

r. Appendices A, B, C, D, K, L, and M are deleted;

5. International Mechanical Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:

a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",

b. Sections 103.1 through 103.4.1 are deleted,

c. Sections 104.1 through 104.7 are deleted,

d. Sections 105.1 through 105.5 are deleted,

e. Sections 106.1 through 106.5.3 are deleted,

f. Sections 107.1 through 107.6 are deleted,

g. Sections 108.1 through 108.7.3 are deleted,

h. Sections 109.1 through 109.7 are deleted,

i. Sections 110.1 through 110.4 are deleted, and

j. Appendix B is deleted;

6. International Plumbing Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:

a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",

b. Sections 103.1 through 103.4.1 are deleted,

c. Sections 104.1 through 104.7 are deleted,

d. Sections 105.1 through 105.4.1 are deleted,

e. Sections 106.1 through 106.6.3 are deleted,

f. Sections 107.1 through 107.7 are deleted,

g. Sections 108.1 through 108.7.3 are deleted,

h. Sections 109.1 through 109.7 are deleted,

i. Sections 110.1 through 110.4 are deleted, and

j. Appendix A is deleted;

7. As adopted by the Office of the State Fire Marshal; ~~International Fire Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:~~

~~a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",~~

~~b. Sections 102.3 and 102.5 are deleted,~~

~~c. Sections 103.1 through 103.4.1 are deleted,~~

~~d. Sections 104.1 through 104.11.3 are deleted,~~

~~e. Sections 105.1 through 105.7.25 are deleted,~~

~~f. Sections 106.1 through 106.5 are deleted,~~

~~g. Sections 107.1 through 107.4 are deleted,~~

~~h. Sections 109.1 through 109.3 are deleted,~~

~~i. Sections 110.1 through 110.4.1 are deleted,~~

j. ~~Sections 111.1 through 111.4 are deleted,~~

~~k. Section 112.1 through 112.4 is deleted,~~

~~l. Section 113.1.is deleted, and~~

~~m. Appendix A is deleted;~~

8. International Fuel Gas Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:.

a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",

b. Section 101.2 is modified by deleting the "Exception",

c. Sections 103.1 through 103.4.1 are deleted,

d. Sections 104.1 through 104.7 are deleted,

e. Sections 105.1 through 105.5 are deleted,

f. Sections 106.1 through 106.6.3 are deleted,

g. Sections 107.1 through 107.6 are deleted,

h. Sections 108.1 through 108.7.3 are deleted,

i. Sections 109.1 through 109.7 are deleted, and

j. Sections 110.1 through 110.4 are deleted;

9. International Private Sewage Disposal Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:.

a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",

b. Sections 103.1 through 103.4.1 are deleted,

c. Sections 104.1 through 104.7 are deleted,

d. Sections 105.1 through 105.5 are deleted,

e. Sections 106.1 through 106.4.3 are deleted,

f. Sections 107.1 through 107.9 are deleted,

g. Sections 108.1 through 108.7.2 are deleted,

h. Sections 109.1 through 109.7 are deleted, and

i. Sections 110.1 through 110.4 are deleted.

**C.** No change

**R9-10-105. License Application**

**A.** A person applying for an initial a health care institution license shall submit to the Department an application packet that contains:

1. An application in a Department-provided format provided by the Department including:

a. The health care institution's:

i. Name;

ii. Street address, city, state, zip code;

iii. Mailing address;

iv. Telephone number, and;

v. E-mail address;

vi. Tax ID number; and

vii. Class or subclass listed in R9-10-102 for which licensing is requested;

b. Except for a home health agency, or hospice service agency, or behavioral health facility, whether the health care institution is located within 1/4 mile of agricultural land;

c. Whether the health care institution is located in a leased facility;

d. Whether the health care institution is ready for a licensing inspection by the Department;

e. If the health care institution is not ready for a licensing inspection by the Department, the date the health care institution will be ready for a licensing inspection;

f. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-10-108;

g. Owner information including:

i. The owner's name, mailing address, telephone number, and e-mail address;

ii. Whether the owner is a sole proprietorship, a corporation, a partnership, a limited liability partnership, a limited liability company, or a governmental agency;

iii. If the owner is a partnership or a limited liability partnership, the name of each partner;

iv. If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;

v. If the owner is a corporation, the name and title of each corporate officer;

vi. If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency;

vii. If the owner is a sole proprietorship, a copy of the applicants;

(1) U.S. Passport, current or expired;

(2) Birth certificate;

(3) Naturalization documents; or

(4) Documentation of legal resident alien status.

~~vii.~~viii. Whether the owner or any person with 10% or more business interest in the health care institution has had a license to operate a health care institution denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license;

~~viii.~~ix. Whether the owner or any person with 10% or more business interest in the health care institution has had a health care professional license or certificate denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license or certificate; and

~~ix.~~x. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;

h. The name and mailing address of the governing authority;

i. The chief administrative officer's:

i. Name,

ii. Title,

iii. Highest educational degree, and

iv. Work experience related to the health care institution class or subclass for which licensing is requested; and

j. Signature required in A.R.S. § 36-422(B);

2. ~~If the health care institution is located in a leased facility, a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility~~ Documentation from the property owner that the property owner approves the health care institution to operate and has exclusive rights of possession on the specified property;

3. If applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents;

4. If applicable, the name and mailing address of each owner or lessee of any agricultural land regulated under A.R.S. § 3-365 and a copy of the written agreement between the applicant and the owner or lessee of agricultural land as prescribed in A.R.S. § 36-421(D);

5. Except for a home health agency, ~~or~~ a hospice service agency, or a nursing-supported group home, one of the following:

a. If the health care institution or a part of the health care institution is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01~~:~~.

~~i.~~ An application packet ~~for approval of architectural plans and specifications~~ as required in R9-10-104(A)~~;~~;or

~~ii. Documentation of the Department's approval of the health care institution's architectural plans and specifications approval in R9-10-104 R9-10-104(D); or~~

b. If ~~a no part of~~ the health care institution or a part of the health care institution is not required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01:

i. One of the following:

(1) Documentation from the local jurisdiction of compliance with applicable local building codes and zoning ordinances, specific to the class or subclass of the health care institution; ~~or~~

(2) A certificate of occupancy specific to the class or subclass of the health care institution; or

~~(2)~~(3) If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;

ii. The licensed capacity requested by the applicant for the health care institution;

iii. If applicable, the licensed occupancy requested by the applicant for the health care institution;

iv. If applicable, the respite capacity requested by the applicant for the health care institution;

v. A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and, if applicable, each swimming pool on the health care institution premises; and

vi. A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device;

6. The health care institution's proposed scope of services; and

7. The applicable application fee required by R9-10-106.

**B.** No change

**C.** No change

**D.** No change

1. No change

   a. No change

   b. No change

2. No change

**R9-10-107. Submission of Health Care Institution Licensing Fees**

**A.** No change

1. No change

2. No change

~~**B.** The Department shall notify a licensee of the due date of the facility's health care institution licensing fees no later than 90 calendar days before the date the facility's health care institution licensing fee is due to the Department.~~

~~**C.**~~**B.** Except as specified in subsection (E), a licensee shall submit to the Department, no earlier than 60 calendar days before the anniversary date of the facility's health care institution license:

1. The following information in a Department-provided format:

   a. The licensee's name, and

   b. The facility's name and license number;

~~2. Verification of the information in the Department's current records for the health care institution;~~

~~3. If applicable, information or documentation required in another Article of this Chapter, specific to the health care institution, to be submitted with the relevant fees required in R9-10-106; and~~

~~4.~~2. The applicable annual licensing fees in R9-10-106.

~~**D.**~~**C.** If any information in the Department's current records for a health care institution is incorrect, before a licensee submits annual licensing fees according to subsection (C), the licensee shall comply with the applicable requirements in R9-10-109 or R9-10-110 to update the Department's records for the health care institution.

~~**E.**~~**D.** A licensee may submit to the Department the information in subsection (C)(1), verification in subsection (C)(2), applicable information or documentation in subsection (C)(3), and applicable annual licensing fees in R9-10-106:

1. Within 30 calendar days after the anniversary date of the facility's health care institution license, with the payment of the additional late payment fee in R9-10-106(F); or

2. If an alternate licensing fee due date has been established for the licensee according to subsections (F) and (G):

   a. By the anniversary date of the facility's health care institution license, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the alternate licensing fee due date;

   b. By the alternate licensing fee due date;

   c. If a new alternate licensing fee due date has been established, by the current alternate licensing fee due date, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the new alternate licensing fee due date; or

   d. Within 30 calendar days after the alternate licensing fee due date, with the payment of the additional late payment fee in R9-10-106(F).

~~**F.**~~**E.** Except as specified in subsection (H), a licensee may request a licensing fee due date for a facility that is different from the anniversary date of a facility's health care institution license by submitting an application for an alternate licensing fee due date

to the Department, at least 30 calendar days before the anniversary date of the facility's health care institution license, that includes the following information in a Department-provided format:

1. The licensee's name and e-mail address,
2. The facility's name and license number,
3. The current licensing fee due date,
4. The proposed alternate licensing fee due date,
5. The reason the licensee is requesting an alternate licensing fee due date, and
6. The name of the health care institution's ~~administrator's~~ administrator or individual representing the health care institution as designated in A.R.S. § 36-422 and the dated signature of the administrator or individual.

~~G.~~**F.** The Department shall review a request made according to subsection (F) according to R9-10-108.

~~H.~~**G.** A licensee may not request an alternate licensing fee due date according to subsection (F):

1. More frequently than once in each three-year period, or
2. For a facility for which the payment of licensing fees is not up-to-date.

**R9-10-108. Time-frames**

**A.** No change

**B.** The administrative completeness review time-frame for each type of approval granted by the Department as prescribed in this Article is listed in Table 1.1. The administrative completeness review time-frame begins on the date the Department receives an application packet or a written request for an alternate licensing fee due date.

1. The application packet for a health care institution license is not complete until the applicant provides the Department with written notice that the health care institution is ready for a licensing inspection by the Department.
2. If the application packet or written request is incomplete, the Department shall provide a written notice to the applicant specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the missing document or information from the applicant.
3. When an application packet or written request is complete, the Department shall provide a written notice of administrative completeness to the applicant.
4. For ~~an application packet for review of architectural plans and specifications,~~ a health care institution license application packet, an application packet for a modification ~~not requiring review of architectural plans and specifications,~~ or a written request for an alternate licensing fee due date, the Department shall consider the application or written request withdrawn if the applicant fails to supply the missing documents or information included in the notice described in subsection (B)(2) within 60 calendar days after the date of the notice described in subsection (B)(2).
5. If the Department issues a license or grants an approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.

**C.** The substantive review time-frame is listed in Table 1.1 and begins on the date of the notice of administrative completeness.

1. The Department may conduct an onsite inspection of the facility:
   ~~a. As part of the substantive review for approval of architectural plans and specifications;~~
   ~~b.~~a. As part of the substantive review for issuing a health care institution license; or
   ~~c.~~b. As part of the substantive review for approving a modification of a health care institution's license.
2. During the substantive review time-frame, the Department may make one comprehensive written request for additional information or documentation. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation. The time-frame for the Department to

complete the substantive review is suspended from the date of a written request for additional information or documentation until the Department receives the additional information or documentation.

3. The Department shall send a written notice of approval to an applicant that is in substantial compliance with applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter.
4. After an applicant for a health care institution license receives the written notice of approval in subsection (C)(3), the applicant shall submit the applicable health care institution license fee in R9-10-106 according to R9-10-107(A).
5. After receiving the applicable health care institution licensing fee from an applicant according to subsection (C)(4) and R9-10-107(A), the Department shall send a health care institution license to the applicant.
6. The Department shall provide a written notice of denial that complies with A.R.S. § 41-1076 to an applicant who does not:
   a. For a health care institution license application or ~~a request for approval of a~~ modification of a health care institution requiring architectural plans and specifications, submit the information or documentation in subsection (C)(2) within 120 calendar days after the Department's written request to the applicant;
   b. For ~~a request for approval of~~ a modification of a health care institution not requiring architectural plans and specifications or a written request for an alternate licensing fee due date, submit the information or documentation in subsection (C)(2) within 30 calendar days after the Department's written request to the applicant;
   c. Comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; or
   d. If applicable, submit a fee required in R9-10-106 or R9-10-107.
7. An applicant may file a written notice of appeal with the Department within 30 calendar days after receiving the notice described in subsection (C)(6). The appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.
8. If a time-frame's last day falls on a Saturday, a Sunday, or an official state holiday, the Department shall consider the next working day to be the time-frame's last day.

**Table 1.1 Time-frames**

| **Type of Approval** | **Statutory Authority** | **Overall Time-frame** | **Administrative Completeness Time-frame** | **Substantive Review Time-frame** |
|---|---|---|---|---|
| ~~Approval of architectural plans and specifications R9-10-104~~ | ~~A.R.S. §§ 36-405, 36-406(1)(b), and 36-421~~ | ~~105 calendar days~~ | ~~45 calendar days~~ | ~~60 calendar days~~ |
| Health care institution license R9-10-105 | A.R.S. §§ 36-405, 36-407, 36-421, 36-422, 36-424, and 36-425 | 120 calendar days | 30 calendar days | 90 calendar days |
| Approval of an alternate licensing fee due date R9-10-107 | A.R.S. § 36-405 | 30 calendar days | 10 calendar days | 20 calendar days |
| Approval of a modification of a | A.R.S. §§ 36-405, | 75 calendar days | 15 calendar days | 60 calendar days |

| | | | | |
|---|---|---|---|---|
| health care institution<br>R9-10-110 | 36-407, and 36-422 | | | |

**R9-10-109. Changes Affecting a License**

**A.** A licensee shall ensure that:

1. The Department is notified in writing at least 30 calendar days before the effective date of:
   a. Except as provided in subsection (I), a change in the name of:
      i. A health care institution, or
      ii. The licensee;
   b. A change in the hours of operation:
      i. Of an administrative office, or
      ii. For providing physical health services or behavioral health services to patients of the health care institution;
   c. A change in the address of a health care institution that does not provide medical services, nursing services, behavioral health services, or health-related services ~~on the premises~~; or
   d. A change in the geographic region to be served by the hospice service agency or home health agency; and
2. Documentation supporting the change is provided to the Department with the notification required in subsection (A)(1).

**B.** No change:

1. No change
2. No change

**C.** No change

**D.** No change

~~**E.** Except as provided in A.R.S. § 36-424(B), if a licensee submits to the Department a health care institution's current accreditation report from a nationally recognized accrediting organization, the Department shall not conduct an onsite compliance inspection of the health care institution during the time the accreditation report is valid.~~

~~**F.**~~**E.** If a licensee is an adult behavioral health therapeutic home or a behavioral health respite home, the licensee shall ensure that:

1. The Department is notified in writing if the licensee does not have a written agreement with a collaborating health care institution, as required in R9-10-1603(A)(3) or R9-10-1803(A)(3) as applicable; and
2. The adult behavioral health therapeutic home or behavioral health respite home does not accept an individual as a resident or recipient, as applicable, or provide services to a resident or recipient, as applicable, until:
   a. The adult behavioral health therapeutic home or behavioral health respite home has a written agreement with a collaborating health care institution;
   b. The collaborating health care institution has approved the adult behavioral health therapeutic home's or behavioral health respite home's:
      i. Scope of services, and
      ii. Policies and procedures; and
   c. The collaborating health care institution has verified the provider's skills and knowledge.

~~**G.**~~**F.** If a licensee is an affiliated outpatient treatment center, the licensee shall ensure that if the affiliated outpatient treatment center:

1. Plans to begin providing administrative support to a counseling facility at a time other than during the affiliated outpatient treatment center's license application process, the following information for each counseling facility is submitted to the Department before the affiliated outpatient treatment center begins providing administrative support:
    a. The counseling facility's name,
    b. The license number assigned to the counseling facility by the Department, and
    c. The date the affiliated outpatient treatment center will begin providing administrative support to the counseling facility; or
2. No longer provides administrative support to a counseling facility previously identified by the affiliated outpatient treatment center as receiving administrative support from the affiliated outpatient treatment center, the following information for each counseling facility is submitted to the Department within 30 calendar days after the affiliated outpatient treatment center no longer provides administrative support:
    a. The counseling facility's name,
    b. The license number assigned to the counseling facility by the Department, and
    c. The date the affiliated outpatient treatment center stopped providing administrative support to the counseling facility.

~~H.~~**G.** If a licensee is a counseling facility, the licensee shall ensure that if the counseling facility:

1. Plans to begin receiving administrative support from an affiliated outpatient treatment center at a time other than during the counseling facility's license application process, the following information for the affiliated outpatient treatment center is submitted to the Department before the counseling facility begins receiving administrative support:
    a. The affiliated outpatient treatment center's name,
    b. The license number assigned to the affiliated outpatient treatment center by the Department, and
    c. The date the counseling facility will begin receiving administrative support;
2. No longer receives administrative support from an affiliated outpatient treatment center previously identified by the counseling facility as providing administrative support to the counseling facility, the following information for the affiliated outpatient treatment center is submitted to the Department within 30 calendar days after the counseling facility no longer receives administrative support from the affiliated outpatient treatment center:
    a. The affiliated outpatient treatment center's name,
    b. The license number assigned to the affiliated outpatient treatment center by the Department, and
    c. The date the counseling facility stopped receiving administrative support from the affiliated outpatient treatment center;
3. Plans to begin sharing administrative support with an affiliated counseling facility at a time other than during the counseling facility's license application process, the following information for each affiliated counseling facility sharing administrative support with the counseling facility is submitted to the Department before the counseling facility and affiliated counseling facility begin sharing administrative support:
    a. The affiliated counseling facility's name,
    b. The license number assigned to the affiliated counseling facility by the Department, and
    c. The date the counseling facility and the affiliated counseling facility will begin sharing administrative support; or
4. No longer shares administrative support with an affiliated counseling facility previously identified by the counseling facility as sharing administrative support with the counseling facility, the following information is submitted for each affiliated counseling facility within 30 calendar days after the counseling facility and affiliated counseling facility no longer share administrative support:

a. The affiliated counseling facility's name,

b. The license number assigned to the affiliated counseling facility by the Department, and

c. The date the counseling facility and affiliated counseling facility will no longer be sharing administrative support.

~~I.~~**H.** A governing authority shall submit a license application required in R9-10-105 for:

1. A change in ownership of a health care institution;
2. A change in the address or location of a health care institution that provides medical services, nursing services, health-related services, or behavioral health services ~~on the premises~~; or
3. A change in a health care institution's class or subclass.

~~J.~~**I.** A governing authority is not required to submit the documentation required in R9-10-105(A)(5) for a license application if:

1. The health care institution has not ceased operations for more than 30 calendar days,
2. A modification has not been made to the health care institution,
3. The services the health care institution is authorized by the Department to provide are not changed, and
4. The location of the health care institution's premises is not changed.

**J.** To request a duplicate license, a licensee shall submit a written request to the Department for the duplicate license in a format provided by the Department that includes:

1. The licensee's name and address,
2. The licensee's license number and expiration date,
3. The licensee's signature and date of signature, and
4. If applicable, the fee in R9-10-106.

**R9-10-110. Modification of a Health Care Institution**

**A.** No change

1. No change
2. No change
3. No change
4. No change
5. No change
   a. No change
   b. No change

**B.** A licensee of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01 shall submit an application ~~packet~~, according to R9-10-104(A), ~~for approval of architectural plans and specifications~~ for a modification of the health care institution described in subsections (A)(3) through (5).

**C.** A licensee of a health care institution shall submit ~~a written request~~ an application ~~packet~~ for a modification of the health care institution in a Department-provided format that contains:

1. The following information in a Department-provided format:
   a. The health care institution's name, mailing address, e-mail address, and license number;
   b. A narrative description of the modification, including as applicable:
      i. The services the licensee is requesting be added or removed as an authorized service;
      ii. The name and license number of an associated licensed provider being added or removed as a colocator;

iii. The name and professional license number of an exempt health care provider being added or removed as a colocator;

iv. If an associated licensed provider or exempt health care provider is being added as a colocator, the proposed scope of services;

v. The current and proposed licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations;

vi. The change being made in the physical plant; and

vii. The change being made that affects compliance with applicable physical plant codes and standards incorporated by reference in R9-10-104.01; and

c. The name and e-mail address of the health care institution's administrator's or individual representing the health care institution as designated in according to A.R.S. § 36-422 and the dated signature of the administrator or individual; and

2. Documentation that demonstrates that the requested modification complies with applicable requirements in this Chapter, including as applicable:

a. A floor plan showing the location of each colocator's proposed treatment area and the areas of the collaborating outpatient treatment center's premises shared with a colocator;

b. For a change in the licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations or a modification of the physical plant:

i. A floor plan showing, for each story of the facility affected by the modification, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device; or

ii. For a health care institution or part of the health care institution that is required to comply with the physical plant codes and standards incorporated by reference in R9-10-104.01 or the building, documentation of the Department's approval of the health care institution's architectural plans and specifications in R9-10-104(D); and

c. Any other documentation to support the requested modification; and

3. If applicable, a copy of the written agreement the associated licensed provider or exempt health care provider has with the collaborating outpatient treatment center.

**D.** No change

**E.** No change

**F.** A licensee shall submit the applicable fee according to R9-10-106.

**R9-10-112. Denial, Revocation, or Suspension of License**

**A.** The Department may deny, revoke, or suspend a license to operate a health care institution if an applicant, a licensee, or a controlling person of the health care institution:

1. Provides false or misleading information to the Department;

2. Has had in any state or jurisdiction any of the following:

a. An application or license to operate a health care institution denied, suspended, or revoked, unless the denial was based on failure to complete the licensing process or to pay a required licensing fee within a required time-frame; or

b. A health care professional license or certificate denied, revoked, or suspended;

3. Does not comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; ~~or~~

4. Has operated a health care institution, within the preceding ten years, in violation of A.R.S. Title 36, Chapter 4 or this Chapter, that posed a direct risk to the life, health, or safety of a patient~~.~~; or

5. Has operated a health care institution without seeing a patient within twelve consecutive months.

**B.** No change

**R9-10-113. Tuberculosis Screening**

**A.** If a health care institution is subject to the requirements of this Section, as specified in an Article in this Chapter, the health care institution's chief administrative officer shall ensure that the health care institution establishes, documents, and implements tuberculosis infection control activities that:

1. Are consistent with recommendations in Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, published by the U.S. Department of Health and Human Services, Atlanta, GA 30333, available at https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm, incorporated by reference, on file with the Department, and including no future editions or amendments; and
2. Include:
   a. For each individual who is employed by the health care institution, provides volunteer services for the health care institution, or is admitted to the health care institution and who is subject to the requirements of this Section, baseline screening, on or before the date specified in the applicable Article of this Chapter, that consists of:
      i. Assessing risks of prior exposure to infectious tuberculosis,
      ii. Determining if the individual has signs or symptoms of tuberculosis, and
      iii. Obtaining documentation of the individual's freedom from infectious tuberculosis according to subsection (B)(1);
   b. If an individual may have a latent tuberculosis infection, as defined in A.A.C. R9-6-1201:
      i. Referring the individual for assessment or treatment; and
      ii. Annually obtaining documentation of the individual's freedom from symptoms of infectious tuberculosis, signed by a medical practitioner, ~~occupation~~ occupational health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101;
   c. Annually providing training and education related to recognizing the signs and symptoms of tuberculosis to individuals employed by or providing volunteer services for the health care institution;
   d. Annually assessing the health care institution's risk of exposure to infectious tuberculosis;
   e. Reporting, as specified in A.A.C. R9-6-202, an individual who is suspected of exposure to infectious tuberculosis; and
   f. If an exposure to infectious tuberculosis occurs in the health care institution, coordinating and sharing information with the local health agency, as defined in A.A.C. R9-6-101, for identifying, locating, and investigating contacts, as defined in A.A.C. R9-6-101.

**B.** A health care institution's chief administrative officer shall:

1. For an individual for whom baseline screening and documentation of freedom from infectious tuberculosis is required by an Article in this Chapter, as specified in subsection (A)(2)(a), obtain one of the following as evidence of freedom from infectious tuberculosis:
   a. Documentation of a negative Mantoux skin test or other tuberculosis screening test that:
      i. Is recommended by the U.S. Centers for Disease Control and Prevention (CDC),
      ii. Was administered within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution, and
      iii. Includes the date and the type of tuberculosis screening test;

b. If the individual had a history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, compliance with subsection (A)(2)(b); or

c. If the individual had a positive Mantoux skin test or other tuberculosis screening test according to subsection (B)(1)(a) and does not have history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, a written statement:

i. That the individual is free from infectious tuberculosis, signed by a medical practitioner or local health agency, as defined in A.A.C. R9-6-101; and

ii. Dated within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution; and

2. As part of the annual assessment of the health care institution's risk of exposure to infectious tuberculosis according to subsection (A)(2)(d), ensure that documentation is obtained for each individual required to be screened for infectious tuberculosis that:

a. Indicates the individual's freedom from symptoms of infectious tuberculosis; and

b. Is signed by a medical practitioner, ~~occupation~~ occupational health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101.

**R9-10-118. Collaborating Health Care Institution**

**A.** No change

1. No change
2. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
         (1) No change
         (2) No change
      vi. No change
      vii. No change
   c. No change
      i. No change
      ii. No change
      iii. No change
   d. No change
   e. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
3. No change
4. No change
5. No change

a. No change

b. No change

i. No change

ii. No change

iii. No change

c. No change

**B.** For a patient referred to an adult behavioral health therapeutic home or a behavioral health respite home, an administrator shall ensure that:

1. A resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home does not present a threat to the referred patient, based on the resident's or recipient's developmental levels, social skills, verbal skills, and personal history;
2. The referred patient does not present a threat to a resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home based on the referred patient's developmental levels, social skills, verbal skills, and personal history;
3. The referred patient requires services within the adult behavioral health therapeutic home's or behavioral health respite home's scope of services;
4. A provider of the adult behavioral health therapeutic home or behavioral health respite home has the verified skills and knowledge to provide behavioral health services to the referred patient;
5. A treatment plan for the referred patient, which includes information necessary for a provider to meet the referred patient's needs for behavioral health services, is completed and forwarded to the provider before the referred patient is accepted as a resident or recipient;
6. A patient's treatment plan is reviewed and updated at least once every 12 months, and a copy of the patient's updated treatment plan is forwarded to the patient's provider;
7. If documentation of a significant change in a patient's behavioral, physical, cognitive, or functional condition and the action taken by a provider to address patient's changing needs is received by the collaborating health care institution, a behavioral health professional or behavioral health technician reviews the documentation and:
    a. Documents the review; and
    b. If applicable:
        i. Updates the patient's treatment plan, and
        ii. Forwards the updated treatment plan to the provider within 10 working days after receipt of the documentation of a significant change;
8. If the review and updated treatment plan required in subsection (B)(7) is performed by a behavioral health technician, a behavioral health professional reviews and signs the review and updated treatment plan to ensure the patient is receiving the appropriate behavioral health services; and
9. In addition to the requirements for a medical record for a patient in this Chapter, a referred patient's medical record contains:
    a. The provider's name and the street address and license number of the adult behavioral health therapeutic home or behavioral health respite home to which the patient is referred,
    b. A copy of the treatment plan provided to the adult behavioral health therapeutic home or behavioral health respite home,
    c. Documentation received according to and required by subsection (B)(7),
    d. Any information about the patient received from the adult behavioral health therapeutic home or behavioral health respite home, and

e. Any follow-up actions taken by the collaborating health care institution related to the patient.

**C.** No change

**R9-10-120. Opioid Prescribing and Treatment**

**A.** No change

**B.** No change

1. No change
2. No change

**C.** No change

1. No change
   a. No change
   b. No change
      i. No change
      ii. No change
   c. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
      vii. No change
   d. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   e. No change
   f. No change
   g. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   h. No change
   i. No change
   j. No change
2. No change
   a. No change
   b. No change
3. No change
4. No change
   a. No change
      i. No change

ii. No change

iii. No change

b. No change

c. No change

d. No change

e. No change

f. No change

g. No change

**D.** Except as provided in subsection (H), an administrator of a health care institution where opioids are prescribed as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to prescribe an opioid in treating a patient:

1. Before prescribing an opioid for a patient of the health care institution:

   a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted during the patient's same episode of care;

   b. Except as exempted by ~~A.R.S. § 36-2606(G)~~ A.R.S. § 36-2606(H), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;

   c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted during the same episode of care by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;

   d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;

   e. Explains alternatives to a prescribed opioid; and

   f. Obtains informed consent from the patient or the patient's representative that meets the requirements in subsection (C)(4), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:

      i. Is also prescribed or ordered a sedative-hypnotic medication, or

      ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;

2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:

   a. The patient's diagnosis;

   b. The patient's medical history, including ~~co-occurring disorders~~ co-morbidities;

   c. The opioid to be prescribed;

   d. Other medications or herbal supplements being taken by the patient;

   e. If applicable:

      i. The effectiveness of the patient's current treatment,

      ii. The duration of the current treatment, and

      iii. Alternative treatments tried by or planned for the patient;

   f. The expected benefit of the treatment and, if applicable, the benefit of the new treatment compared with continuing the current treatment; and

g. Other factors relevant to the patient's being prescribed an opioid; and

3. If applicable, specifies in the patient's discharge plan how medically indicated pain control will occur after discharge to meet the patient's needs.

**E.** Except as provided in subsection (G) or (H), an administrator of a health care institution where opioids are ordered for administration to a patient in the health care institution as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to order an opioid in treating a patient:

1. Before ordering an opioid for a patient of the health care institution:
   a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted:
      i. During the patient's same episode of care; or
      ii. Within the previous 30 calendar days, at a health care institution transferring the patient to the health care institution or by the medical practitioner who referred the patient for admission to the health care institution;
   b. Except as exempted by ~~A.R.S. § 36-2606(G)~~ A.R.S. § 36-2606(H), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
   c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted within the previous 30 calendar days by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
   d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
   e. If applicable, explains alternatives to an ordered opioid; and
   f. Obtains informed consent from the patient or the patient's representative, according to subsection (D)(1)(f); and
2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
   a. The patient's diagnosis;
   b. The patient's medical history, including ~~co-occurring disorders~~ co-morbidities;
   c. The opioid being ordered and the reason for the order;
   d. Other medications or herbal supplements being taken by the patient; and
   e. If applicable:
      i. The effectiveness of the patient's current treatment,
      ii. The duration of the current treatment,
      iii. Alternative treatments tried by or planned for the patient,
      iv. The expected benefit of a new treatment compared with continuing the current treatment, and
      v. Other factors relevant to the patient's being ordered an opioid.

**F.** No change

1. No change
   a. No change
   b. No change

c. No change

d. No change

e. No change

2. No change

a. No change

b. No change

3. No change

4. No change

a. No change

b. No change

c. No change

i. No change

ii. No change

**G.** No change

1. No change

a. No change

b. No change

c. No change

2. No change

a. No change

b. No change

3. No change

**H.** No change

1. No change

2. No change

a. No change

b. No change

3. No change

4. No change

a. No change

b. No change

**R9-10-121. Disease Prevention and Control**

**A.** No change

1. No change

2. No change

**B.** No change

1. No change

2. No change

3. No change

**C.** No change

1. No change

2. No change

3. No change

4. No change

**D.** No change

1. No change
2. No change
3. No change
4. No change
5. No change

**E.** No change

**F.** No change

1. No change
2. No change
   a. No change
   b. No change
      i. No change
      ii. No change
   c. No change
      i. No change
      ii. No change
   d. No change
      i. No change
      ii. No change
   e. No change

**G.** An administrator or manager, as applicable, shall ensure that door handles, tables, chair backs and arm rests, light switches, and other frequently touched surfaces are cleaned and disinfected, according to policies and procedures, with:

1. An alcohol solution containing at least 70% alcohol;
2. A bleach solution containing four teaspoons of bleach per quart of water; or
3. An EPA-approved household disinfectant ~~specified in a list, which is incorporated by reference, available at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19, and does not include any later amendments or editions of the incorporated matter~~.

## ARTICLE 2. HOSPITALS

**R9-10-201. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article unless otherwise specified:

1. "Adult" No change
2. "Aftercare" No change
   a. No change
   b. No change
3. "Aftercare provider" No change
   a. No change
   b. No change
   c. No change
4. "Care plan" No change
5. "Continuing care nursery" No change.
6. "Critically ill inpatient" No change

a. No change

b. No change

c. No change

7. “Device” No change

8. “Diet” No change

9. “Diet manual” No change

10. “Dietary services” No change

11. “Diversion” No change

12. “Drug formulary” No change

13. “Gynecological services” No change

14. “Hospital services” No change

15. “Infection control risk assessment” No change

16. “Inpatient” No change

a. No change

b. No change

c. No change

17. “Intensive care services” No change

18. “Medical staff regulations” No change

19. “Multi-organized service unit” No change

20. “Neonate” No change

a. No change

b. No change

21. “Nurse anesthetist” ~~means a registered nurse who meets the requirements of A.R.S. § 32-1601 and who has clinical privileges to administer anesthesia~~ has the same meaning as “certified registered nurse anesthetist” in A.R.S. § 32-1601.

22. “Nurse executive” No change

23. “Nursery” No change

~~24. “Nurse supervisor” means a registered nurse accountable for managing nursing services provided in an organized service in a hospital.~~

~~25.~~24. “Nutrition assessment” means a process for determining a patient’s dietary needs using information contained in the patient’s medical record.

~~26.~~25. “On duty” means that an individual is at work and performing assigned responsibilities.

~~27.~~26. “Organized service” means specific medical services, such as surgical services or emergency services, provided in an area of a hospital designated for the provision of those medical services.

~~28.~~27. “Outpatient” means an individual who:

a. Is admitted to a hospital with the expectation that the individual will receive hospital services for less than 24 consecutive hours; or

b. Except as provided in subsection (17) receives, hospital services for less than 24 consecutive hours.

~~29.~~28. “Pathology” means an examination of human tissue for the purpose of diagnosis or treatment of an illness or disease.

~~30.~~29. “Patient care” means hospital services provided to a patient by a personnel member or a medical staff member.

~~31.~~30. “Pediatric” means pertaining to an individual designated by a hospital as a child based on the hospital’s criteria.

~~32.~~31. “Perinatal services” means medical services for the treatment and management of obstetrical patients and neonates.

~~33.~~32. "Post-anesthesia care unit" means a designated area for monitoring a patient following a medical procedure for which anesthesia was administered to the patient.

~~34.~~33. "Private duty staff" means an individual, excluding a personnel member, compensated by a patient or the patient's representative.

~~35. "Psychiatric services" means the diagnosis, treatment, and management of a mental disorder.~~

~~36.~~34. "Social services" means assistance, other than medical services or nursing services, provided by a personnel member to a patient to assist the patient to cope with concerns about the patient's illness or injury while in the hospital or the anticipated needs of the patient after discharge.

~~37. "Specialty" means a specific branch of medicine practiced by a licensed individual who has obtained education or qualifications in the specific branch in addition to the education or qualifications required for the individual's license.~~

~~38.~~35. "Surgical services" means medical services involving a surgical procedure.

~~39.~~36. "Transfusion" means the introduction of blood or blood products from one individual into the body of another individual.

~~40.~~37. "Unit" means a designated area of an organized service.

~~41. "Vital record" has the same meaning as in A.R.S. § 36-301.~~

~~42.~~38. "Well-baby bassinet" means a receptacle used for holding a neonate who does not require treatment and whose anticipated discharge is within 96 hours after birth.

**R9-10-202. Supplemental Application, Notification, and Documentation Submission Requirements**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and Article 1 of this Chapter, an applicant for a hospital license shall include:

1. On the application the requested licensed capacity for the hospital, including:
   a. The number of inpatient beds for each organized service, not including well-baby bassinets; and
   b. If applicable, the number of inpatient beds for each multi-organized service unit;
2. On the application, if applicable, the requested licensed occupancy for providing behavioral health observation/stabilization services to:
   a. Individuals who are under 18 years of age, and
   b. Individuals 18 years of age and older; and
3. A list, in a Department-provided format, of medical staff specialties and subspecialties~~.~~, as in a specific branch of medicine practiced by a licensed individual who has obtained education or qualifications in the specific branch in addition to the education or qualifications required for the individual's license.

**B.** No change

1. No change
2. No change
3. No change
4. No change
5. No change

**C.** No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change

**D.** No change

1. No change
2. No change

**E.** No change

1. No change
    a. No change
    b. No change
        i. No change
        ii. No change
    c. No change
2. No change

**R9-10-203. Administration**

**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a hospital;
2. Establish, in writing:
    a. A hospital's scope of services,
    b. Qualifications for an administrator,
    c. Which organized services are to be provided in the hospital, and
    d. The organized services that are to be provided in a multi-organized service unit according to R9-10-228(A);
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Grant, deny, suspend, or revoke a clinical privilege of a medical staff member or delegate authority to an individual to grant or suspend a clinical privilege for a limited time, according to medical staff bylaws;
5. Adopt a quality management program according to R9-10-204;
6. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
7. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
    a. Expected not to be present on a hospital's premises for more than 30 calendar days, or
    b. Not present on a hospital's premises for more than 30 calendar days;
8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) if there is a change of administrator and identify the name and qualifications of the new administrator; and
9. For a health care institution under a single group license, except for outpatient treatment centers, that are exempt pursuant to A.R.S. § 36-402, ensure that the health care institution complies with the applicable requirements in this Chapter for the class or subclass of the health care institution.

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
    a. Cover job descriptions, duties, and qualifications, including required skills and knowledge for personnel members, employees, volunteers, and students;

b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;

c. Include how a personnel member may submit a complaint relating to patient care;

d. Cover the prevention and reporting of abuse, neglect, and exploitation of minors and vulnerable adults in compliance with A.R.S. §§ 13-3620 and 46-454 including:

i. Annual training for personnel members who have patient interaction, prescribed in the hospital's policies and procedures on how to recognize the signs and symptoms of minor or vulnerable adult abuse, neglect, and exploitation;

ii. Reporting suspected abuse, neglect or exploitation of a minor or vulnerable adult;

iii. Submitting to the Department reports of suspected abuse, neglect or exploitation that are filed with law enforcement or the Department of Economic Security; and

iv. Maintaining documentation relating to an abuse, neglect, or exploitation investigation for at least 12 months after an initial allegation, including any steps taken to stop or deter substantiated abuse, neglect, or exploitation;

~~d.~~e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;

~~e.~~f. Cover cardiopulmonary resuscitation training required in R9-10-206(5) including:

i. The method and content of cardiopulmonary resuscitation training,

ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,

iii. The time-frame for renewal of cardiopulmonary resuscitation training, and

iv. The documentation that verifies an individual has received cardiopulmonary resuscitation training;

~~f.~~g. Cover use of private duty staff, if applicable;

~~g.~~h. Cover diversion, including:

i. The criteria for initiating diversion;

ii. The categories or levels of personnel or medical staff that may authorize or terminate diversion;

iii. The method for notifying emergency medical services providers of initiation of diversion, the type of diversion, and termination of diversion; and

iv. When the need for diversion will be reevaluated;

~~h.~~i. Include a method to identify a patient to ensure the patient receives hospital services as ordered;

~~i.~~j. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;

~~j.~~k. Cover health care directives;

~~k.~~l. Cover medical records, including electronic medical records;

~~l.~~m. Cover quality management, including incident reports and supporting documentation;

~~m.~~n. Cover contracted services;

~~n.~~o. Cover tissue and organ procurement and transplant; ~~and~~

~~o.~~p. Cover when an individual may visit a patient in a hospital, including visiting a neonate in a nursery, if applicable, that comply with A.R.S. § 36-407.03; and

q. Cover a workplace violence prevention plan according to A.R.S. § 36-420.03;

2. Policies and procedures for hospital services are established, documented, and implemented to protect the health and safety of a patient that:

a. Cover patient screening, admission, transport, and transfer;

b. Cover discharge planning and discharge, including the requirements in R9-10-225(B) for an inpatient who was admitted after a suicide attempt or who exhibits suicidal ideation;

c. Cover the provision of hospital services;

d. Cover acuity, including a process for obtaining sufficient nursing personnel to meet the needs of patients;

e. Include when general consent and informed consent are required;

f. Include the age criteria for providing hospital services to pediatric patients;

g. Cover dispensing, administering, and disposing of medication;

h. Cover prescribing a controlled substance to minimize substance abuse by a patient;

i. Cover infection control;

j. Cover restraints that:

i. Require an order, including the frequency of monitoring and assessing the restraint; or

ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a patient's sudden, intense, or out-of-control behavior;

k. Cover seclusion of a patient including:

i. The requirements for an order, and

ii. The frequency of monitoring and assessing a patient in seclusion;

l. Cover communicating with a midwife when the midwife's client begins labor and ends labor;

m. Cover ~~telemedicine~~ telehealth, if applicable; and

n. Cover environmental services that affect patient care;

3. Policies and procedures are reviewed at least once every three years and updated as needed;

4. Policies and procedures are available to personnel members;

5. The licensed capacity in an organized service is not exceeded, except for an emergency admission of a patient;

6. A patient is only admitted to an organized service that has exceeded the organized service's licensed capacity after a medical staff member reviews the medical history of the patient and determines that the patient's admission is an emergency; and

7. Unless otherwise stated:

a. Documentation required by this Article is provided to the Department within two hours after a Department request; and

b. When documentation or information is required by this Chapter to be submitted on behalf of a hospital, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the hospital.

**D.** No change

1. No change

2. No change

**E.** An administrator shall provide written notification to the Department of a patient's:

1. Death associated with the use of restraints or seclusion by the hospital, within one working day after the patient's death;

2. Death caused by suicide occurring within the hospital, within one working day after the patient's death; and

3. Self-injury, within two working days after the patient inflicts a self-injury on the premises that requires medical treatment by a physician.

**R9-10-209. Discharge Planning; Discharge**

**A.** No problem

1. No problem

2. No problem

3. No problem

4. No problem

a. No problem

b. No problem

i. No problem

ii. No problem

5. No problem

6. No problem

**B.** For an inpatient discharge or a transfer of an inpatient, an administrator shall ensure that:

1. There is a discharge summary that includes:

a. A description of the patient's medical condition and the medical services provided to the patient, and

b. The signature of the medical practitioner coordinating the patient's medical services;

2. There is a documented discharge order for the patient by a medical practitioner coordinating the patient's medical services before discharge unless the patient leaves the hospital against a medical staff member's advice;

3. If the patient is not being transferred:

a. There are documented discharge instructions; and

b. The patient or patient's representative and the patient's aftercare provider, if designated, is provided with a copy of the discharge instructions; and

4. If the patient is being transferred, the transfer complies with R9-10-211

5. If applicable, the discharge or transfer information required in A.R.S. § 36-420.04.

**C.** No problem

**D.** No problem

**E.** No problem

1. No problem

2. No problem

**R9-10-212. Patient Rights**

**A.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

**B.** No change

1. No change

2. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

g. No change

h. No change

i. No change

j. No change

k. No change

3. No change

a. No change

b. No change

c. No change

i. No change

ii. No change

iii. No change

iv. No change

d. No change

i. No change

ii. No change

(1) No change

(2) No change

e. No change

f. No change

i. No change

ii. No change

**C.** A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To have access to a telephone;
5. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
6. To receive a referral to another health care institution if the hospital is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
7. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
8. To participate or refuse to participate in research or experimental treatment; ~~and~~
9. To participate in visitation, in compliance with A.R.S. § 36-407.03; and

~~9.~~10. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

**R9-10-215. Surgical Services**

An administrator of a general hospital shall ensure that:

1. There is an organized service that provides surgical services under the direction of a medical staff member;
2. There is a designated area for providing surgical services as an organized service;
3. The area of the hospital designated for surgical services is managed by a registered nurse or a physician;

4. Documentation is available in the surgical services area that specifies each medical staff member's clinical privileges to perform surgical procedures in the surgical services area;
5. Postoperative orders are documented in the patient's medical record;
6. There is a chronological log of surgical procedures performed in the surgical services area that contains:
    a. The date of the surgical procedure,
    b. The patient's name,
    c. The type of surgical procedure,
    d. The time in and time out of the operating room,
    e. The name and title of each individual performing or assisting in the surgical procedure,
    f. The type of anesthesia used,
    g. An identification of the operating room used, and
    h. The disposition of the patient after the surgical procedure;
7. The chronological log required in subsection (6) is maintained in the surgical services area for at least 12 months after the date of the surgical procedure and then maintained by the hospital for an additional 12 months;
8. The medical staff designate in writing the surgical procedures that may be performed in areas other than the surgical services area;
9. The hospital has the medical staff members, personnel members, and equipment to provide the surgical procedures offered in the surgical services area;
10. A patient and the surgical procedure to be performed on the patient are identified before initiating the surgical procedure;
11. Except in an emergency, a medical staff member or a surgeon performs a medical history and physical examination within 30 calendar days before performing a surgical procedure on a patient;
12. Except as provided in subsection (14), a medical staff member or a surgeon enters an interval note in the patient's medical record before performing a surgical procedure;
13. Except as provided in subsection (14), the following are documented in a patient's medical record before a surgical procedure:
    a. A preoperative diagnosis;
    b. Each diagnostic test performed in the hospital;
    c. A medical history and physical examination as required in subsection (11) and an interval note as required in subsection (12);
    d. A consent or refusal for blood or blood products signed by the patient or the patient's representative, if applicable; and
    e. Informed consent according to policies and procedures; ~~and~~
14. In an emergency, the documentation required in subsections (12) and (13) is completed within 24 hours after a surgical procedure on a patient is completed~~.~~;
15. A physician discharges a patient from the designated area in subsection (2); and
16. A smoke evacuation system is used in each designated area to prevent exposure to surgical smoke as described in A.R.S. § 36-434.01.

**R9-10-218. Pharmaceutical Services**

An administrator shall ensure that:

1. Pharmaceutical services are provided under the direction of a pharmacist according to A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23;
2. A copy of the pharmacy license is provided to the Department for review upon the Department's request;

3. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
   a. Develop a drug formulary,
   b. Update the drug formulary at least once every 12 months,
   c. Develop medication usage and medication substitution policies and procedures, and
   d. Specify which medications and medication classifications are required to be automatically stopped after a specified time period unless the ordering medical staff member specifically orders otherwise;
4. An expired, mislabeled, or unusable medication is disposed of according to policies and procedures;
5. A medication administration error or an adverse reaction is reported to the ordering medical staff member or the medical staff member's designee;
6. A pharmacy medication dispensing error is reported to the pharmacist;
7. In a pharmacist's absence, personnel members designated by policies and procedures have access to a locked area containing a medication;
8. A medication is maintained at temperatures recommended by the manufacturer;
9. A cart used for an emergency:
   a. Contains medication, supplies, and equipment as specified in policies and procedures;
   b. Is available to a unit; and
   c. Is sealed until opened in an emergency;
10. Emergency cart contents and sealing of the emergency cart are verified and documented according to policies and procedures;
11. Policies and procedures specify individuals who may:
   a. Order medication, and
   b. Administer medication;
12. A medication is administered in compliance with an order;
13. A medication administered to a patient is documented as required in R9-10-213;
14. If pain medication is administered to a patient, documentation in the patient's medical record includes:
   a. An assessment of the patient's pain before administering the medication, and
   b. The effect of the pain medication administered; and
15. Policies and procedures specify a process for review through the quality management program of:
   a. A medication administration error,
   b. An adverse reaction to a medication, and
   c. A pharmacy medication dispensing error.
16. If applicable, policies and procedures are established for donated medicine according to A.R.S. § 32-1909.

**R9-10-234. Physical Plant Standards**

**A.** An administrator shall ensure that:

1. ~~A hospital complies with the applicable physical plant health and safety codes and standards incorporated by reference in~~ A hospital complies with the applicable physical plant health and safety codes and standards incorporated by reference in R9-10-104.01 in effect on the date the hospital submitted the application packet including the notarized attestation of architectural plans~~,~~ according to R9-10-104~~, an application for an approval of architectural plans and specifications to the Department~~;
2. A hospital's premises or any part of the hospital premises is not leased to or used by another person;
3. A unit with inpatient beds is not used as a passageway to another health care institution; and
4. A hospital's premises are not licensed as more than one health care institution.

**B.** No change

1. No change
2. No change
3. No change

## ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES

**R9-10-303. Administration**

**A.** No change

1. No change
2. No change
   a. No change
   b. No change
3. No change
4. No change
5. No change
6. No change
   a. No change
   b. No change
7. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a patient;
   d. Include methods to prevent abuse or neglect of a patient, including:
      i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
      ii. Reporting of abuse or neglect of a patient;
   ~~d.~~e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   ~~e.~~f. Cover cardiopulmonary resuscitation training including:
      i. The method and content of cardiopulmonary resuscitation training,
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
      iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
      iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
   ~~f.~~g. Cover first aid training;
   ~~g.~~h. Cover the requirements in subsection (J), if applicable;
   ~~h.~~i. Include a method to identify a patient to ensure the patient receives physical health and behavioral health services as ordered;
   ~~i.~~j. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;

~~j.~~k. Cover specific steps for:

i. A patient to file a complaint, and

ii. The behavioral health inpatient facility to respond to a patient's complaint;

~~k.~~l. Cover health care directives;

~~l.~~m. Cover medical records, including electronic medical records;

~~m.~~n. Cover quality management, including incident reports and supporting documentation;

~~n.~~o. Cover contracted services; and

~~o.~~p. Cover when an individual may visit a patient in the behavioral health inpatient facility;

2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a patient that:

a. Cover patient screening, admission, assessment, treatment plan, transport, and transfer;

b. Cover discharge planning and discharge, including the requirements in R9-10-309(B) for a patient who was admitted after a suicide attempt or who exhibits suicidal ideation;

c. Cover the provision of behavioral health services and physical health services;

d. Include when general consent and informed consent are required;

e. Cover restraint and, if applicable, seclusion;

f. Cover dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;

g. Cover prescribing a controlled substance to minimize substance abuse by a patient;

h. Cover infection control;

i. Cover ~~telemedicine~~ telehealth, if applicable;

j. Cover environmental services that affect patient care;

k. Cover patient outings;

l. Cover whether pets and animals are allowed on the premises, including procedures to ensure that any pets or animals allowed on the premises do not endanger the health or safety of patients or the public;

m. If the behavioral health inpatient facility is involved in research, cover the establishment or use of a Human Subject Review Committee;

n. Cover the process for receiving a fee from a patient and refunding a fee to a patient;

o. Cover the process for obtaining patient preferences for social, recreational, or rehabilitative activities and meals and snacks;

p. Cover the security of a patient's possessions that are allowed on the premises; and

q. Cover smoking and the use of tobacco products on the premises;

3. Policies and procedures are reviewed at least once every three years and updated as needed;

4. Policies and procedures are available to personnel members, employees, volunteers, and students; and

5. Unless otherwise stated:

a. Documentation required by this Article is provided to the Department within two hours after a Department request; and

b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health inpatient facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health inpatient facility.

**D.** No change

1. No change

a. No change

b. No change

c. No change

2. No change

a. No change

b. No change

c. No change

3. No change

**E.** No change

1. No change

2. No change

**F.** No change

**G.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

4. No change

5. No change

a. No change

b. No change

c. No change

d. No change

6. No change

**H.** No change

1. No change

2. No change

3. No change

**I.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

4. No change

**J.** No change

1. No change

2. No change

a. No change

b. No change

c. No change

d. No change

3. No change

a. No change

b. No change

c. No change

d. No change

e. No change

4. No change

5. No change

**R9-10-307. Admission; Assessment**

**A.** Except as provided in R9-10-315(E) or (F), an administrator shall ensure that:

1. A patient is admitted based upon the patient's presenting behavioral health issue and treatment needs and the behavioral health inpatient facility's ability and authority to provide physical health services, behavioral health services, and ancillary services consistent with the patient's treatment needs;
2. A patient is admitted on the order of a medical practitioner or clinical director;
3. A medical practitioner or clinical director, authorized by policies and procedures to accept a patient for admission, is available;
4. Except in an emergency or as provided in subsections (A)(6) and (7), general consent is obtained from a patient or, if applicable, the patient's representative before or at the time of admission;
5. The general consent obtained in subsection (A)(4) or the lack of consent in an emergency is documented in the patient's medical record;
6. General consent is not required from a patient receiving a court-ordered evaluation or court-ordered treatment;
7. General consent is not required from a patient receiving treatment according to A.R.S. § 36-512;
8. A medical practitioner performs a medical history and physical examination on a patient within 30 calendar days before admission or within 24 hours after admission and documents the medical history and physical examination in the patient's medical record within 24 hours after admission;
9. If a medical practitioner performs a medical history and physical examination on a patient before admission, the medical practitioner enters an interval note into the patient's medical record within seven calendar days after admission;
10. Except when a patient needs crisis services, a behavioral health assessment of a patient is completed to determine the acuity of the patient's behavioral health issue and to identify the behavioral health services needed by the patient before treatment for the patient is initiated and whenever the patient has a significant change in condition or experiences an event that affects treatment;
11. If the patient was admitted after a suicide attempt or exhibits suicidal ideation, the behavioral health assessment in subsection (A)(10) includes a suicide assessment;
12. If a behavioral health assessment in subsection (A)(10), including a suicide assessment in subsection (A)(11) if applicable, is conducted by a:
    a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed under A.R.S. Title 32 to provide the behavioral health services needed by the patient, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by and the acuity of the patient; or
    b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed under A.R.S. Title 32 to provide the behavioral health services needed by the patient, supervises the behavioral health

paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by and the acuity of the patient;

13. When a patient is admitted, a registered nurse:
    a. Conducts a nursing assessment of a patient's medical condition and history;
    b. Determines whether the:
        i. Patient requires immediate physical health services, and
        ii. Patient's behavioral health issue may be related to the patient's medical condition and history;
    c. Determines the acuity of the patient's medical condition;
    d. Documents the patient's nursing assessment and the determinations required in subsection (A)(13)(b) and (c) in the patient's medical record; and
    e. Signs the patient's medical record;
14. A behavioral health assessment:
    a. Documents the patient's:
        i. Presenting issue, including the acuity of the patient's presenting issue;
        ii. Substance abuse history;
        iii. ~~Co-occurring disorder~~ Co-morbidity;
        iv. Legal history, including:
            (1) Custody,
            (2) Guardianship, and
            (3) Pending litigation;
        v. Court-ordered evaluation;
        vi. Court-ordered treatment;
        vii. Criminal justice record;
        viii. Family history;
        ix. Behavioral health treatment history;
        x. Symptoms reported by the patient; and
        xi. Referrals needed by the patient, if any; and
    b. Includes:
        i. Recommendations for further assessment or examination of the patient's needs;
        ii. Recommendations for staffing levels or personnel member qualifications related to the patient's treatment to ensure patient health and safety;
        iii. For a patient who:
            (1) Is admitted to receive crisis services, the behavioral health services and physical health services that will be provided to the patient; or
            (2) Does not need crisis services, the behavioral health services or physical health services that will be provided to the patient until the patient's treatment plan is completed; and
        iv. The signature and date signed of the personnel member conducting the behavioral health assessment;
15. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
16. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;

17. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;

18. The request in subsection (A)(16) and the opportunity in subsection (A)(17) are documented in the patient's medical record;

19. For a patient who is admitted to receive crisis services, the patient's behavioral health assessment is documented in the patient's medical record within eight hours after admission;

20. Except as provided in subsection (A)(19), a patient's behavioral health assessment is documented in the patient's medical record within 24 hours after completing the assessment; and

21. If the information listed in subsection (A)(14) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained.

**B.** No change

**R9-10-320. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:

1. Include:
   a. A process for providing information to a patient about medication prescribed for the patient including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse ı to a medication, or
      iii. A medication overdose;
   c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs;
   d. Procedures for documenting medication ı and assistance in the self-administration of medication;
   e. Procedures for assisting a patient in obtaining medication; and
   f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
   g. If applicable, donated medicine according to A.R.S. § 32-1909.
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication

**B.** No change

1. No change
   a. No change
   b. No change
      i. No change
      ii. No change
   c. No change
   d. No change
2. No change

3. No change
    a. No change
    b. No change

**C.** No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
        i. No change
        ii. No change
        iii. No change
    e. No change
3. No change
4. No change
    a. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
5. No change
6. No change
    a. No change
    b. No change

**D.** No change

1. No change
2. No change
3. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
    b. No change
    c. No change
    d. No change

**E.** No change

1. No change
2. No change
3. No change
    a. No change
    b. No change

c. No change

d. No change

**F.** No change

**R9-10-321. Food Services**

**A.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
4. No change
5. No change

**B.** A registered dietitian or director of food services shall ensure that:

1. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the behavioral health inpatient facility are served according to posted menus;
3. Meals and snacks for each day are planned using:
   a. The applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2015~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture, and
   b. Preferences for meals and snacks obtained from patients;
4. A patient is provided:
   a. A diet that meets the patient's nutritional needs as specified in the patient's assessment or treatment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(4)(d);
   c. The option to have a daily evening snack identified in subsection (B)(4)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. A patient group agrees; and
      ii. The patient is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
5. A patient requiring assistance to eat is provided with assistance that recognizes the patient's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
6. Water is available and accessible to patients.

**C.** No change

1. No change
2. No change
3. No change
   a. No change

b. No change

4. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
5. No change
6. No change
7. No change

## ARTICLE 4. NURSING CARE INSTITUTIONS

**R9-10-402. Supplemental Application Requirements**

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a nursing care institution shall include:

1. In a Department-provided format whether the applicant:
    a. Has:
        i. A secured area for a resident with Alzheimer's disease or other dementia, or
        ii. An area for a resident on a ventilator;
    b. Is requesting authorization to provide to a resident:
        i. Behavioral health services,
        ii. Clinical laboratory services,
        iii. Dialysis services, or
        iv. Radiology services and diagnostic imaging services; and
    c. Is requesting authorization to operate a nutrition and feeding assistant training program; and
2. If the governing authority is requesting authorization to operate a nutrition and feeding assistant training program, the information and documentation in R9-10-116(B)(1)(a), (B)(1)(c), and (B)(2).

**R9-10-403. Administration**

**A.** No change
1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
    a. No change
    b. No change
7. No change

**B.** An administrator:
1. No change
2. No change
3. No change
4. No change
5. No change

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
    a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
    b. Cover orientation and in-service education for personnel members, employees, volunteers, and students, including the training required in A.R.S. § 36-420.01;
    c. Include how a personnel member may submit a complaint relating to resident care;

d. Include methods to prevent abuse or neglect of a resident and reporting requirements in compliance with A.R.S. §§ 13-3620 and 46-454, including:

i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and

ii. Reporting of abuse or neglect of a resident;

~~d.~~e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;

~~e.~~f. Cover requirements related to cardiopulmonary resuscitation ~~training~~ including:

i. Which personnel members are required to obtain cardiopulmonary resuscitation training~~,~~;

ii. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;

iii. The qualifications for an individual to provide cardiopulmonary resuscitation training~~,~~;

iv. The time-frame for renewal of cardiopulmonary resuscitation training~~,~~; ~~and~~

v. The documentation that verifies an individual has received cardiopulmonary resuscitation training; and

vi. The circumstances for providing cardiopulmonary resuscitation to a resident, consistent with A.R.S. § 36-420(B);

~~f.~~g. Cover requirements related to first aid, including training and the circumstances for providing first aid to a resident, consistent with A.R.S. § 36-420(B);

~~g.~~h. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;

~~h.~~i. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;

~~i.~~j. Cover specific steps for:

i. A resident to file a complaint, and

ii. The nursing care institution to respond to a resident's complaint;

~~j.~~k. Cover health care directives;

~~k.~~l. Cover medical records, including electronic medical records;

~~l.~~m. Cover a quality management program, including incident reports and supporting documentation;

~~m.~~n. Cover contracted services;

~~n.~~o. Cover resident's personal accounts;

~~o.~~p. Cover petty cash funds;

~~p.~~q. Cover fees and refund policies;

~~q.~~r. Cover misappropriation of resident property; ~~and~~

~~r.~~s. Cover when an individual may visit a resident in a nursing care institution; and

t. Cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02; and

2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that:

a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;

b. Cover the provision of physical health services and behavioral health services;

c. Include when general consent and informed consent are required;

d. Cover storing, dispensing, administering, and disposing of medication;

e. Cover infection control;

f. Cover how personnel members will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;

g. Cover ~~telemedicine~~ telehealth, if applicable; and

h. Cover environmental services that affect resident care;

3. Policies and procedures are reviewed at least once every three years and updated as needed;

4. Policies and procedures are available to personnel members, employees, volunteers, and students; and

5. Unless otherwise stated:

a. Documentation required by this Article is provided to the Department within two hours after a Department request; and

b. When documentation or information is required by this Chapter to be submitted on behalf of a nursing care institution, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the nursing care institution.

**D.** No change

**E.** No change

1. No change

2. No change

**F.** No change

1. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

4. No change

5. No change

a. No change

b. No change

c. No change

d. No change

6. No change

**G.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

i. No change

ii. No change

iii. No change

c. No change

d. No change

e. No change

i. No change

ii. No change

**H.** No change

1. No change

2. No change

**I.** No change

1. No change

2. No change

3. No change

4. No change

5. No change

6. No change

7. No change

**J.** No change

1. No change

a. No change

b. No change

2. No change

**R9-10-406. Personnel**

**A.** No change

**B.** No change

1. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

iii. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

**C.** An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

~~**C.**~~**D.** Except as provided in R9-10-415, an administrator shall ensure that, if a personnel member provides social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, the personnel member is licensed under A.R.S. Title 32, Chapter 33, Article 5.

~~D.~~**E.** An administrator shall ensure that an individual who is a licensed baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision as defined in 4 A.A.C. 6, Article 1.

~~E.~~**F.** An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis:

1. On or before the date the individual begins providing services at or on behalf of the nursing care institution, and
2. As specified in R9-10-113.

~~F.~~**G.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's compliance with the requirements in A.R.S. § 36-411;
   d. Orientation and in-service education as required by policies and procedures;
   e. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;
   ~~e.~~f. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   ~~f.~~g. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   ~~g.~~h. Cardiopulmonary resuscitation training, if required for the individual according to ~~R9-10-303(C)(1)(e)~~ R9-10-403(C)(1)(f);
   ~~h.~~i. First aid training, if required for the individual according to this Article or policies and procedures; and
   ~~i.~~j. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection ~~(E)~~(F); and
   ~~j.~~k. If the individual is a nutrition and feeding assistant:
      i. Completion of the nutrition and feeding assistant training course required in R9-10-116, and
      ii. A nurse's observations required in ~~R9-10-423(C)(6)~~ R9-10-423(C)(6).

~~G.~~**H.** An administrator shall ensure that personnel records are:

1. Maintained:
   a. Throughout the individual's period of providing services in or for the nursing care institution, and
   b. For at least 24 months after the last date the individual provided services in or for the nursing care institution; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the nursing care institution during the previous 12 months, provided to the Department within 72 hours after the Department's request.

~~H.~~**I.** An administrator shall ensure that:

1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,

b. The date of the orientation, and

c. The subject or topics covered in the orientation;

4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;

5. A personnel member's in-service education is documented, to include:

a. The personnel member's name,

b. The date of the training, and

c. The subject or topics covered in the training~~.~~; and

~~5.~~6. A work schedule of each personnel member is developed and maintained at the nursing care institution for at least 12 months after the date of the work schedule.

~~I.~~**J.** An administrator shall designate a qualified individual to provide:

1. Social services, and

2. Recreational activities.

**R9-10-410. Resident Rights**

**A.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

**B.** No change

1. No change

a. No change

b. No change

c. No change

d. No change

2. No change

3. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

g. No change

h. No change

i. No change

j. No change

k. No change

4. No change

a. No change

b. No change

c. No change

d. No change

i. No change

ii. No change

e. No change

f. No change

g. No change

h. No change

i. No change

j. No change

k. No change

l. No change

i. No change

ii. No change

m. No change

n. No change

o. No change

p. No change

q. No change

r. No change

**C.** A resident has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;
3. To choose activities and schedules consistent with the resident's interests that do not interfere with other residents;
4. To participate in social, religious, political, and community activities that do not interfere with other residents;
5. To retain personal possessions including furnishings and clothing as space permits unless use of the personal possession infringes on the rights or health and safety of other residents;
6. To share a room with the resident's spouse if space is available and the spouse consents;
7. To receive a referral to another health care institution if the nursing care institution is not authorized or not able to provide physical health services or behavioral health services needed by the resident;
8. To participate or have the resident's representative participate in the development of, or decisions concerning, treatment;
9. To participate or refuse to participate in research or experimental treatment; ~~and~~
10. To participate in religious visitation by a clergy member according to A.R.S. § 36-407.02; and
~~10.~~11. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

**R9-10-411. Medical Records**

**A.** No change

1. No change
2. No change

a. No change

b. No change

c. No change

3. No change
   a. No change
   b. No change
   c. No change
4. No change
5. No change
   a. No change
   b. No change
   c. No change
6. No change

**B.** No change

1. No change
2. No change

**C.** An administrator shall ensure that a resident's medical record contains:

1 Resident information that includes:
   a. The resident's name;
   b. The resident's date of birth; and
   c. Any known allergies, including medication allergies;
2. The admission date and, if applicable, the date of discharge;
3. The admitting diagnosis or presenting symptoms;
4. Documentation of general consent and, if applicable, informed consent;
5. If applicable, the name and contact information of the resident's representative and:
   a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
   b. If the resident's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
6. The medical history and physical examination required in R9-10-407(6);
7. A copy of the resident's living will or other health care directive, if applicable;
8. The name and telephone number of the resident's attending physician;
9. Orders;
10. Care plans;
11. Behavioral care plans, if the resident is receiving behavioral care;
12. Documentation of nursing care institution services provided to the resident;
13. Progress notes;
14. If applicable, documentation of any actions taken to comply with A.R.S. § 36-420;
~~14.~~15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
~~15.~~16. If applicable, documentation that evacuation from the nursing care institution would cause harm to the resident;
~~16.~~17. The disposition of the resident after discharge;
~~17.~~18. The discharge plan;

~~18.~~19. The discharge summary;

~~19.~~20. Transfer documentation;

~~20.~~21. If applicable:

a. A laboratory report,

b. A radiologic report,

c. A diagnostic report, and

d. A consultation report;

~~21.~~22. Documentation of freedom from infectious tuberculosis required in R9-10-407(7);

~~22.~~23. Documentation of a medication administered to the resident that includes:

a. The date and time of administration;

b. The name, strength, dosage, and route of administration;

c. The type of vaccine, if applicable;

d. For a medication administered for pain on a PRN basis:

i. An evaluation of the resident's pain before administering the medication, and

ii. The effect of the medication administered;

e. For a psychotropic medication administered on a PRN basis:

i. An evaluation of the resident's symptoms before administering the psychotropic medication, and

ii. The effect of the psychotropic medication administered;

f. The identification, signature, and professional designation of the individual administering the medication; and

g. Any adverse reaction a resident has to the medication;

~~23.~~24. If the resident has been assessed for receiving nutrition and feeding assistance from a nutrition and feeding assistant, documentation of the assessment and the determination of eligibility; and

~~24.~~25. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

**R9-10-413. Medical Services**

**A.** No change

**B.** A medical director shall ensure that:

1. A resident has an attending physician;

2. An attending physician is available 24 hours a day;

3. An attending physician designates a physician who is available when the attending physician is not available;

4. A physical examination is performed on a resident at least once every 12 months after the date of admission by an individual listed in R9-10-407(6);

5. As required in A.R.S. § 36-406, vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:

a. The attending physician provides documentation that the vaccination is medically contraindicated;

b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical record that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or

c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the ~~last~~ previous five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention; and

6. If the any of the following services are not provided by the nursing care institution and needed by a resident, the resident is assisted in obtaining, at the resident's expense:
   a. Vision services;
   b. Hearing services;
   c. Dental services;
   d. Clinical laboratory services from a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
   e. Psychosocial services;
   f. Physical therapy;
   g. Speech therapy;
   h. Occupational therapy;
   i. Behavioral health services; and
   j. Services for an individual who has a developmental disability, as defined in A.R.S. Title 36, Chapter 5.1, Article 1.

**R9-10-414. Comprehensive Assessment; Care Plan**

**A.** A director of nursing shall ensure that:

1. A comprehensive assessment of a resident:
   a. Is conducted or coordinated by a registered nurse in collaboration with an interdisciplinary team;
   b. Is completed for the resident within 14 calendar days after the resident's admission to a nursing care institution;
   c. Is updated:
      i. No later than 12 months after the date of the resident's ~~last~~ previous comprehensive assessment, and
      ii. When the resident experiences a significant change;
   d. Includes the following information for the resident:
      i. Identifying information;
      ii. An evaluation of the resident's hearing, speech, and vision;
      iii. An evaluation of the resident's ability to understand and recall information;
      iv. An evaluation of the resident's mental status;
      v. Whether the resident's mental status or behaviors:
         (1) Put the resident at risk for physical illness or injury,
         (2) Significantly interfere with the resident's care,
         (3) Significantly interfere with the resident's ability to participate in activities or social interactions,
         (4) Put other residents or personnel members at significant risk for physical injury,
         (5) Significantly intrude on another resident's privacy, or
         (6) Significantly disrupt care for another resident;
      vi. Preferences for customary routine and activities;
      vii. An evaluation of the resident's ability to perform activities of daily living;
      viii. Need for a mobility device;
      ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
      x. Any diagnosis that impacts nursing care institution services that the resident may require;

xi. Any medical conditions that impact the resident's functional status, quality of life, or need for nursing care institution services;

xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;

xiii. An evaluation of the resident's oral and dental status;

xiv. An evaluation of the condition of the resident's skin;

xv. Identification of any medication or treatment administered to the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;

xvi. Identification of any treatment or medication ordered for the resident;

xvii. A description of the resident or resident's representative's participation in the comprehensive assessment;

xviii. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;

xix. Potential for rehabilitation; and

xx. Potential for discharge; and

e. Is signed and dated by:

i. The registered nurse who conducts or coordinates the comprehensive assessment or review; and

ii. If a behavioral health professional is required to review according to subsection (A)(2), the behavioral health professional who reviewed the comprehensive assessment or review;

2. If any of the conditions in (A)(1)(d)(v) are answered in the affirmative during the comprehensive assessment or review, a behavioral health professional reviews a resident's comprehensive assessment or review and care plan to ensure that the resident's needs for behavioral health services are being met;

3. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing care institution unless a physician, an individual designated by the physician, or a registered nurse determines the resident has a significant change in condition; and

4. A resident's comprehensive assessment is reviewed by a registered nurse at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition.

**B.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

**R9-10-421. Medication Services**

**A.** No change

1. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

i. No change

ii. No change

iii. No change

c. No change

d. No change

e. No change

2. No change

a. No change

b. No change

**B.** No change

1. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

d. No change

2. No change

3. No change

a. No change

b. No change

4. No change

a. No change

b. No change

**C.** No change

1. No change

2. No change

a. No change

b. No change

c. No change

**D.** When medication is stored at a nursing care institution, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.
   e. If applicable, donated medicine according to A.R.S. § 32-1909.

**E.** No change

**R9-10-423. Food Services**

**A.** No change

1. No change
2. No change
3. No change
    a. No change
    b. No change
4. No change
    a. No change
    b. No change
    c. No change
5. No change

**B.** A registered dietitian or director of food services shall ensure that:

1. Food is prepared:
    a. Using methods that conserve nutritional value, flavor, and appearance; and
    b. In a form to meet the needs of a resident such as cut, chopped, ground, pureed, or thickened;
2. A food menu:
    a. Is prepared at least one week in advance,
    b. Includes the foods to be served on each day,
    c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
    d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
    e. Is maintained for at least 60 calendar days after the last day included in the food menu;
3. Meals and snacks for each day are planned and served using the applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2010.asp~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
4. A resident is provided:
    a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and care plan;
    b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(4)(d);
    c. The option to have a daily evening snack identified in subsection (B)(4)(d)(ii) or other snack; and
    d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
        i. A resident group agrees; and
        ii. The resident is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
5. A resident is provided with food substitutions of similar nutritional value if the resident:
    a. ~~The resident refuses~~ Refuses to eat the food served, or
    b. ~~The resident requests~~ Requests a substitution;
6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning;
7. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils;
8. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair;
9. A resident eats meals in a dining area unless the resident chooses to eat in the resident's room or is confined to the resident's room for medical reasons documented in the resident's medical record; and

10. Water is available and accessible to residents.

**C.** No change

1. No change
    a. No change
    b. No change
    c. No change
    d. No change;
    e. No change
    f. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change
5. No change
6. No change
7. No change
8. No change
    a. No change
    b. No change

**R9-10-426. Physical Plant Standards**

**A.** An administrator shall ensure that:

1. A nursing care institution complies with:
    a. The applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the date the nursing care institution submitted the application including the notarized attestation of architectural plans ~~and specifications to the Department for approval~~ according to R9-10-104; and
    b. The requirements for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01;
2. The premises and equipment are sufficient to accommodate:
    a. The services stated in the nursing care institution's scope of services, and
    b. An individual accepted as a resident by the nursing care institution;
3. A nursing care institution is ventilated by windows or mechanical ventilation, or a combination of both;
4. The corridors are equipped with handrails on each side that are firmly attached to the walls and are not in need of repair;
5. No more than two individuals reside in a resident room unless:
    a. The nursing care institution was operating before October 31, 1982; and

b. The resident room has not undergone a modification as defined in A.R.S. § 36-401;

6. A resident has a separate bed, a nurse call system, and furniture to meet the resident's needs in a resident room or suite of rooms;

7. A resident room has:

a. A window to the outside with window coverings for controlling light and visual privacy, and the location of the window permits a resident to see outside from a sitting position;

b. A closet with clothing racks and shelves accessible to the resident; and

c. If the resident room contains more than one bed, a curtain or similar type of separation between the beds for privacy; and

8. A resident room or a suite of rooms:

a. Is accessible without passing through another resident's room; and

b. Does not open into any area where food is prepared, served, or stored.

**B.** No change

1. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

i. No change

ii. No change

iii. No change

2. No change

**C.** No change

## ARTICLE 6. HOSPICES

**R9-10-606. Personnel**

**A.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:

a. Are based on:

i. The type of physical health services expected to be provided by the personnel member according to the established job description, and

ii. The acuity of the patients receiving physical health services from the personnel member according to the established job description; and

b. Include:

i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services listed in the established job description,

ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services listed in the established job description, and

iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are available and, for a hospice inpatient facility, present on the hospice inpatient facility's premises, with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the hospice's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient;
4. Orientation occurs within the first week of providing hospice services and includes:
   a. Informing personnel about Department rules for licensing and regulating hospices and where the rules may be obtained,
   b. Reviewing the process by which a personnel member may submit a complaint about patient care to a hospice, and
   c. Providing the information required by hospice policies and procedures;
5. Personnel receive in-service education according to criteria established in hospice policies and procedures;
6. In-service education documentation for a personnel member includes:
   a. The subject matter,
   b. The date of the in-service education, and
   c. The signature of each individual who participated in the in-service education; and
7. A personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the hospice service facility or hospice inpatient facility, and
   b. As specified in R9-10-113~~.~~; and
8. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**B.** An administrator shall ensure that record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures; and
   e. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(7).
   f. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;

**C.** No change
1. No change
   a. No change

b. No change

2. No change

**R9-10-613. Medication Services**

**A.** No change

1. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

i. No change

ii. No change

iii. No change

c. No change

d. No change

i. No change

ii. No change

e. No change

f. No change

2. No change

a. No change

b. No change

**B.** No change

1. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

d. No change

2. No change

3. No change

a. No change

b. No change

**C.** No change

1. No change

2. No change

3. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

c. No change

d. No change

**D.** When medication is stored at a hospice inpatient facility, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of patients who received recalled medication; ~~and~~
   d. Storing, inventorying, and dispensing controlled substances~~.~~; and
   e. If applicable, donated medicine according to A.R.S. § 32-1909.

**E.** No change

## ARTICLE 9. OUTPATIENT SURGICAL CENTERS

**R9-10-901. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following apply in this Article, unless otherwise specified:

1. "Inpatient care" means postsurgical services provided in a hospital.
2. "Outpatient surgical services" means anesthesia and surgical services provided to a patient in an outpatient surgical center.
3. "Surgical suite" means an area of an outpatient surgical center that includes one or more operating rooms, one or more procedure rooms, and one or more recovery rooms.

**R9-10-902. Administration**

**A.** No change

1. No change
2. No change
   a. No change
   b. No change
3. No change
4. No change
5. No change
6. No change
7. No change
   a. No change
   b. No change
8. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to patient care;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Include a method to identify a patient to ensure that the patient receives services as ordered;
   f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
   g. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. The outpatient surgical center to respond to a patient complaint;
   h. Cover health care directives;

i. Cover medical records, including electronic medical records;

j. Cover a quality management program, including incident reports and supporting documentation; and

k. Cover contracted services;

2. Policies and procedures for medical services and nursing services provided by an outpatient surgical center are established, documented, and implemented to protect the health and safety of a patient that:

a. Cover patient screening, admission, transfer, and discharge;

b. Cover the provision of medical services, nursing services, and health-related services in the outpatient surgical center's scope of services;

c. Include when general consent and informed consent are required;

d. Cover dispensing, administering, and disposing of medications;

e. Cover prescribing a controlled substance to minimize substance abuse by a patient;

f. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;

g. Cover infection control; ~~and~~

h. Cover environmental services that affect patient care; and

i. Cover prevention of surgical smoke exposure in compliance with A.R.S. § 36-434.01, if applicable;

3. Policies and procedures are:

a. Available to personnel members, employees, volunteers, and students of the outpatient surgical center; and

b. Reviewed at least once every three years and updated as needed;

4. A pharmacy maintained by the outpatient surgical center is licensed according to A.R.S. Title 32, Chapter 18;

5. Pathology services are provided by a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Act of 1967;

6. If the outpatient surgical center meets the definition of "abortion clinic" in A.R.S. § 36-449.01, abortions and related services are provided in compliance with the requirements in Article 15 of this Chapter; and

7. Unless otherwise stated:

a. Documentation required by this Article is provided to the Department within two hours after a Department request; and

b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient surgical center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient surgical center.

**R9-10-905. Personnel**

**A.** No change

1. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

iii. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

4. No change

a. No change

b. No change

5. No change

6. No change

7. No change

a. No change

b. No change

c. No change

8. No change

9. No change

a. No change

b. No change

c. No change

**B.** No change

1. No change

2. No change

**C.** An administrator shall ensure that a personnel record for each personnel member, employee, volunteer, or student includes:

1. The individual's name, date of birth, and contact telephone number;

2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and

3. Documentation of:

a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;

b. The individual's education and experience applicable to the individual's job duties;

c. The individual's completed orientation and in-service education as required by policies and procedures;

d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;

e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;

f. Cardiopulmonary resuscitation training, if required for the individual according to subsection (B);

g. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(4)~~.~~; and

h. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training.

**D.** No change

1. No change

a. No change

b. No change

2. No change

**R9-10-911. Surgical Services**

**A.** No change

1. No change

2. No change

**B.** No change

**C.** No change

1. No change

2. No change

**D.** An administrator shall ensure that a physician medically discharges a patient from surgery.

**E.** An administrator shall ensure that a physician or an anesthesia provider licensed pursuant to Title 32, Chapter 13, 15, or, 17, discharges a patient from the recovery room.

~~**D.**~~**F.** An administrator shall ensure that ~~a physician~~ one of the following remains on the outpatient surgical center's premises until all patients are discharged from the recovery room:

1. A physician; or

2. An individual authorized under A.R.S. Title 32, Chapter 13, 15, or 17 to administer anesthesia.

**R9-10-914. Medication Services**

**A.** No change

1. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

i. No change

ii. No change

iii. No change

c. No change

2. No change

a. No change

b. No change

**B.** No change

1. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

d. No change

2. No change

3. No change

a. No change

b. No change

**C.** No change

1. No change

2. No change

3. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

c. No change

d. No change

**D.** When medication is stored at an outpatient surgical center, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of patients who received recalled medication; ~~and~~
   d. Storing, inventorying, and dispensing controlled substances~~.~~; and
   e. If applicable, donated medicine according to A.R.S. § 32-1909.

**E.** No change

**R9-10-918. Physical Plant Standards**

**A.** An administrator shall ensure that the outpatient surgical center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the date the outpatient surgical center submitted the application packet including the notarized attestation of architectural plans ~~and specifications to the Department for approval~~ according to R9-10-104.

**B.** No change

1. No change
2. No change

**C.** No change

1. No change
2. No change
3. No change

**D.** No change

**E.** No change

1. No change
2. No change
3. No change
4. No change
5. No change

## ARTICLE 10. OUTPATIENT TREATMENT CENTERS

**R9-10-1003. Administration**

**A.** No change

**B.** No change

1. No change
2. No change
    a. No change
    b. No change
3. No change
4. No change
5. No change
6. No change
    a. No change
    b. No change
7. No change

**C.** No change

1. No change
2. No change
3. No change

**D.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
    a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
    b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
    c. Include how a personnel member may submit a complaint relating to services provided to a patient;
    d. Cover the requirements in Title 36, Chapter 4, Article 11;
    e. Cover cardiopulmonary resuscitation training including:
        i. The method and content of cardiopulmonary resuscitation training which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation,
        ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
        iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
        iv. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
    f. Cover first aid training;
    g. Include a method to identify a patient to ensure the patient receives the services ordered for the patient;
    h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
    i. Cover health care directives;
    j. Cover medical records, including electronic medical records;
    k. Cover quality management, including incident report and supporting documentation; and

l. Cover contracted services;

2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, assessment, transport, transfer, discharge plan, and discharge;
   b. Cover the provision of medical services, nursing services, behavioral health services, health-related services, and ancillary services;
   c. Include when general consent and informed consent are required;
   d. Cover obtaining, administering, storing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
   e. Cover prescribing a controlled substance to minimize substance abuse by a patient;
   f. Cover infection control;
   g. Cover ~~telemedicine~~ telehealth, if applicable;
   h. Cover environmental services that affect patient care;
   i. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. An outpatient treatment center to respond to a complaint;
   j. Cover smoking tobacco products on an outpatient treatment center's premises; and
   k. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
3. Outpatient treatment center policies and procedures are:
   a. Reviewed at least once every three years and updated as needed, and
   b. Available to personnel members and employees;
4. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient treatment center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient treatment center;
5. The following are conspicuously posted:
   a. The current license for the outpatient treatment center issued by the Department;
   b. The name, address, and telephone number of the Department;
   c. A notice that a patient may file a complaint with the Department about the outpatient treatment center;
   d. One of the following:
      i. A schedule of rates according to A.R.S. § 36-436.01(C), or
      ii. A notice that the schedule of rates required in A.R.S. § 36-436.01(C) is available for review upon request;
   e. A list of patient rights;
   f. A map for evacuating the facility; and
   g. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(D), with patient information redacted, are available; and
6. Patient follow-up instructions are:
   a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the outpatient treatment center unless the patient leaves against a personnel member's advice; and

b. Documented in the patient's medical record.

**E.** No change

1. No change
2. No change

**F.** No change

1. No change
2. No change
   a. No change
   b. No change
3. No change
   a. No change
   b. No change
   c. No change
4. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
6. No change

**G.** No change

**R9-10-1008. Patient Rights**

**A.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change

**B.** An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient ~~as~~ is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed in R9-10-1012(B), restraint or seclusion;
   i. Retaliation for submitting a complaint to the Department or another entity; or
   j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:

a. Except in an emergency, either consents to or refuses treatment;

b. May refuse or withdraw consent for treatment before treatment is initiated;

c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;

d. Is informed of the following:

i. The outpatient treatment center's policy on health care directives, and

ii. The patient complaint process;

e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and

f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:

i. Medical record, or

ii. Financial records.

**C.** No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change

**R9-10-1010. Medication Services**

**A.** No change

1. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
   c. No change
   d. No change
   e. No change
   f. No change
2. No change
   a. No change
   b. No change

**B.** No change

1. No change
    a. No change
    b. No change
        i. No change
        ii. No change
    c. No change
    d. No change
2. No change
3. No change
    a. No change
    b. No change

**C.** No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
        i. No change
        ii. No change
        iii. No change
    e. No change
3. No change
4. No change
    a. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
5. No change
6. No change
    a. No change
    b. No change

**D.** No change

1. No change
2. No change
3. No change
    a. No change
    b. No change
    c. No change

**E.** When medication is stored at an outpatient treatment center, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;

2. Medication is stored according to the instructions on the medication container; and

3. Policies and procedures are established, documented, and implemented for:

a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;

b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;

c. A medication recall and notification of patients who received recalled medication; and

d. Storing, inventorying, and dispensing controlled substances.

e. If applicable, donated medicine according to A.R.S. § 32-1909.

**F.** No change

**R9-10-1011. Behavioral Health Services**

**A.** No change

1. No change

2. No change

a. No change

b. No change

i. No change

ii. No change

3. No change

4. No change

**B.** An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:

1. Except as provided in subsection (B)(2), a behavioral health assessment for a patient is completed before treatment for the patient is initiated;

2. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the outpatient treatment center or the outpatient treatment center has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission:

a. The patient's assessment information is reviewed and updated if additional information that affects the patient's assessment is identified, and

b. The review and update of the patient's assessment information is documented in the patient's medical record within 48 hours after the review is completed;

3. If a behavioral health assessment is conducted by a:

a. Behavioral health technician or a registered nurse, within 72 hours a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the patient; or

b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the behavioral health services needed by the patient;

4. A behavioral health assessment:

a. Documents a patient's:

i. Presenting issue;

ii. Substance abuse history;

iii. ~~Co-occurring disorder~~ Co-morbidity;

iv. Medical condition and history;

v. Legal history, including:

(1) Custody,

(2) Guardianship, and

(3) Pending litigation;

vi. Criminal justice record;

vii. Family history;

viii. Behavioral health treatment history; and

ix. Symptoms reported by the patient and referrals needed by the patient, if any;

b. Includes:

i. Recommendations for further assessment or examination of the patient's needs;

ii. The behavioral health services, physical health services, or ancillary services that will be provided to the patient; ~~and~~

iii. Prescribing medication to treat or manage a mental health or substance abuse condition; and

~~iii.~~iv. The signature and date signed of the personnel member conducting the behavioral health assessment; and

c. Is documented in patient's medical record;

5. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;

6. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;

7. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;

8. Documentation of the request in subsection (B)(6) and the opportunity in subsection (B)(7) is in the patient's medical record;

9. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;

10. If information in subsection (B)(4)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;

11. Counseling is:

a. Offered as described in the outpatient treatment center's scope of services,

b. Provided according to the frequency and number of hours identified in the patient's assessment, and

c. Provided by a behavioral health professional or a behavioral health technician;

12. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and

13. Each counseling session is documented in the patient's medical record to include:

a. The date of the counseling session;

b. The amount of time spent in the counseling session;

c. Whether the counseling was individual counseling, family counseling, or group counseling;

d. The treatment goals addressed in the counseling session; and

e. The signature of the personnel member who provided the counseling and the date signed.

**C.** No change

1. No change
2. No change
3. No change
4. No change

**D.** No change

1. No change
2. No change

**R9-10-1012. Behavioral Health Observation/Stabilization Services**

**A.** An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:

1. Behavioral health observation/stabilization services are available 24 hours a day, every calendar day;
2. Behavioral health observation/stabilization services are provided in a designated area that:
   a. Is used exclusively for behavioral health observation/stabilization services;
   b. Has the space for a patient to receive privacy in treatment and care for personal needs; and
   c. For every 15 observation chairs or less, has at least one bathroom that contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue,
      iv. Soap for hand washing,
      v. Paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A means of ventilation;
3. If the outpatient treatment center is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age:
   a. There is a separate designated area for providing behavioral health observation/stabilization services to individuals under 18 years of age that:
      i. Meets the requirements in subsection (B)(2), and
      ii. Has floor to ceiling walls that separate the designated area from other areas of the outpatient treatment center;
   b. A registered nurse is present in the separate designated area; and
   c. A patient under 18 years of age does not share any space, participate in any activity or treatment, or have verbal or visual interaction with a patient 18 years of age or older;
4. A medical practitioner is available;
5. If the medical practitioner present at the outpatient treatment center is a registered nurse practitioner or a physician assistant, a physician is on-call;
6. A registered nurse is present and provides direction for behavioral health observation/stabilization services in the designated area;
7. A nurse monitors each patient at the intervals determined according to subsection (A)(12) and documents the monitoring in the patient's medical record;

8. An individual who arrives at the designated area for behavioral health observation/stabilization services in the outpatient treatment center is screened within 30 minutes, by a qualified person who is on the premises, after entering the designated area to determine whether the individual is in need of immediate physical health services;
9. If a screening indicates that an individual needs immediate physical health services that the outpatient treatment center is:
    a. Able to provide according to the outpatient treatment center's scope of services, the individual is examined by a medical practitioner within 30 minutes after being screened; or
    b. Not able to provide, the individual is transferred to a health care institution capable of meeting the individual's immediate physical health needs;
10. If a screening indicates that an individual needs behavioral health observation/stabilization services and the outpatient treatment center has the capabilities to provide the behavioral health observation/stabilization services, the individual is admitted to the designated area for behavioral health observation/stabilization services and may remain in the designated area and receive observation/stabilization services for up to 23 hours and 59 minutes;
11. Before a patient is discharged from the designated area for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be:
    a. If the behavioral health observation/stabilization services are provided in a health care institution that also provides inpatient services and is capable of meeting the patient's needs, admitted to the health care institution as an inpatient;
    b. Transferred to another health care institution capable of meeting the patient's needs;
    c. Provided a referral to another entity capable of meeting the patient's needs; or
    d. Discharged and provided patient follow-up instructions;
12. When a patient is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the patient includes the interval for monitoring the patient based on the patient's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the patient;
13. If a patient is not being admitted as an inpatient to a health care institution, before discharging the patient from a designated area for behavioral health observation/stabilization services, a personnel member:
    a. Identifies the specific needs of the patient after discharge necessary to assist the patient to function independently;
    b. Identifies any resources, including family members, community social services, peer support services, and Regional Behavioral Health Agency staff, that may be available to assist the patient; and
    c. Documents the information in subsection (A)(13)(a) and the resources in subsection (A)(13)(b) in the patient's medical record;
14. When a patient is discharged from a designated area for behavioral health observation/stabilization services, a personnel member:
    a. Provides the patient with discharge information that includes:
        i. The identified specific needs of the patient after discharge, and
        ii. Resources that may be available for the patient; and
    b. Contacts any resources identified as required in subsection (A)(13)(b);
15. Except as provided in subsection (A)(16), a patient is not re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge from a designated area for behavioral health observation/stabilization services;
16. A patient may be re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge if:

a. It is at least one hour since the time of the patient's discharge;

b. A law enforcement officer or the patient's case manager accompanies the patient to the outpatient treatment center;

c. Based on a screening of the patient, it is determined that re-admission for behavioral health observation/stabilization is necessary for the patient; and

d. The name of the law enforcement officer or the patient's case manager and the reasons for the determination in subsection (A)(16)(c) are documented in the patient's medical record;

17. A patient admitted for behavioral health observation/stabilization services is provided:

a. An observation chair; or

b. A separate piece of equipment for the patient to use to sit or recline that:

i. Is at least 12 inches from the floor; and

ii. Has sufficient space around the piece of equipment to allow a personnel member to provide behavioral health services and physical health services, including emergency services, to the patient;

18. If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety, which may include:

a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services;

b. Establishing a method to notify the individual when there is an observation chair available;

c. Referring or providing transportation to the individual to another health care institution;

d. Assisting the individual to contact the individual's support system; and

e. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual;

19. Personnel members establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken;

20. The log required in subsection (A)(19) is maintained for at least 12 months after the date of documentation in the log;

21. An observation chair or, as provided in subsection (A)(17)(b), a piece of equipment used by a patient to sit or recline is visible to a personnel member;

22. Except as provided in subsection (A)(23), a patient admitted to receive behavioral health observation/stabilization services is visible to a personnel member;

23. A patient admitted to receive behavioral health observation/stabilization services may use the bathroom and not be visible to a personnel member, if the personnel member:

a. Determines that the patient is capable of using the bathroom unsupervised,

b. Is aware of the patient's location, and

c. Is able to intervene in the patient's actions to ensure the patient's health and safety; and

24. An observation chair:

a. Effective until July 1, 2015, has space around the observation chair that allows a personnel member to provide behavioral health services and physical health services, including emergency services, to a patient in the observation chair; and

b. Effective on July 1, 2015, has at least three feet of clear floor space:

i. On at least two sides of the observation chair, and

ii. Between the observation chair and any other observation chair.

**B.** No change

1. No change
2. No change

**C.** No change

1. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
   b. No change
2. No change
   a. No change
   b. No change
3. No change
   a. No change
      (i.) No change
      (ii.) No change
   b. No change

**R9-10-1017. Diagnostic Imaging Services**

An administrator of an outpatient treatment center that is authorized to provide diagnostic imaging services shall:

1. Designate an individual to provide direction for diagnostic imaging services who is a:
   a. Radiologic technologist, certified under A.R.S. Title 32, Chapter 28, Article 2, who has at least 12 months experience in an outpatient treatment center;
   b. Physician; or
   c. Radiologist; and
2. Ensure that:
   a. Diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
   b. ~~A copy of a certificate documenting~~ Written documentation of compliance with subsection (2)(a) is maintained;
   c. Diagnostic imaging services are provided to a patient according to an order that includes:
      i. The patient's name,
      ii. The name of the ordering individual,
      iii. The diagnostic imaging procedure ordered, and
      iv. The reason for the diagnostic imaging procedure;
   d. A ~~physician~~ medical staff member or radiologist interprets the diagnostic image; and
   e. A diagnostic imaging patient report is completed that includes:
      i. The patient's name,
      ii. The date of the procedure, and
      iii. A physician's or radiologist's interpretation of the diagnostic image.
      medical staff member qualified to interpret the diagnostic image, as approved by individual designated in subsection (1)

**R9-10-1018. Dialysis Services**

**A.** No change

1. "Caregiver" No change
2. "Chief clinical officer" No change
3. "Long-term care plan" No change
4. "Modality" No change
5. "Nutritional assessment" No change
6. "Patient care plan" No change
7. "Peritoneal dialysis" No change
8. "Psychosocial evaluation" No change
9. "Reprocessing" No change
10. "Self-dialysis" No change
11. "Social worker" No change
12. "Stable means" No change
13. "Transplant surgeon" No change
    a. No change
    b. No change

**B.** No change

1. No change
2. No change
    a. No change
    b. No change

**C.** No change

1. No change
    a. No change
    b. No change
    c. No change
    d. No change
2. No change
3. No change
    a. No change
    b. No change
4. No change
5. No change

**D.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:

1. The premises of the outpatient treatment center where dialysis services are provided complies with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01, that were in effect on the date listed on the building permit or zoning clearance submitted, as required by R9-10-104, as part of the application ~~for approval of the~~ including the notarized attestation of architectural plans and specifications submitted before initial approval of the inclusion of dialysis services in the outpatient treatment center's scope of services;
2. Before a modification of the premises of an outpatient treatment center where dialysis services are provided is made, an application including the notarized attestation of ~~for approval of the~~ architectural plans and specifications of the outpatient treatment center required in R9-10-104(A):

a. Is submitted to the Department; and

b. Demonstrates compliance with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01, in effect on the date:

i. Listed on the building permit or zoning clearance submitted as part of the application including the notarized attestation of ~~for approval of the~~ architectural plans and specifications for the modification, or

ii. The application including the notarized attestation of ~~for approval of the~~ architectural plans and specifications of the modification of the outpatient treatment center required in R9-10-104(A) is submitted to the Department; and

3. A modification of the outpatient treatment center complies with applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01 in effect on the date:

a. Listed on the building permit or zoning clearance submitted as part of the application including the notarized attestation of ~~for approval of the~~ architectural plans and specifications for the modification, or

b. The application including the notarized attestation of ~~for approval of the~~ architectural plans and specifications required in R9-10-104(A) is submitted to the Department.

**E.** No change

1. No change
2. No change
   a. No change
   b. No change
3. No change
   a. No change
   b. No change
4. No change
   a. No change
   b. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
      i. No change
      ii No change
6. No change
7. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change

f. No change

8. No change

9. No change

10. No change

11. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

c. No change

d. No change

i. No change

ii. No change

iii. No change

iv. No change

e. No change

f. No change

12. No change

13. No change

14. No change

15. No change

a. No change

b. No change

**F.** No change

1. No change

a. No change

b. No change

2. No change

3. No change

4. No change

5. No change

6. No change

a. No change

b. No change

7. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

i. No change

ii. No change

iii. No change

iv. No change

v. No change

vi. No change

**G.** No change

1. No change
2. No change
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5. No change
6. No change
7. No change

**H.** No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change

**I.** No change

1. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change
    g. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change

**J.** No change

1. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change

2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
    a. No change
    b. No change
    c. No change
9. No change
10. No change
    a. No change
    b. No change

**K.** No change

1. No change
2. No change
3. No change
4. No change
    a. No change
    b. No change
5. No change

**L.** No change

1. No change
2. No change

**M.** No change

**N.** No change

**R9-10-1022. Physical Health Services**

An administrator of an outpatient treatment center that is authorized to provide physical health services shall ensure that:

1. Medical services provided at or by the outpatient treatment center are provided under ~~the direction of a physician or a registered nurse practitioner~~ A.R.S. § 36-401(A)(33),
2. Nursing services provided at or by the outpatient treatment center are provided under the direction of a registered nurse, and
3. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise.

**R9-10-1027. Urgent Care Services Provided in a Freestanding Urgent Care Setting**

An administrator of an outpatient treatment center that is authorized to provide urgent care services in a freestanding urgent care setting shall ensure that:

1. In addition to the policies and procedures required in R9-10-1003(D)(1), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover ~~basic life support training and pediatric basic life support training including~~:

a. ~~Method and content of training,~~ Basic life support training and pediatric basic life support training including:

i. Method and content of training,

ii. Qualifications of individuals providing the training, and

iii. Documentation that verifies a medical practitioner has received the training; and

b. ~~Qualifications of individuals providing the training, and~~ A workplace violence prevention plan according to A.R.S. § 36-420.03.

~~c. Documentation that verifies a medical practitioner has received the training;~~

2. A medical practitioner is on the premises during hours of clinical operation to provide the medical services, nursing services, and health-related services included in the outpatient treatment center's scope of services;

3. If a physician is not on the premises during hours of operation, a notice stating this fact is conspicuously posted in the waiting room according to A.R.S. § 36-432;

4. If a patient's death occurs at the outpatient treatment center, a written report is submitted to the Department as required in A.R.S. § 36-445.04;

5. A medical practitioner completes basic life support training and pediatric basic life support training:

a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center, and

b. At least once every 24 months after the initial date of employment;

6. Except as provided in subsection (5), a personnel member completes basic adult and pediatric cardiopulmonary resuscitation training:

a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center; and

b. At least once every 24 months after the initial date of employment or volunteer service; and

7. In addition to the requirements in R9-10-1006(11), a medical practitioner's record includes documentation of completion of basic life support training and pediatric basic life support training.

**R9-10-1031. Colocation Requirements**

**A.** No change

**B.** No change

**C.** No change

1. No change

2. No change

3. No change

4. No change

**D.** In addition to the requirements for a license application in R9-10-105, a governing authority of an outpatient treatment center requesting authorization to operate or continue to operate as a collaborating outpatient treatment center shall submit, in a Department-provided format:

1. The following information for each proposed colocator that may share an area of the collaborating outpatient treatment center's premises and nontreatment personnel at the collaborating outpatient treatment center:

a. For each proposed associated licensed provider:

i. Name,

ii. The associated licensed provider's license number or the date the associated licensed provider submitted to the Department a license application for an outpatient treatment center or a counseling facility license,

iii. Proposed scope of services, and

iv. A copy of the written agreement with the collaborating outpatient treatment center required in subsection (E); and

b. For each exempt health care provider, unless exempt pursuant to A.R.S. § 36-402:

i. Name,

ii. Current health care professional license number,

iii. Proposed scope of services, and

iv. A copy of the written agreement required in subsection (F) with the collaborating outpatient treatment center; and

2. In addition to the requirements in R9-10-105(A)(5)(b)(vi), a floor plan that shows:

a. Each colocator's proposed treatment area, and

b. The areas of the collaborating outpatient treatment center's premises shared with a colocator.

**E.** No change

1. No change

a. No change

b. No change

c. No change

d. No change

i. No change

ii. No change

iii. No change

e. No change

f. No change

g. No change

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i. No change

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i. No change

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i. No change

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(4) No change

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iii. No change

l. No change

m. No change

n. No change

2. No change

**F.** No change

1. No change

a. No change

b. No change

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d. No change

i. No change

ii. No change

iii. No change

e. No change

f. No change

g. No change

h. No change

i. No change

j. No change

i. No change

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(3) No change

(4) No change

ii. No change

iii. No change

k. No change

i. No change

(1) No change

(2) No change

(3) No change

(4) No change

ii. No change

iii. No change

l. No change

m. No change

n. No change

2. No change

**G.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

d. No change

4. No change

5. No change

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9. No change

10. No change

**H.** No change

1. No change

a. No change

b. No change

c. No change

2. No change

3. No change

**I.** No change

## ARTICLE 11. ADULT DAY HEALTH CARE FACILITIES

**R9-10-1106. Personnel**

**A.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the participants receiving physical health services or behavioral health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are present on an adult day health care facility's premises when participants are present and have the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the adult day health care facility's scope of services,
   b. Meet the needs of a participant, and
   c. Ensure the health and safety of a participant; ~~and~~
4. A personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a participant for more than eight hours a week, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the adult day health care facility, and
   b. As specified in R9-10-113~~.~~; and
5. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**B.** No change

1. No change
2. No change

**C.** An administrator shall ensure that a personnel record for each personnel member, employee, volunteer, or student:

1. Includes:
   a. The individual's name, date of birth, and contact telephone number;
   b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
   c. Documentation of:

i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;

ii. The individual's education and experience applicable to the individual's job duties;

iii. The individual's completed orientation and in-service education as required by policies and procedures;

iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;

v. Cardiopulmonary resuscitation training, if required for the individual according to this Article and policies and procedures;

vi. First aid training, if required for the individual according to this Article and policies and procedures; and

vii. Evidence of freedom from infectious tuberculosis, if required for the individual according to this Article or policies and procedures;

2. Is maintained:

a. Throughout the individual's period of providing services in or for the adult day health care facility, and

b. For at least 24 months after the last date the individual provided service in or for the adult day health care facility; and

3. For a personnel member who has not provided physical health services or behavioral health services at or for the adult day health care facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.

4. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;

**D.** No change

1. No change
2. No change
3. No change
4. No change

a. No change

b. No change

**R9-10-1107. Enrollment**

**A.** An administrator shall ensure that a participant provides evidence of freedom from infectious tuberculosis:

1. Before ~~or within seven calendar days after~~ the participant's ~~enrollment~~ participation, and
2. As specified in R9-10-113.

**B.** No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change

9. No change

**C.** No change

**D.** No change

1. No change
2. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change

**E.** No change

1. No change
2. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
    b. No change

**F.** No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
3. No change
    a. No change
    b. No change
    c. No change

**R9-10-1114. Food Services**

**A.** No change

1. No change
2. No change
    a. No change
        i. No change
        ii. No change
    b. No change

**B.** A food service supervisor shall ensure that:

1. A food menu:
    a. Is prepared at least one week in advance,
    b. Includes the foods to be served each day,
    c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
    d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
    e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the adult day health care facility are served according to posted menus;
3. Meals and snacks for each day are planned using the applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2010.asp~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
4. A participant is provided a diet that meets the participant's nutritional needs as specified in the participant's comprehensive assessment, under R9-10-1107(F), or the participant's care plan;
5. Water is available and accessible to participants at all times, unless otherwise stated by the participant's medical practitioner; and
6. A participant requiring assistance to eat is provided with assistance that recognizes the participant's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the participant.

**C.** An administrator shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Food is prepared:
    a. Using methods that conserve nutritional value, flavor, and appearance; and
    b. In a form to meet the needs of a participant, such as cut, chopped, ground, pureed, or thickened;
4. Potentially hazardous food is maintained as follows:
    a. Foods requiring refrigeration are maintained at 41° F or below;
    b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
        i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
        ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
        iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
        iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
        v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
        vi. Leftovers are reheated to a temperature of at least 165° F;
5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, at the warmest part of the refrigerator;
6. Frozen foods are stored at a temperature of 0° F or below; and
7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**D.** No change
1. No change
    a. No change
    b. No change

2. No change

3. No change

**R9-10-1117. Physical Plant Standards**

**A.** An administrator shall ensure that an adult day health care facility complies with the physical plant health and safety codes and standards incorporated by reference in R9-10-104.01, in effect on the date the adult day health care facility submitted the application including the notarized attestation of architectural plans ~~and specifications to the Department for approval,~~ according to R9-10-104.

**B.** No change

1. No change

2. No change

**C.** No change

**D.** No change

1. No change

2. No change

3. No change

4. No change

**E.** No change

1. No change

2. No change

   a. No change

   b. No change

   c. No change

   d. No change

   e. No change

3. No change

4. No change

   a. No change

   b. No change

   c. No change

   d. No change

5. No change

6. No change

7. No change

8. No change

**F.** If the adult day health care facility has a swimming pool on the premises, an administrator shall ensure that:

1. The swimming pool is equipped with the following:

   a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:

      i. A removable strainer,

      ii. Two swimming pool inlets located on opposite sides of the swimming pool, and

      iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and

b. An operational vacuum cleaning system;

2. The swimming pool is enclosed by a wall or fence that:

   a. Is at least five feet in height as measured on the exterior of the wall or fence;

   b. Has no vertical openings greater that four inches across;

   c. Has no horizontal openings, except as described in subsection ~~(C)(2)(e)~~ (F)(2)(e);

   d. Is not chain-link;

   e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and

   f. Has a self-closing, self-latching gate that:

      i. Opens away from the swimming pool,

      ii. Has a latch located at least 54 inches from the ground; and

      iii. Is locked when the swimming pool is not in use;

3. A life preserver or shepherd's crook is available and accessible in the pool area; and

4. If the swimming pool is used by participants, pool safety requirements are conspicuously posted in the pool area.

## ARTICLE 13. BEHAVIORAL HEALTH SPECIALIZED TRANSITIONAL FACILITY

**R9-10-1302. Administration**

**A.** No change

1. No change
2. No change
   a. No change
      i. No change
      ii. No change
   b. No change
   c. No change
   d. No change
   e. No change
      i. No change
      ii. No change
   f. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Cover patient admission, assessment, treatment plan, transfer, discharge planning, and recordkeeping;
   d. Cover discharge, including the amount of medication provided to a patient at discharge, based on an assessment of the patient's medical condition;
   e. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
   f. Cover the requirements in A.R.S. §§ 36-3708, 36-3709, and 36-3714;
   g. Establish the process for warning an identified or identifiable individual, as described in A.R.S. § 36-517.02 (B) through (C), if a patient communicates to a personnel member a threat of imminent serious physical harm or death to the identified or identifiable individual and the patient has the apparent intent and ability to carry out the threat;
   h. Cover when informed consent is required and how informed consent is obtained;
   i. Cover the criteria and process for conducting research using patients or patients' medical records;
   j. Include the establishment of, disbursing from, and recordkeeping for a patient personal funds account;
   k. Include a method of patient identification to ensure a patient receives the services ordered for the patient;
   l. Cover contracted services;
   m. Cover health care directives;

n. Cover medical records, including electronic medical records;

o. Cover medication procurement, storage, inventory monitoring and control, and disposal;

p. Cover infection control;

q. Cover and designate which personnel members or employees are required to have current certification in cardiopulmonary resuscitation and first aid training;

r. Cover environmental services that affect patient care;

s. Cover training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect and reporting suspected or alleged abuse, neglect, exploitation, or other criminal activity;

t. Cover quality management, including incident reports and supporting documentation;

u. Cover emergency treatment and disaster plan;

v. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;

w. Include security of the facility, patients and their possessions, personnel members, and visitors at the behavioral health specialized transitional facility;

x. Include preventing unauthorized patient absences;

y. Cover transportation of patients, including the criteria for using a locking mechanism to restrict a patient's movement during transportation;

z. Cover specific steps for:

i. A patient to file a complaint, and

ii. The behavioral health specialized transitional facility to respond to a patient's complaint;

aa. Cover visitation, telephone usage, sending or receiving mail, computer usage, and other recreational activities; ~~and~~

bb. Include equipment inspection and maintenance; and

cc. Cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02;

2. Policies and procedures are available to each personnel member;

3. Laboratory services are provided by a laboratory that holds a certificate of accreditation or certificate of compliance issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;

4. Food services are provided as specified in R9-10-1314;

5. The following individuals have access to a patient:

a. The patient's representative,

b. An individual assigned by a court of law to provide services to the patient, and

c. An attorney hired by the patient or patient's family;

6. Labor performed by a patient for the behavioral health specialized transitional facility is consistent with A.R.S. § 36-510 and applicable state and federal law; and

7. The following information is posted in an area easily viewed by a patient or an individual entering or leaving the behavioral health specialized transitional facility:

a. Patient rights,

b. Telephone number for the Department and the Office of Human Rights,

c. Location of inspection reports,

d. Complaint procedures, and

e. Visitation hours and procedures.

**D.** No change

1. No change
    a. No change
    b. No change
    c. No change
2. No change
3. No change

**E.** No change

1. No change
2. No change
3. No change
    a. No change
    b. No change
    c. No change
4. No change
5. No change
    a. No change
    b. No change
    c. No change
    d. No change
6. No change

**F.** No change

1. No change
    a. No change
    b. No change
2. No change
    a. No change
    b. No change
3. No change
    a. No change
    b. No change
    c. No change

**G.** No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change

**H.** A clinical director:

1. Is responsible for the behavioral health services provided to patients;
2. Shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:

a. Assessing the competency and proficiency of a behavioral health personnel member for each type of service the personnel member provides and each type of patient to which the personnel member is assigned;

b. Providing:

i. Supervision to behavioral health paraprofessionals, according to ~~R9-10-115(1)~~ R9-10-115(2); and

ii. Clinical oversight to behavioral health technicians, according to ~~R9-10-115(2)~~ R9-10-115(3);

c. The qualifications for personnel members who provide clinical oversight;

d. The process for patient assessments, including the identification of and criteria for the on-going monitoring of a patient's behavioral health issues;

e. The process for developing and implementing a patient's treatment plan;

f. The frequency of and process for reviewing and modifying a patient's treatment plan, based on the ongoing monitoring of the patient's response to treatment; and

g. The process for determining whether a patient is eligible for discharge or conditional release to a less restrictive alternative;

3. Shall ensure that patient services are provided by personnel that are competent and proficient in providing the services; and

4. Shall ensure that clinical oversight of personnel members is provided according to the policies and procedures.

**R9-10-1305. Personnel Requirements and Records**

**A.** No change

1. No change

2. No change

a. No change

b. No change

**B.** No change

1. No change

2. No change

**C.** No change

1. No change

2. No change

**D.** No change

1. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

iii. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

**E.** No change

**F.** No change

1. No change
2. No change

**G.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   f. Cardiopulmonary resuscitation training, if required for the individual according to this Article or policies and procedures;
   g. First aid training, if required for the individual according to this Article or policies and procedures; and
   h. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).
   i. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;

**H.** No change

1. No change
2. No change

**I.** An administrator shall ensure that:

1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented and implemented; ~~and~~
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training~~.~~; and

6. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**R9-10-1306. Admission Requirements**

**A.** No change

1. No change
2. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** Within seven calendar days after a patient is admitted to the behavioral health specialized transitional facility, a medical director shall ensure that:

1. A medical history is taken from the patient and a physical examination performed on the patient;
2. Except as specified in subsection (C)(3), a patient provides evidence of freedom from infectious tuberculosis as required in R9-10-113;
3. A patient is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
   a. Fewer than 12 months have passed since the patient was screened for tuberculosis, and
   b. The documentation of freedom from infectious tuberculosis required in subsection (C)(2) accompanies the patient at the time of the patient's admission to the behavioral health specialized transitional facility; and
4. An assessment for the patient is completed:
   a. According to the behavioral health specialized transitional facility's policies and procedures;
   b. That includes the patient's:
      i. Legal history, including criminal justice record;
      ii. Behavioral health treatment history;
      iii. Medical conditions and history; and
      iv. Symptoms reported by the patient and referrals needed by the patient, if any; and
   c. That includes:
      i. Recommendations for further assessment or examination of the patient's needs,
      ii. The physical health services or ancillary services that will be provided to the patient until the patient's treatment plan is completed; and
      iii. The signature of the personnel member conducting the assessment and the date signed.

**R9-10-1313. Medication Services**

**A.** No change

1. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   b. No change
      i. No change
      ii. No change
      iii. No change

c. No change

d. No change

2. No change

a. No change

b. No change

**B.** No change

1. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

2. No change

3. No change

4. No change

a. No change

b. No change

5. No change

a. No change

b. No change

**C.** If a behavioral health specialized transitional facility provides assistance in the self-administration of medication, a medical director shall ensure that:

1. A patient's medication is stored by the behavioral health specialized transitional facility;

2. The following assistance is provided to a patient:

a. A reminder when it is time to take the medication;

b. Opening the medication container for the patient;

c. Observing the patient while the patient removes the medication from the container;

d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:

i. The patient taking the medication is the individual stated on the medication container label,

ii. The dosage of the medication is the same as stated on the medication container label, and

iii. The medication is being taken by the patient at the time stated on the medication container label; ~~or~~ and

e. Observing the patient while the patient takes the medication;

3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;

4. Training for a personnel member, other than a medical practitioner or nurse, in assistance in the self-administration of medication:

a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and

b. Includes:

i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,

ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and

iii. Process for notifying the appropriate entities when an emergency medical intervention is needed;

5. A personnel member, other than a medical practitioner or nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and

6. Assistance in the self-administration of medication provided to a patient:

a. Is in compliance with an order, and

b. Is documented in the patient's medical record.

**D.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

**E.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

d. No change

e. No change

**F.** No change

**R9-10-1314. Food Services**

**A.** No change

1. No change

2. No change

3. No change

a. No change

b. No change

4. No change

5. No change

**B.** A registered dietitian or director of food services shall ensure that:

1. A food menu:

a. Is prepared at least one week in advance,

b. Includes the foods to be served each day,

c. Is conspicuously posted at least one day before the first meal on the food menu will be served,

d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and

e. Is maintained for at least 60 calendar days after the last day included in the food menu;

2. Meals and snacks provided by the behavioral health specialized transitional facility are served according to posted menus;
3. Meals for each day are planned using the applicable dietary guidelines ~~in http://www.health.gov/dietaryguidelines/2010.asp~~ according to the U.S. Department of Health and Human Services and the U.S. Department of Agriculture;
4. A patient is provided:
    a. A diet that meets the patient's nutritional needs as specified in the patient's assessment plan;
    b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(4)(d);
    c. The option to have a daily evening snack identified in subsection (B)(4)(d)(ii) or other snack; and
    d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
        i. A patient group agrees; and
        ii. The patient is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
5. A patient requiring assistance to eat is provided with assistance that recognizes the patient's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
6. Water is available and accessible to a patient at all times, unless otherwise specified in the patient's treatment plan.

**C.** No change

1. No change
2. No change
3. No change
    a. No change
    b. No change
4. No change
    a. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
        v. No change
        vi. No change
5. No change
6. No change
7. No change

**R9-10-1315. Emergency and Safety Standards**

**A.** No change

1. No change
2. No change
3. No change
4. No change
5. No change

**B.** No change

**C.** No change

1. No change
2. No change

**D.** An administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
    a. Procedures for protecting the health and safety of patients and other individuals at the behavioral health specialized transitional facility;
    b. When, how, and where patients will be relocated;
    c. How each patient's medical record will be available to personnel providing services to the patient during a disaster;
    d. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
    e. A plan for obtaining food and water for individuals present in the behavioral health specialized transitional facility or the behavioral health specialized transitional facility's relocation site during a disaster;
2. The disaster plan required in subsection (D)(1) is reviewed at least once every 12 months;
3. A disaster drill is performed on each shift at least once every 12 months;
4. Documentation of a disaster plan review required in subsection (D)(2) and a disaster drill required in subsection (D)(3) is created, is maintained for at least 12 months after the date of the disaster plan review or disaster drill, and includes:
    a. The date and time of the disaster plan review or disaster drill;
    b. The name of each personnel member, employee, or volunteer participating in the disaster plan review or disaster drill;
    c. A critique of the disaster plan review or disaster drill; and
    d. If applicable, recommendations for improvement;
5. An evacuation drill <u>for employees and patients:</u> ~~is conducted on each shift at least once every three months;~~
    <u>a. Is conducted on each shift at least once every three months;</u>
    <u>b. Includes all individuals on the premises except for:</u>
        <u>i. A patient whose medical record contains documentation that evacuation from the behavioral health inpatient facility would cause harm to the patient, and</u>
        <u>ii. Sufficient personnel members to ensure the health and safety of patients not evacuated according to subsection (B)(5)(b)(i);</u>
6. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
    a. The date and time of the evacuation drill;
    b. The amount of time taken for all employees and patients to evacuate the behavioral health specialized transitional facility;
    c. If applicable, an identification of patients needing assistance for evacuation;
    d. Any problems encountered in conducting the evacuation drill; and
    e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health specialized transitional facility.

**E.** No change

1. No change

2. No change

3. No change

**R9-10-1317. Physical Plant Standards**

**A.** An administrator shall ensure that a behavioral health specialized transitional facility complies with the applicable physical plant health and safety codes and standards for secure residential facilities, incorporated by reference in R9-10-104.01, in effect on the date the behavioral health specialized transitional facility submitted the application including the notarized attestation of architectural plans ~~and specifications to the Department for approval~~ according to R9-10-104.

**B.** No change

1. No change

2. No change

**C.** An administrator shall ensure that a behavioral health specialized transitional facility has:

~~1.~~ ~~A behavioral health specialized transitional facility has:~~

~~a.~~1. An area in which a patient may meet with a visitor,

~~b.~~2. Areas where patients may receive individual treatment,

~~c.~~3. Areas where patients may receive group counseling or other group treatment,

~~d.~~4. An area for community dining; and

~~e.~~5. Sufficient space in one or more common areas for individual and group activities.

**D.** An administrator shall ensure that the behavioral health specialized transitional facility has:

1. A bathroom adjacent to a common area for use by patients and visitors that:
   a. Provides privacy to the user; and
   b. Contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue dispenser,
      iv. Dispensed soap for hand washing,
      v. Single use paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A means of ventilation;
2. An indoor common area that is not used as a sleeping area and that has:
   a. A working telephone that allows a patient to make a private telephone call;
   b. A distortion-free mirror;
   c. A current calendar and an accurate clock;
   d. A variety of books, current magazines and newspapers, and arts and crafts supplies appropriate to the age, educational, cultural, and recreational needs of patients; and
   e. A working television and access to a radio;
3. A dining room or dining area that:
   a. Is lighted and ventilated,
   b. Contains tables and seats, and
   c. Is not used as a sleeping area;
4. An outdoor area that:
   a. Is accessible to patients,
   b. Has sufficient space to accommodate the social and recreational needs of patients, and

c. Has shaded and unshaded areas;

5. For every ten patients, at least one working toilet that flushes and has a seat and dispensed toilet tissue;

6. For every 12 patients, at least one sink with running water, dispensed soap for hand washing, and single use paper towels or a mechanical air hand dryer;

7. For every 12 patients, at least one working bathtub or shower with a slip resistant surface; and

8. For each patient, a private bedroom that:

   a. Contains at least 60 square feet of floor space, not including the closet;

   b. Has walls from floor to ceiling;

   c. Has a door that opens into a hallway or common area;

   d. Is constructed and furnished to provide unimpeded access to the door;

   e. Is not used as a passageway to another bedroom or a bathroom, unless the bathroom is for the exclusive use of ~~a~~ the patient occupying the bedroom; and

   f. Has sufficient lighting for a patient to read.

## ARTICLE 14. SUBSTANCE ABUSE TRANSITIONAL FACILITIES

**R9-10-1405. Personnel**

**A.** No change

1. No change
    a. No change
    b. No change
2. No change
3. No change
4. No change

**B.** No change

1. No change
    a. No change
        i. No change
        ii. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
2. No change
    a. No change
    b. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change
5. No change
6. No change
    a. No change
    b. No change
    c. No change
7. No change
8. No change
    a. No change
    b. No change
9. No change
    a. No change
    b. No change
    c. No change

**C.** No change

**D.** No change

1. No change

2. No change

**E.** No change

**F.** An administrator shall ensure that a personnel record is maintained for a personnel member, employee, volunteer, or student that contains:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. The individual's completion of the training required in subsection (B)(8), if applicable;
   f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   g. Cardiopulmonary resuscitation training, if required for the individual according to subsection (H) or policies and procedures;
   h. First aid training, if required for the individual according to subsection (H) or policies and procedures; and
   i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (D).
   j. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;

**G.** No change

1. No change
   a. No change
   b. No change
2. No change

**H.** No change

**I.** An administrator shall ensure that:

1. At least one personnel member is present and awake at a substance abuse transitional facility at all times when a participant is on the premises;
2. In addition to the personnel member in subsection (I)(1), at least one personnel member is on-call and available to come to the substance abuse transitional facility if needed;
3. A substance abuse transitional facility has sufficient personnel members to provide general participant supervision and treatment and sufficient personnel members or employees to provide ancillary services to meet the scheduled and unscheduled needs of each participant;
4. There is a daily staffing schedule that:
   a. Indicates the date, scheduled work hours, and name of each individual assigned to work, including on-call individuals;
   b. Includes documentation of the employees who work each day and the hours worked by each employee; and
   c. Is maintained for at least 12 months after the last date on the documentation;
5. A behavioral health professional is present on the substance abuse transitional facility's premises or on-call; ~~and~~
6. A registered nurse is present on the substance abuse transitional facility's premises or on-call~~.~~; and

7. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**R9-10-1406. Admission; Assessment**

An administrator shall ensure that:

1. A participant is admitted based upon the participant's presenting behavioral health issue and treatment needs and the substance abuse transitional facility's ability and authority to provide behavioral health services or physical health services consistent with the participant's needs;
2. General consent is obtained from a participant or the participant's representative before or at the time of admission;
3. The general consent obtained in subsection (2) is documented in the participant's medical record;
4. An assessment of a participant is completed or updated by an emergency medical care technician or a registered nurse;
5. If an assessment is completed or updated by an emergency medical care technician, a registered nurse reviews the assessment within 24 hours after the completion of the assessment to ensure that the assessment identifies the behavioral health services and physical health services needed by the participant;
6. If an assessment that complies with the requirements in this Section is received from a behavioral health provider other than the substance abuse transitional facility or the substance abuse transitional facility has a medical record for the participant that contains an assessment that was completed within 12 months before the date of the participant's current admission:
    a. The participant's assessment information is reviewed and updated if additional information that affects the participant's assessment is identified, and
    b. The review and update of the participant's assessment information is documented in the participant's medical record within 48 hours after the review is completed;
7. An assessment:
    a. Documents a participant's:
        i. Presenting issue;
        ii. Substance abuse history;
        iii. ~~Co-occurring disorder~~ Co-morbidity;
        iv. Medical condition and history;
        v. Behavioral health treatment history;
        vi. Symptoms reported by the participant; and
        vii. Referrals needed by the participant, if any;
    b. Includes:
        i. Recommendations for further assessment or examination of the participant's needs,
        ii. The behavioral health services and physical health services that will be provided to the participant, and
        iii. The signature and date signed of the personnel member conducting the assessment; and
    c. Is documented in participant's medical record;
8. A participant is referred to a medical practitioner if a determination is made that the participant requires immediate physical health services or the participant's behavioral health issue may be related to the participant's medical condition;
9. If a participant requires behavioral health services that the substance abuse transitional facility is not authorized or not able to provide, a personnel member arranges for the participant to be provided transportation to transfer to another health care institution where the behavioral health services can be provided;

10. A request for participation in a participant's assessment is made to the participant or the participant's representative;
11. An opportunity for participation in the participant's assessment is provided to the participant or the participant's representative;
12. Documentation of the request in subsection (10) and the opportunity in subsection (11) is in the participant's medical record; and
13. A participant's assessment information is:
    a. Documented in the medical record within 48 hours after completing the assessment, and
    b. Reviewed and updated when additional information that affects the participant's assessment is identified.

**R9-10-1412. Medication Services**

**A.** No change
1. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
    c. No change
    d. No change
    e. No change
    f. No change
2. No change
    a. No change
    b. No change

**B.** No change
1. No change
    a. No change
    b. No change
        i. No change
        ii. No change
    c. No change
    d. No change
2. No change
3. No change
    a. No change
    b. No change

**C.** No change
1. No change
2. No change
    a. No change

b. No change

c. No change

d. No change

i. No change

ii. No change

iii. No change

e. No change

3. No change

4. No change

a. No change

b. No change

i. No change

ii. No change

iii. No change

5. No change

6. No change

a. No change

b. No change

**D.** No change

1. No change

2. No change

**E.** When medication is stored at the substance abuse transitional facility, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;

2. Medication is stored according to the instructions of the medication container; and

3. Policies and procedures are established, documented, and implemented for:

a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;

b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;

c. A medication recall and notification of participants who received recalled medication;

d. Storing, inventorying, and dispensing controlled substances; ~~and~~

e. If applicable, donated medicine according to A.R.S. § 32-1909; and

~~e.~~f. Documenting the maintenance of a medication requiring refrigeration.

**F.** No change

**R9-10-1413. Food Services**

**A.** No change

1. No change

a. No change

b. No change

2. No change

a. No change

b. No change

3. No change

4. No change

**B.** A registered dietitian or director of food services shall ensure that:

1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a participant such as cut, chopped, ground, pureed, or thickened;
2. A food menu is:
   a. Prepared at least one week in advance,
   b. Conspicuously posted, and
   c. Maintained for at least 60 calendar days after the last day included in the food menu;
3. If there is a change to a posted food menu, the change is noted on the posted menu no later than the morning of the day the change occurs;
4. Meals and snacks provided by the substance abuse transitional facility are served according to posted menus;
5. Meals and snacks for each day are planned using the applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2010.asp~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
6. A participant is provided:
   a. A diet that meets the participant's nutritional needs as specified in the participant's assessment;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(6)(d);
   c. The option to have a daily evening snack identified in subsection (B)(6)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. The participant agrees; and
      ii. The participant is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
7. A participant requiring assistance to eat is provided with assistance that recognizes the participant's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
8. Water is available and accessible to participants at all times, unless otherwise stated in a participant's assessment.

**C.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
4. No change
5. No change
6. No change

## ARTICLE 15. ABORTION CLINICS

**R9-10-1515. Physical Plant Standards**

**A.** A licensee shall ensure that an abortion clinic complies with all local building codes, ordinances, fire codes, and zoning requirements. If there are no local building codes, ordinances, fire codes, or zoning requirements, the abortion clinic shall comply with the applicable codes and standards incorporated by reference in ~~A.A.C. R9-1-412~~ R9-10-104.01 that were in effect on the date the abortion ~~clinic's~~ clinic submitted the application including the notarized attestation of architectural plans according to R9-10-104 ~~and specifications were submitted to the Department for approval~~.

**B.** No change

1. No change
    a. No change
    b. No change
    c. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change

**C.** No change

## ARTICLE 17. UNCLASSIFIED HEALTH CARE INSTITUTIONS

**R9-10-1702. Administration**

**A.** No change

1. No change
2. No change
    a. No change
    b. No change
3. No change
4. No change
5. No change
6. No change
    a. No change
    b. No change
7. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
    a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers and students;
    b. Cover orientation and in-service education for personnel members, employees, volunteers and students;
    c. Include how a personnel member may submit a complaint relating to services provided to a patient;
    d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
    e. Cover cardiopulmonary resuscitation training, including:
        i. The method and content of cardiopulmonary resuscitation training,
        ii. The qualifications for an individual providing cardiopulmonary resuscitation training,
        iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
        iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
    f. Include a method to identify a patient to ensure the patient receives services as ordered;
    g. Cover first aid training;
    h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
    i. Cover specific steps for:
        i. A patient to file a complaint, and
        ii. The health care institution to respond to and resolve a patient complaint;
    j. Cover medical records, including electronic medical records;
    k. Cover a quality management program, including incident report and supporting documentation;
    l. Cover contracted services;

m. Cover health care directives; ~~and~~

n. Cover when an individual may visit a patient in a health care institution; and

o. Cover fall prevention and fall recovery that complies with requirements in A.R.S. § 36-420.01;

2. Policies and procedures for health care institution services are established, documented, and implemented to protect the health and safety of a patient that:

a. Cover patient screening, admission, assessment, treatment plan, transport, transfer, and discharge, if applicable;

b. Cover patient outings, if applicable;

c. Include when general consent and informed consent are required;

d. Cover the provision of services listed in the health care institution's scope of services;

e. Cover administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances, if applicable;

f. Cover infection control;

g. Cover ~~telemedicine~~ telehealth, if applicable;

h. Cover environmental services that affect patient care;

i. Cover smoking and the use of tobacco products on the health care institution's premises;

j. Cover how the health care institution will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;

k. Cover how incidents are reported and investigated; and

l. Designate which employees or personnel members are required to have current certification in cardiopulmonary resuscitation and first aid training;

3. Policies and procedures are reviewed at least once every three years and updated as needed;

4. Policies and procedures are available to personnel members, employees, volunteers, and students; and

5. Unless otherwise stated:

a. Documentation required by this Article is provided to the Department within two hours after the Department's request; and

b. When documentation or information is required by this Chapter to be submitted on behalf of a health care institution, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the health care institution.

**D.** No change

1. No change

2. No change

**E.** No change

1. No change

2. No change

**F.** No change

1. No change

2. No change

**G.** No change

1. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

4. No change

5. No change

a. No change

b. No change

c. No change

d. No change

6. No change

**H.** No change

1. No change

2. No change

3. No change.

**R9-10-1704. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article,

2. ~~Documented~~ Documentation of current contracted services ~~is maintained~~ that includes a description of the contracted services provided is maintained.

**R9-10-1705. Personnel**

**A.** No change

1. No change

a. No change

b. No change

2. No change

3. No change

4. No change

**B.** No change

1. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

iii. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

**C.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
   c. No change
4. No change
5. No change
   a. No change
   b. No change
   c. No change
6. No change

**D.** No change

a. No change

b. No change

**E.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. If the health care institution provides ~~serves~~ services to children, the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03;
   f. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-1702(C)(2)(l);
   g. First aid training, if required for the individual according to this Article or policies and procedures; and
   h. Evidence of freedom from infectious tuberculosis, if the individual is required to provide evidence of freedom according to subsection (D).

**F.** No change

1. No change
   a. No change
   b. No change
2. No change

**G.** No change

**H.** An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**R9-10-1706. Transport; Transfer**

**A.** No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
3. No change
    a. No change
    b. No change
    c. No change
    d. No change

**B.** No change

1. No change
2. No change
3. No change
4. No change

**C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
    a. An evaluation of the patient is conducted before the transfer;
    b. Information in the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
    c. A personnel member explains the risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
    a. Communication with an individual at a receiving health care institution;
    b. The date and time of the transfer;
    c. The mode of transportation; and
    d. If applicable, the name of the personnel member accompanying the patient during a transfer.

**R9-10-1709. Medication Services**

**A.** An administrator shall ensure that:

1. Policies and procedures for medication services include:
    a. A process for providing information to a patient about medication prescribed for the patient including the prescribed medications:
        i. ~~The prescribed medication's anticipated~~ Anticipated results,
        ii. ~~The prescribed medication's potential~~ Potential adverse reactions,
        iii. ~~The prescribed medication's potential~~ Potential side effects, and
        iv. Potential adverse reactions that could result from not taking the medication as prescribed;
    b. Procedures for preventing, responding to, and reporting a medication error;
    c. Procedures for responding to and reporting an unexpected reaction to a medication;
    d. Procedures to ensure that a patient's medication regimen and method of administration is reviewed by a medical practitioner and to ensure the medication regimen meets the patient's needs;
    e. Procedures for:

i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and

ii. Monitoring a patient who self-administers medication;

f. Procedures for assisting a patient in obtaining medication; and

g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and

2. A process is specified for review through the quality management program of:

a. A medication administration error, and

b. An adverse reaction to a medication.

**B.** No change

1. No change

2. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

d. No change

3. No change

4. No change

a. No change

b. No change

**C.** No change

1. No change

2. No change

a. No change

b. No change

c. No change

d. No change

i. No change

ii. No change

iii. No change

e. No change

3. No change

4. No change

a. No change

b. Includes:

i. No change

ii. No change

iii. No change

5. No change

6. No change

a. No change

b. No change

**D.** No change

1. No change
2. No change
3. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   b. No change
   c. No change
   d. No change

**E.** When medication is stored at a health care institution, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of patients who received recalled medication; ~~and~~
   d. Storing, inventorying, and dispensing controlled substances~~.~~;
   e. If applicable, donated medicine according to A.R.S. § 32-1909.

**F.** No change

**R9-10-1712. Physical Plant, Environmental Services, and Equipment Standards**

**A.** If applicable, an administrator shall ensure that a health care institution:

1. Is in a building that:
   a. Has a certificate of occupancy from the local jurisdiction; and
   b. Is free of any plumbing, electrical, ventilation, mechanical, or structural hazard that may jeopardize the health or safety of a patient;
2. Has a living room accessible at all times to a patient;
3. Has a dining area furnished for group meals that is accessible to the provider, patients, and any other individuals present in the health care institution;
4. Has:
   a. At least one bathroom for ~~each~~ every six individuals residing in the health care institution, including patients; and
   b. A bathroom accessible for use by a patient that contains:
      i. A working sink with running water, and
      ii. A working toilet that flushes and has a seat; and
5. Has equipment and supplies to maintain a patient's personal hygiene that are accessible to the patient.

**B.** No change

1. No change
    a. No change
    b. No change
    c. No change
    d. No change
2. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
        v. No change
        vi. No change
        vii. No change
    b. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change
5. No change
6. No change
    a. No change
    b. No change
7. No change
    a. No change
    b. No change
    c. No change
    d. No change
8. No change
9. No change

## ARTICLE 19. COUNSELING FACILITIES

**R9-10-1903. Administration**

**A.** No change

1. No change
2. No change
   a. No change
   b. No change
3. No change
4. No change
5. No change
6. No change
   a. No change
   b. No change
7. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator or the administrator of the counseling facility's affiliated outpatient treatment center shall establish policies and procedures to protect the health and safety of a patient that:

1. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience, for personnel members, employees, volunteers, and students;
2. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
3. Include how a personnel member may submit a complaint relating to services provided to a patient;
4. Cover the requirements in Title 36, Chapter 4, Article 11;
5. Cover patient screening, admission, assessment, discharge planning, and discharge;
6. Cover medical records;
7. Cover the provision of counseling and any services listed in the counseling facility's scope of services;
8. Include when general consent and informed consent are required;
9. Cover ~~telemedicine~~ telehealth, if applicable;
10. Cover specific steps for:
    a. A patient or a patient's representative to file a complaint, and
    b. A counseling facility to respond to a complaint; and
11. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual.

**D.** No change

1. No change
2. No change
   a. No change
   b. No change
3. No change

a. No change

b. No change

4. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

5. No change

a. No change

b. No change

6. No change

**E.** No change

1. No change

2. No change

**F.** No change

1. No change

2. No change

a. No change

b. No change

3. No change

a. No change

b. No change

c. No change

4. No change

5. No change

a. No change

b. No change

c. No change

d. No change

6. No change

**R9-10-1909. Counseling**

**A.** No change

1. No change

2. No change

3. No change

**B.** An administrator of a counseling facility shall ensure that:

1. Before counseling for a patient is initiated, there is a behavioral health assessment for the patient that complies with the requirements in this Section that is:

a. Available:

i. In the patient's medical record maintained by the counseling facility;

ii. If the counseling facility is an affiliated counseling facility, in the patient's integrated medical record; or

iii. If the counseling facility has an affiliated outpatient treatment center, in the patient's integrated medical record maintained by the counseling facility's affiliated outpatient treatment center; and

b. Either:

i. Completed by a personnel member at the counseling facility; or

ii. Obtained from a behavioral health provider other than the counseling facility;

2. A behavioral health assessment, obtained from a behavioral health provider other than the counseling facility or available in a medical record or integrated medical record, was completed within 12 months before the date of the patient's current admission;

3. If a behavioral health assessment is obtained from a behavioral health provider other than the counseling facility or is available as stated in subsection (B)(1)(a), the information in the behavioral health assessment is reviewed and updated if additional information that affects the patient's behavioral health assessment is identified;

4. The review and update of the patient's assessment information in subsection (B)(3) is documented in the patient's medical record within 48 hours after the review is completed;

5. If a behavioral health assessment is conducted by a:

a. Behavioral health technician or a registered nurse, within 72 hours after the behavioral health assessment is conducted, a behavioral health professional certified or licensed to provide the counseling needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the counseling needed by the patient; or

b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the counseling needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the counseling needed by the patient;

6. A behavioral health assessment:

a. Documents a patient's:

i. Presenting issue;

ii. Substance use history;

iii. ~~Co-occurring disorder~~ Co-morbidity;

iv. Medical condition and history;

v. Legal history, including:

(1) Custody,

(2) Guardianship, and

(3) Pending litigation;

vi. Criminal justice record;

vii. Family history;

viii. Behavioral health treatment history; and

ix. Symptoms reported by the patient or the patient's representative and referrals needed by the patient, if any;

b. Includes:

i. Recommendations for further assessment or examination of the patient's needs;

ii. A description of the counseling, including type, frequency, and number of hours, that will be provided to the patient; and

iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and

c. Is documented in patient's medical record;

7. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;

8. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;

9. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;

10. Documentation of the request in subsection (B)(8) and the opportunity in subsection (B)(9) is in the patient's medical record;

11. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;

12. If information in subsection (B)(6)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;

13. Counseling is:

a. Offered as described in the counseling facility's scope of services;

b. Provided according to the type, frequency, and number of hours identified in the patient's assessment; and

c. Provided by a behavioral health professional or a behavioral health technician;

14. A personnel member providing counseling to address a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and

15. Each counseling session is documented in the patient's medical record to include:

a. The date of the counseling session;

b. The amount of time spent in the counseling session;

c. Whether the counseling was individual counseling, family counseling, or group counseling;

d. The treatment goals addressed in the counseling session; and

e. The signature of the personnel member who provided the counseling and the date signed.

**C.** No change

1. No change

2. No change

3. No change

4. No change

**D.** No change

1. No change

2. No change

## ARTICLE 22. NURSING-SUPPORTED GROUP HOMES

**R9-10-2203. Administration**

**A.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
4. No change
5. No change
6. No change
   a. No change
   b. No change
7. No change
   a. No change
   b. No change

**B.** No change

1. No change
2. No change
3. No change
4. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover the process for checking on a personnel member through the adult protective services registry, established according to A.R.S. § 46-459, or the central registry, established according to A.R.S. § 8-804, as applicable;
   c. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   d. Include methods to prevent abuse or neglect of a resident, including:
      i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
      ii. Reporting of abuse or neglect of a resident;
   e. Include how a personnel member may submit a complaint relating to resident care;
   f. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   g. Cover cardiopulmonary resuscitation training including:
      i. Which personnel members are required to obtain cardiopulmonary resuscitation training;

ii. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the ability to perform cardiopulmonary resuscitation;

iii. The qualifications for an individual to provide cardiopulmonary resuscitation training;

iv. The time-frame for renewal of cardiopulmonary resuscitation training; and

v. The documentation that verifies an individual has received cardiopulmonary resuscitation training;

h. Cover first aid training;

i. Include a method to identify a resident to ensure the resident receives physical health services, habilitation services, and behavioral care as ordered;

j. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;

k. Cover specific steps for:

i. A resident to file a complaint, and

ii. The nursing-supported group home to respond to a resident's complaint;

l. Cover health care directives;

m. Cover medical records, including electronic medical records;

n. Cover a quality management program, including incident reports and supporting documentation;

o. Cover contracted services;

p. Cover resident's personal accounts;

q. Cover petty cash funds;

r. If the nursing-supported group home may admit a resident who is not placed in the nursing-supported group home by the Division, cover:

i. Fees and the process for receiving a fee for a resident,

ii. The reasons and process for terminating residency, and

iii. The process for refunding a fee for a resident;

s. Cover smoking and the use of tobacco products on the premises;

t. Cover the storage and use of alcoholic beverages on the premises; and

u. Cover when an individual may visit a resident in a nursing-supported group home;

2. Policies and procedures for physical health services, habilitation services, and behavioral care are established, documented, and implemented to protect the health and safety of a resident that:

a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;

b. Cover the provision of physical health services, habilitation services, and behavioral care;

c. Cover acuity, including a process for obtaining sufficient nursing personnel and other personnel members to meet the needs of residents;

d. Include when general consent and informed consent are required;

e. Cover storing, dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;

f. Cover infection control;

g. Cover interventions to address a resident's inappropriate behavior, including:

i. The hierarchy for use;

ii. Use of time-outs for inappropriate behavior; and

iii. Except in an emergency, require positive techniques for behavior modification to be used before more restrictive methods are used;

h. Cover restraints, both chemical restraints and physical restraints if applicable, that:
   i. Require an order, including the frequency of monitoring and assessing the restraint; and
   ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a resident's sudden, intense, or out-of-control behavior;
i. Cover ~~telemedicine~~ telehealth, if applicable;
j. Cover environmental services that affect resident care;
k. Cover the security of a resident's possessions that are allowed on the premises;
l. Cover methods to encourage participation of a resident's family or friends or other individuals in activities planned according to R9-10-2210(B);
m. Include a method for obtaining an advocate for a resident, if necessary;
n. Cover resident outings;
o. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks; and
p. Cover whether pets and animals are allowed on the premises, including procedures to ensure that any pets or animals allowed on the premises do not endanger the health or safety of residents or the public;

3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a nursing-supported group home, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the nursing-supported group home.

**D.** No change
1. No change
2. No change

**E.** No change
1. No change
2. No change
   a. No change
   b. No change
3. No change
   a. No change
   b. No change
   c. No change
4. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
6. No change

**F.** An administrator shall:

1. Allow a resident advocate to assist a resident or the resident's representative with a request or recommendation, and document in writing any complaint submitted to the nursing-supported group home;
2. Ensure that a monthly schedule of recreational activities for residents is developed, documented, and implemented; and
3. Ensure that the following are conspicuously posted on the premises:
    a. The current nursing-supported group home license issued by the Department;
    b. The name, address, and telephone number of:
        i. The Department's Bureau of ~~Long Term Care~~ Assisted Living Facilities Licensing;
        ii. Adult Protective Services of the Department of Economic Security; and
        iii. If applicable, Child Protective Services of the Department of Child Safety;
    c. A notice that a resident may file a complaint with the Department concerning the nursing-supported group home;
    d. The monthly schedule of recreational activities; and
    e. One of the following:
        i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect; or
        ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.

**G.** No change
1. No change
2. No change

**H.** No change
1. No change
    a. No change
    b. No change
    c. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change

**I.** No change
1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change

**J.** No change

1. No change
    a. No change
    b. No change
2. No change

**K.** No change

1. No change
    a. No change
    b. No change
2. No change
3. No change

**L.** No change

1. No change
2. No change
3. No change

**M.** No change

**R9-10-2206. Personnel**

**A.** No change

1. No change
    a. No change
    b. No change
2. No change
3. No change
4. No change

**B.** No change

1. No change
    a. No change
        i. No change
        ii. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
2. No change
    a. No change
    b. No change
3. No change
    a. No change
    b. No change
    c. No change

**C.** No change

1. No change
2. No change

**D.** No change

**E.** No change

**F.** No change

1. No change
2. No change

**G.** No change

1. No change
2. No change
   a. No change
   b. No change
   c. No change
   d. No change
3. No change

**H.** No change

**I.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's compliance with the requirements in A.R.S. § 36-411;
   d. The nursing-supported group home's check on the individual in the adult protective services registry, established according to A.R.S. § 46-459, or the central registry, established according to A.R.S. § 8-804, as applicable;
   e. Orientation and in-service education as required by policies and procedures;
   f. Training in preventing, recognizing, and reporting abuse or neglect, required according to R9-10-2203(C)(1)(d)(i);
   g. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   h. If applicable, the individual's qualifications and on-going training for each type of restraint used, as required in R9-10-2217;
   i. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-2203(C)(1)(g);
   j. First aid training, if required for the individual according to this Article or policies and procedures; ~~and~~
   k. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F)~~.~~; and
   l. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training

**J.** No change

1. No change
   a. No change
   b. No change
2. No change

**K.** An administrator shall ensure that:

1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
2. A personnel member completes orientation before providing physical health services, habilitation services, or behavioral care;
3. An individual's orientation is documented, to include:
    a. The individual's name,
    b. The date of the orientation, and
    c. The subject or topics covered in the orientation;
4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;
5. A personnel member's in-service education is documented, to include:
    a. The personnel member's name,
    b. The date of the training, and
    c. The subject or topics covered in the training; and
6. A work schedule of each personnel member is developed and maintained at the nursing-supported group home for at least 12 months after the date of the work schedule.

**L.** An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**R9-10-2221. Medication Services**

**A.** No change
1. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
    c. No change
    d. No change
    e. No change
2. No change
    a. No change
    b. No change

**B.** No change
1. No change
    a. No change
    b. No change
        i. No change
        ii. No change
    c. No change

d. No change

2. No change

3. No change

a. No change

b. No change

4. No change

a. No change

b. No change

**C.** No change

1. No change

2. No change

a. No change

b. No change

c. No change

d. No change

i. No change

ii. No change

iii. No change

e. No change

3. No change

4. No change

a. No change

b. No change

i. No change

ii. No change

iii. No change

5. No change

6. No change

a. No change

b. No change

**D.** No change

1. No change

2. No change

a. No change

b. No change

c. No change

**E.** When medication is stored at a nursing-supported group home, an administrator shall ensure that:

1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;

2. Medication is stored according to the instructions on the medication container; and

3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for:

a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;

b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;

c. A medication recall and notification of residents who received recalled medication; and

d. Storing, inventorying, and dispensing controlled substances.

e. If applicable, donated medicine according to A.R.S. § 32-1909.

**F.** No change


**TITLE 9. HEALTH SERVICES**

**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES -**
**HEALTH CARE INSTITUTIONS: LICENSING**

# ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

**February 2025**

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**
**TITLE 9. HEALTH SERVICES**
**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES -**
**HEALTH CARE INSTITUTIONS: LICENSING**

## 1. An identification of the rulemaking

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions (HCIs). In order to ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 require the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions. The Department has adopted rules to implement these statutes in Arizona Administrative Code Title 9, Chapter 10. The Department plans to amend the rules to align with the following statutory changes: Laws 2021, Ch. 320, related to definitions regarding telehealth; Laws 2022, Ch. 128, requires the Department to make exemptions of certain outpatient treatment centers from licensing requirements; Laws 2022, Ch. 179, requires the Department to ensure a healthcare institution's visitation policy allows a clergy member to visit a resident; Laws 2022, Ch. 296, requires the Department to ensure a hospital develops a visitation policy, especially during end-of-life care; Laws 2022, Ch. 34, amends the requirements for architectural plans and specifications for health care institutions construction or modifications; Laws 2022, Ch. 190, requires the Department to ensure a health care institution develops a written workplace violence prevention plan to assist in the decrease of assaults on health care workers; Laws 2022, Ch. 57, requires the Department to adopt rules that relate to outpatient surgical centers requiring policies related to surgical smoke evacuation; and Laws 2021, Ch. 363, related to staffing and approvals of surgical discharges from facility premises. The Department also plans to address policies and procedures for the use of naloxone; be consistent with other statutory provisions or legislation including: A.R.S. § 32-1909 regarding donated medicine; A.R.S. § 36-420 regarding CPR and first aid; A.R.S. § 11-593 regarding reporting a death; and A.R.S. §§ 13-3620 and 46-454 regarding reporting abuse, neglect, or exploitation; and making other changes necessary for the proper administration and enforcement of the laws relating to public health to promote continuity and improve patient outcomes. After receiving rulemaking approval pursuant to A.R.S. § 41-1039, the Department began rulemaking to adhere to the statutory changes identified above, address issues identified in recent five-year review reports approved by the Governor's Regulatory Review Council (GRRC), and make the rules clearer and more concise and understandable. The Department anticipates that the rules may increase the regulatory burden or cost on some affected persons. However, the Department believes that the benefits of the rules will far outweigh any potential cost. Any proposed changes will conform to rulemaking format and style requirements of GRRC and the Office of the Secretary of State.

## 2. Cost/Benefit Analysis

This analysis covers the costs and benefits associated with the rule changes related to implementing new legislation, updating rules, and making other changes necessary for the proper administration and enforcement of the laws relating to public health to promote continuity and improve patient outcomes. The annual cost and revenue changes are designated as minimal when $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. Costs are listed as significant when meaningful or important, but not readily subject to quantification.

## 3. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rules

a. The Department
b. HCIs
c. The General Public

## A. The Department

A.R.S. §§ 36-3201 and 36-405 requires the Department to adopt rules that establish minimum standards and requirements for constructing, modifying and licensing health care institutions to ensure the public health, safety and welfare. Prescribed standards and requirements for health care institutions must pertain to the construction, equipment, sanitation and staffing of the institution and be in accordance with generally accepted practices of health care. An HCI is any place, institution, building or agency that provides facilities with medical services, nursing services, behavioral health services, health screening services, other health-related services, supervisory care services, personal care services, or directed care services and includes home health agencies, outdoor behavioral health care programs and hospice service agencies.

The proposed amendments seek to align the rules with recent statutory changes, including creating a new subclass for secured behavioral health residential facilities to improve rule effectiveness. They address policies and procedures for naloxone use and ensure consistency with other statutory provisions, such as those related to donated medicine, CPR and first aid, reporting deaths, and reporting abuse, neglect, or exploitation. Additionally, the changes respond to issues identified in recent five-year-review reports by the Governor's Regulatory Review Council, including clarifying and simplifying the rules, updating cross-references, correcting grammatical errors, and improving public health administration and patient outcomes.

Key amendments include establishing standards for outpatient surgical centers regarding the presence of physicians during discharges and implementing smoke evacuation systems to prevent exposure to surgical smoke. The Department is also updating rules to accommodate new requirements for architectural plans, exempt

certain outpatient treatment centers from licensure, and mandate the development of workplace violence prevention plans. Furthermore, the amendments address policies for clergy and visitor access in hospitals, update terminology from "telemedicine" to "telehealth," and revise dietary guidelines. These changes will require updates to multiple Articles in Chapter 10, ensuring the rules are clear, concise, and consistent with current statutes. These modifications aim to enhance public health administration, promote patient safety, and ensure compliance with state regulations.

The rule amendments are expected to have various cost implications. Primarily, the Department will need to invest in training and educating staff and stakeholders on the new statutory requirements and updated processes. This includes ensuring compliance with new safety standards, such as the implementation of smoke evacuation systems and the development of workplace violence prevention plans. Additionally, there will be administrative costs associated with updating forms, records, and internal systems to reflect the changes, as well as public awareness efforts to inform healthcare providers and the public. The Department will also need to allocate resources for monitoring and reporting compliance, particularly concerning new reporting requirements for visitation policies and prescription medication donations. Moreover, the rulemaking process itself, including legal and procedural expenses, will contribute to the overall cost. The Department expects to incur minimal to no costs to implement the new rules and ensure that HCIs are in compliance with the new rules. The Department believes that the proposed rule amendments are essential for maintaining public health standards, ensuring patient safety, and complying with state regulations.

**B. HCIs**

The proposed amendments to the Department's rules are designed to align with recent statutory changes and address various issues identified in regulatory reviews. These updates aim to improve the effectiveness and clarity of existing regulations, ensure consistency with other laws, and enhance public health and safety. Key areas of focus include the establishing a secured behavioral health residential facility as a new HCI subclass, outpatient surgical centers, and workplace violence prevention. Additionally, the amendments will update terminology, clarify procedural guidelines, and make necessary adjustments to reflect the latest public health policies and practices. By implementing these changes, the Department seeks to promote better compliance, streamline administrative processes, and ultimately improve patient care and outcomes.

Laws 2021, Ch. 363, related to surgical discharges, amends A.R.S. § 36-405 and establishes that minimum standards prescribed for health care institutions must permit outpatient surgical centers to require the presence of specified physicians or anesthesia providers until all patients have been discharged. The new requirements establish standards prescribed for an HCI to require specified physicians to medically discharge patients from surgery; and allow outpatient surgical centers to require the presence of a licensed anesthesia

provider or a licensed physician on the premises of the surgical center until all patients have been discharged from the recovery room. Due to these changes, the Department is amending language in R9-10-911.

Laws 2022, Ch. 34, related to architectural plans and specifications, amends A.R.S. §§ 36-405, 36-421, and 36-422. The new statutory changes remove the requirement that an HCI license application include architectural plans and specifications and instead requires a notarized attestation from a licensed architect that verifies architectural plans meet or exceed the Department's standards. In addition, the new statutory changes repeals the Department's authority to establish fees for architectural plans and specifications reviews. Due to these changes, the Department is amending language in R9-10-104, R9-10-105, R9-10-106, R9-10-108, Table 1.1, R9-10-110, R9-10-918, R9-10-1018, R9-10-1117, and R9-10-1515. The Department anticipates that the new changes will provide a significant benefit to HCIs.

Laws 2022, Ch. 57, related to outpatient surgical centers: surgical smoke evacuation system, amends A.R.S. § 36-434.01. The new legislation requires outpatient surgical centers and hospitals to adopt and implement policies to prevent exposure to surgical smoke by using a smoke evacuation system for each procedure generating surgical smoke. The Department is required to ensure compliance with smoke evacuation system use during onsite inspections and in response to any complaint received relating to the system. Due to these changes, the Department is amending language in R9-10-902.

Laws 2022, Ch. 128, related to outpatient treatment centers exemption, amends A.R.S. §§ 32-1651, 36-401, 36-402, 36-422, 36-439, 36-439.01, 36-439.04 and 36-439.05. The new changes exempt outpatient treatment centers that have the same governing authority as a licensed hospital from Department licensure, supervision, regulation, and control. Due to these changes, the Department is amending language in R9-10-203.

Laws 2022, Ch. 179 and Laws 2022, Ch. 296, both related to visitation policy, establish A.R.S. § 36-407.02. The new statute requires hospitals to develop a visitation policy that allows a patient to have daily in-person visitation by a designated visitor of the patient's choice, including the patient's spouse, parent or child. If a physician denies visitation, the patient or the patient's representative may request a meeting with the physician and one of the outlined hospital officials to receive a review and provide an explanation within 24 hours of the decision to deny visitation. Additionally, the statute requires health care institutions to allow clergy members to visit a resident if the healthcare institution's visitation policy allows any kind of in-person visitation or when a resident's death is imminent. A hospital's visitation policy must ensure that the patient and the patient's visitors may have physical contact, especially during end-of-life visitation, unless a physician determines based on the patient's condition that the visitation does not meet health and safety standards or is reasonably likely to harm the patient. A visitor may file a complaint with the Department if the designated visitor's request for visitation is denied or not resolved at the meeting with hospital officials. Due to these changes, the Department is amending language in R9-10-403.

Laws 2022, Ch. 190, related to a workplace violence prevention plan, amends A.R.S. § 36-420.02. The new legislation requires health care employers to develop, implement and maintain a written workplace violence prevention plan. The prevention plan should include: a) components specifically tailored to the conditions and hazards of the health care employer's sites and patient-specific risk factors; b) the identity of the individual responsible for implementing and overseeing the plan; c) the requirements of conspicuous posting of signs in public areas throughout the health care employer's sites, including all emergency facilities, that are at least 12 inches by 12 inches in size and that provide notice that assault on a health care worker may be prosecuted as a felony; d) the reporting procedures, incident response procedures and post incident investigation procedures; and e) require health care employers to provide information to health care workers about a worker's ability to report any assault to law enforcement and, on request, to assist the worker in reporting the assault. A person commits an aggravated assault if the person commits the assault under outlined circumstances, including if the person: 1) causes serious physical injury to another; 2) uses a deadly weapon or dangerous instrument; 3) commits the assault by any means of force that causes temporary but substantial disfigurement, temporary but substantial loss or impairment of any body organ or part, or a fracture of any body part; and 4) commits the assault knowing or having reason to know that the victim is a certified or licensed health care practitioner or a person summoned and directed by the licensed health care practitioner while engaged in the person's professional duties. A certified or licensed health care practitioner includes a licensed or certified physician, nurse, osteopathic physician or surgeon, or a physician's assistant. The assault on a certified or licensed health care practitioner is not an aggravated assault if the person who commits the assault is seriously mentally ill or is afflicted with Alzheimer's disease or related dementia. A person commits aggravated assault if the person commits assault by: 1) intentionally, knowingly or recklessly causing any physical injury to another person; 2) intentionally placing another person in reasonable apprehension of imminent physical injury; or 3) knowingly touching another person with the intent to injure the person. Due to these changes, the Department is amending language in R9-10-1027.

The Arizona State Board of Pharmacy has established a Prescription Medication Donation Program (Program) to accept and dispense prescription medications, HCIs that opt-in to the Program and meet prescribed criteria may accept donated medications. Laws 2021, Ch. 137, related to medical donation, amends A.R.S. § 32-1909. The bill establishes requirements and prohibitions for donating, accepting, and dispensing donated prescription medications. Statute requires that prescription medications be accepted or dispensed by the Program only in the original, sealed and tamper-evident unit dose packaging, except that opened prescription medications packaged in single unit doses can be accepted and dispensed if the single unit dose packaging is undisturbed. Prescription donations cannot be accepted if the medication expires within six months or if the medication is deemed to be adulterated. The Department is amending rules in Chapter 10 to require that when medication is stored, an administrator shall ensure that policies and procedures are established, documented, and implemented

to protect the health and safety of a resident for receiving medical donation, in compliance with A.R.S. § 32-1909. Sections R9-10-320, R9-10-218, R9-10-421, R9-10-613, R9-10-914, R9-10-1010, R9-10-1412, R9-10-1709.

In addition to updating the rules to align with new statutory changes, the Department is making other changes to the rules to improve the effectiveness of rules, make the rules more clear, concise, and understandable, address issues identified in recent five-year review reports, and correct cross-references and grammatical errors throughout this rulemaking for Chapter 10. Laws 2021, Ch. 320, amended the definitions in A.R.S. § 36-3601 regarding telehealth in the state of Arizona. There was a change of language in this legislation, where “telemedicine” is now defined using the term “telehealth.” Several Sections of Chapter 10 were amended to update “telemedicine” to “telehealth,” including R9-10-101, R9-10-203, R9-10-303, R9-10-403, R9-10-1003, R9-10-1702, R9-10-1903, and R9-10-2203. Another update the Department made in several Sections for this rulemaking is updating the meal and snack guidelines to the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture. Sections that included these amendments are R9-10-321, R9-10-423, R9-10-1114, R9-10-1314, and R9-10-1413.

In Article 1, General, the Department is amending 15 Sections and one Table to update the rules, correct grammatical errors, and implement new statutory changes. In R9-10-101, Definitions, the Department is amending several terms to update the language, correct grammatical errors, and update cross-references. The Department is amending the definition of an “outing” to a social or recreational activity that is longer than two hours rather than four hours. The previous four-hour timeframe was too long and did not adequately cover shorter outings, which are common in many facilities. By lowering the threshold to two hours, the Department ensures that all outings, regardless of duration, are subject to regulatory oversight, thereby enhancing the safety and well-being of participants. This change also reflects a more accurate representation of typical outing durations, ensuring that facilities maintain appropriate staffing and supervision levels for all activities. Importantly, since facilities are already required to have sufficient staff for outings, this amendment does not impose additional staffing burdens but instead clarifies existing obligations, ensuring that all outings, regardless of length, are conducted safely and in compliance with regulatory standards. The Department is also creating two new definitions for “psychiatric services” and “secure behavioral health residential facility.” By defining "psychiatric services," the Department can more precisely delineate the scope and nature of the mental health care provided, which helps in setting appropriate standards and guidelines for these services. Similarly, defining "secure behavioral health residential facility" establishes a clear distinction between this type of facility and other healthcare or residential facilities. This definition helps in specifying the unique security and care requirements for these facilities, which are designed to provide a safe and structured environment for individuals with significant behavioral health needs. It also aids in regulatory oversight, ensuring that facilities meeting this definition adhere to specialized standards that protect the safety and well-being of both residents and staff. In

addition, the Department is amending the definition of a "behavioral health professional" to include that the licensed professionals that provide services specifically within the scope of practices defined by their profession. Furthermore, the Department is adding a psychiatric physician assistant to the list of licensed professionals who may be a behavioral health professional. This change is expected to open the options and availability of who may become a behavioral health professional, and provide a significant benefit to behavioral health services. Overall, these new definitions enhance the effectiveness and enforceability of regulations, contributing to improved care quality and patient safety within the state's healthcare system. The Department expects costs related to the new changes in definitions to be minimal, and HCIs to significantly benefit from having updated and clearer rules.

In R9-10-102, *Health Care Institution Classes and Subclasses; Requirements*, the Department is adding an exemption for an outpatient treatment center, pursuant to A.R.S. § 36-402. In compliance with Laws 2022, Ch. 352, the Department is adding a secure behavioral health residential facility as a subclass of an HCI. Furthermore, the Department is amending the rules in R9-10-104.01 for *Codes and Standards* to update to the International Fire Code reference to the physical plant health and safety codes and standards adopted by the Office of the State Fire Marshal. The Department expects that HCIs will receive a significant benefit from having updated rules and regulations, along with moderate savings in costs related to implementing A.R.S. § 36-402. HCIs may also receive a significant benefit from having a new subclass for a secure behavioral health residential facility.

In R9-10-105, *License Application*, the Department is adding a requirement for if the owner is a sole proprietor, a copy of the applicant's U.S. passport, current or expired; a birth certificate; naturalization documents; or documentation of legal resident alien status. The Department is also simplifying the rule to clarify the requirement of having documentation from the property owner that approves the health care institution to operate on the specified leased property. Subsection (A)(5) is being amended to add an exception for nursing supported group homes in compliance with Laws 2021, Ch. 60, which amended A.R.S. § 36-421. The new legislation does not require nursing supported group homes to comply with zoning standards for a health care institution. In R9-10-107, *Submission of Health Care Institution Licensing Fees*, the Department is removing the obsolete requirement for a licensee to submit to the Department verification of the information in the Department's current records for the HCI. In R9-10-109, *Changes Affecting a License*, the Department is removing subsection (E) regarding accreditation to align with Laws 2021 Ch. 15 § 1, which amended A.R.S. § 36-424(B). Also, in R9-10-109, the Department is removing the terms "on the premises" so that all HCI's have to submit an application for a change of address. The current rules exclude home health/hospice from having to submit an application for change of location. The Department estimates that this change would be minimal for HCIs to submit a change application to the Department, and the Department may incur minimal costs to process the additional change applications.

In addition, the Department is creating a new subsection to allow for a licensee to obtain a duplicate license. In R9-10-110, *Modification of a Health Care Institution,* the Department is removing language referring to an application packet since everything is now online. In addition, the Department is adding a new subsection to clarify that a licensee shall submit the applicable fee according to R9-10-106. In R9-10-112, *Denial, Revocation, or Suspension of License*, the Department is creating a new subsection allowing the Department to deny, revoke, or suspend a license to operate a health care institution if an applicant, a licensee, or a controlling person of the health care institution has operated a health care institution without seeing a patient within twelve months.

In Article 2, Hospitals, the Department is amending eight Sections. In R9-10-201, *Definitions*, four obsolete terms are being removed, and the definition of the term, "nurse anesthetist" to have the same meaning as "certified registered nurse anesthetist" in A.R.S. § 32-1601. In R9-10-202, *Supplemental Application, Notification, and Documentation Submission Requirements*, the rule is being amended to incorporate the definition of the term "specialty" since this is the only place the term is used. Several changes were made in R9-10-203, R9-10-212, R9-10-215, and R9-10-234 to adhere to new statutory changes, as previously described. Also, the Department is amending R9-10-209 to require that the discharge or transfer information required in A.R.S. § 36-420.04, if applicable.

The Department is amending four Sections in Article 3 for Behavioral Health Inpatient Facilities. In R9-10-303, *Administration*, a new subsection is being added for the administrator to ensure that policies and procedures include methods to prevent abuse or neglect of a patient. In Article 4 for Nursing Care Institutions, the Department is amending nine Sections to provide clarification, correct grammatical errors, and cross-references. R9-10-402, *Supplemental Application Requirements*, is being amended to add a reference to the "documentation." In R9-10-403, *Administration*, the Department is adding reference to the training required in A.R.S. § 36-420.01 and creating a new subsection for policies and procedures to include methods to prevent abuse or neglect of a resident. In addition, the Department is amending language to be more consistent with other rules and include training on the circumstances for providing first aid or CPR to a resident, consistent with A.R.S. § 36-420(B). In Article 9, *Outpatient Surgical Centers*, the Department is amending six Sections to add new statutory changes in R9-10-901, R9-10-902, R9-10-905, R9-10-911, R9-10-914, and R9-10-918 and make other changes consistent with Chapter 10. In R9-10-901, *Definitions*, the Department is amending the definition of a "surgical suite" to include one or more procedure rooms. Also in R9-10-911, *Surgical Services*, the Department is amending the rules to allow for an individual authorized under A.R.S. Title 32, Chapter 13, 15, or 17 to administer anesthesia. The Department expects the new changes to R9-10-911 will significantly benefit an outpatient surgical center by expanding who can administer anesthesia. The Department expects the new changes to R9-10-911 will significantly benefit an outpatient surgical center by expanding the scope of who can administer anesthesia.

In Article 10, *Outpatient Treatment Centers*, the Department is amending eleven Sections. In R9-10-1011, *Behavioral Health Services*, the Department is amending the rule to clarify the difference between an outpatient treatment center and a counseling facility by adding a medication component to the behavioral health assessment including prescribing medication to treat or manage a mental health or substance abuse condition. In R9-10-1017, *Diagnostic Imaging Services*, the Department is amending the language from "a copy of a certificate documenting" to "written documentation of", as the Department does not require a certificate from the administrator of the outpatient treatment center, rather only documentation that diagnostic imaging services are in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7. In addition, the Department is updating language from "physician" to a "medical staff member" to expand services and use the defined terms. Similarly in R9-10-1022, *Physical Health Services*, language for the direction of a physician or a registered nurse practitioner is updated to reference A.R.S. § 36-401(A)(33) instead. R9-10-1031, *Colocation Requirements*, is being amended to include an exemption pursuant to A.R.S. § 36-402. R9-10-1003, R9-10-1018, and R9-10-1027 are being amended to adhere to new statutory changes as described above. The Department does not expect the new changes to impose a cost on outpatient treatment centers, rather the Department expects that outpatient treatment centers will receive a significant benefit for having updated rules.

In Article 11, *Adult Day Health Care Facilities*, the Department is amending four Sections. In R9-10-1107, *Enrollment*, the Department is removing the seven day requirement for TB testing because it is inconsistent with the tuberculosis requirements specified in R9-10-113. The rules in R9-10-113 were revised at 28 A.A.R. 1113 effective May 4, 2022, to include updated recommendations from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) regarding tuberculosis screening. The updated guidance, according to A.A.C. R9-10-113 and the CDC, do not permit a seven-calendar day window for an administrator to ensure that a participant provides evidence of freedom from infectious tuberculosis after the participant's enrollment. On the contrary, an administrator shall ensure that a participant provides evidence of freedom from infectious tuberculosis before enrollment. Also in Article 11, language is being updated in R9-10-1114, and statutory changes are being updated in R9-10-1117.

In Article 13, Behavioral Health Specialized Transitional Facility, the Department is amending seven Sections. R9-10-1302, *Administration*, is being amended to correct a cross-reference and amend the subsection to require training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect. A clarification is being added to R9-10-1306, *Admission Requirements*, that medical history is taken from the patient. In R9-10-1313, *Medication Services*, the Department is changing an "or" to an "and." Lastly, in Article 13, the Department is updating language in R9-10-1314 and R9-10-1317, including updating the rules to adhere to new statutory requirements.

In Article 14, *Substance Abuse Transitional Facilities*, the Department is amending four Sections, R9-10-1413 to update the meal and snack guidelines to the most recent dietary guidelines. In Article 15, *Abortion Clinics*, the Department is amending one Section, R9-10-1515, *Physical Plant Standards* to correct a cross-

reference and adhere to new statutory requirements. Furthermore, amendments in Article 17, *Unclassified Health Care Institution's*, Article 19, Counseling Facilities, and Article 22, *Nursing-Supported Group Homes* are being made to correct grammatical errors, update and simplify language, and adhere to new statutory changes. The Department does not expect HCIs to incur costs related to the new changes, rather the Department expects that the HCIs will receive a significant benefit from having updated rules in alignment with the new statutory changes.

Overall, the proposed amendments to the Department's rules are comprehensive updates designed to ensure alignment with recent statutory changes and address various issues identified in recent five-year review reports. These changes are anticipated to improve the effectiveness and clarity of regulations, enhance public health and safety, and ensure compliance with state laws. Key amendments include establishing new standards for behavioral health residential facilities and outpatient surgical centers, updating terminology, and implementing new policies for workplace violence prevention and visitation in hospitals. Economically, while there may be initial costs associated with implementing some of these changes, the overall impact is expected to be positive. The amendments will streamline administrative processes, reduce unnecessary regulatory burdens, and promote better compliance with updated standards. The Department anticipates that these improvements will ultimately benefit HCIs and the public by enhancing patient care, safety, and outcomes. The clear, concise, and updated rules are expected to provide significant benefits to health care institutions, facilitating a more efficient and effective regulatory environment.

**C. General Public**

The proposed amendments in the Chapter 10 rulemaking are expected to provide a significant benefit to the general public for having increased public health and safety regulations in health care institutions.

New statutes requiring clergy visitation and visitors for patients in healthcare institutions can positively impact the general public by providing emotional and spiritual support, reducing patient isolation, and respecting cultural and religious beliefs. They enhance patient well-being by offering comfort during challenging times and acknowledging the importance of diverse spiritual needs. However, these statutes also raise concerns about privacy, consent, infection control, and logistical challenges. Ensuring patient autonomy, maintaining safety protocols, and addressing resource allocation are critical for successful implementation. Balancing the benefits of such visits with practical and ethical considerations is essential to meet the diverse needs of the community.

The proposed amendments to the Department's rules, aimed at aligning with recent statutory changes and addressing issues identified in regulatory reviews, will have several effects on the general public. These updates are designed to improve the effectiveness and clarity of existing regulations, ensure consistency with other laws, and enhance public health and safety. Key areas of focus include setting new standards for secured

behavioral health residential facilities, outpatient surgical centers, and workplace violence prevention, along with updating terminology and procedural guidelines. These changes are expected to streamline administrative processes, promote better compliance, and ultimately improve patient care and outcomes. Specifically, amendments related to surgical discharges, architectural plans, surgical smoke evacuation system, and visitation policies will directly impact patient safety and experience. Moreover, the inclusion of workplace violence prevention measures aims to protect healthcare workers, enhancing overall safety within healthcare institutions. While there may be initial costs associated with implementing these changes, the anticipated benefits include more efficient operations, reduced regulatory burdens, and a better regulatory environment that prioritizes patient and staff well-being. The general public stands to benefit from improved healthcare standards and enhanced safety measures, resulting in better overall health outcomes.

**a. Identification of the small businesses subject to the rules**

The rules outlined for health care institutions will affect various small businesses within the health care sector. These include a wide range of facilities, such as outpatient treatment centers, adult day health care facilities, behavioral health inpatient and specialized transitional facilities, nursing care institutions, hospices, and outpatient surgical centers. Small businesses operating as behavioral health counseling facilities, nursing-supported group homes, and substance abuse transitional facilities will also be impacted. The regulations cover aspects such as licensing, administration, personnel requirements, patient rights, medication and food services, physical plant standards, and more. These businesses will need to adhere to specific standards and procedures, which may require additional resources for compliance, potentially impacting their operations and financial stability. Therefore, small businesses may incur up to minimal costs for implementing the new rules, but the Department estimates that small businesses may receive a significant benefit for being in compliance with rules in alignment with new statutory requirements that benefit the public health and safety of patients and residents.

**b. The administrative and other costs required for compliance with the rules**

A summary of the administrative effects of the rulemaking is given in the cost and benefit analysis in Section 2. From a healthcare institution standpoint, compliance with the new rules may involve minimal administrative and operational costs. These include expenses for staff training to align with updated standards, such as workplace violence prevention and new patient care protocols. Institutions may also face minimal costs related to upgrading facilities and equipment, like installing surgical smoke evacuation systems and ensuring the presence of required medical professionals during outpatient procedures. Additionally, there will be minimal administrative expenses for updating and maintaining records, complying with new documentation requirements, and managing the submission process for licensure and inspections. While these changes may involve minimal initial expenditures, they aim to streamline processes, enhance compliance, and ultimately improve patient care and institutional efficiency.

**c. A description of the methods that the agency may use to reduce the impact on small businesses**

The Department knows of no other methods to further reduce the impact on small businesses.

**d. The probable costs and benefits to private persons and consumers who are directly affected by the rules**

A summary of the effects of the rulemaking on private persons and consumers is given in the cost and benefit analysis.

**6. A statement of the probable effect on state revenues**

10% of all licensing fees collected are transferred to the State General Fund. However, this rulemaking does not amend a fee and no additional licensing fees would be incurred from this rulemaking.

**7. A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking**

The Department has determined that there are no less intrusive or less costly alternatives for achieving the purpose of the rulemaking.

**8. A description of any data on which the rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data**

Not applicable

February 14, 2025

***Sent Via Electronic Mail***

Thomas Salow
Assistant Director, Public Health Licensing
Arizona Department of Health Services
150 N. 18th Ave, Suite 500, Phoenix, AZ 85007

Re: Public Comment November Draft Health Care Institution (HCI) rules

Dear Mr. Salow,

Thank you for the opportunity to comment on the November 2024 draft of the Arizona Department of Health Services' (ADHS) Health Care Institution (HCI) rules. The Arizona State Hospital (ASH) would like to offer feedback in regards to the proposed language found in Arizona Administrative Code (A.A.C.) Title 9, Chapter 10, Article 13 for Behavioral Health Specialized Transitional Facilities.

ASH's Arizona Community Protection and Treatment Center (ACPTC) is the only Behavioral Health Specialized Transitional Facility located in Arizona as mandated by the Arizona Legislature per Arizona Revised Statutes (A.R.S.) §36-3701 et. seq., and operates under the terms specified in A.A.C R9-10-1301 through R9-10-1317. ACPTC is a Title 36 civil commitment program that provides supervision, care or treatment to those individuals adjudicated as Sexually Violent Persons (SVP). The average length of stay for residents of ACPTC exceeds fourteen (14) years.

The proposed changes to A.A.C. R9-10-1315 requires the facility to conduct an evacuation drill on each shift at least once every three months including all individuals on the campus and only exempts those who have medical documentation that the evacuation would cause harm. As written this would require the same residents to participate in the evacuation drill twelve (12) times annually.

Due to the unique population served by ACPTC, requiring that all residents participate in an evacuation drill this often is excessive and causes disruption to the therapeutic environment. We recognize the importance that staff are trained and knowledgeable in the case of a fire or other disaster. As such, ASH would like to suggest that the proposed language mirror that of the disaster management requirements of a hospital found in A.A.C. R9-10-232. This would ensure staff competency is maintained and patient safety is optimized in emergency preparedness efforts. We suggest that the language in A.A.C. R9-10-1315(D) be updated as follows:

**A.A.C. R9-10-1315(D)**

D. An administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:

a. Procedures for protecting the health and safety of patients and other individuals at the behavioral health specialized transitional facility;

b. When, how, and where patients will be relocated;

c. How each patient's medical record will be available to personnel providing services to the patient during a disaster;

d. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and

e. A plan for obtaining food and water for individuals present in the behavioral health specialized transitional facility or the behavioral health specialized transitional facility's relocation site during a disaster;

2. The disaster plan required in subsection (D)(1) is reviewed at least once every 12 months;

3. A disaster drill is performed on each shift at least once every 12 months;

~~4. Documentation of a disaster plan review required in subsection (D)(2) and a disaster drill required in subsection (D)(3) is created, is maintained for at least 12 months after the date of the disaster plan review or disaster drill, and includes:~~

~~a. The date and time of the disaster plan review or disaster drill;~~

~~b. The name of each personnel member, employee, or volunteer participating in the disaster plan review or disaster drill;~~

~~c. A critique of the disaster plan review or disaster drill; and d. If applicable, recommendations for improvement;~~

4~~5~~. An fire~~evacuation~~ drill is conducted on each shift at least once every three months;

6. Documentation of a disaster drill as required in subsection (3) and a fire drill as required in subsection (4)~~an evacuation drill~~ is created, is maintained for at least 12 months after the date of the ~~evacuation~~ drill, and includes:

a. The date and time of the ~~evacuation~~ drill;

~~b. The amount of time taken for all employees and patients to evacuate the behavioral health specialized transitional facility;~~

~~c. If applicable, an identification of patients needing assistance for evacuation;~~

b~~d~~. Any problems encountered in conducting the ~~evacuation~~ drill; and

c~~e~~. Recommendations for improvement, if applicable; and

7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health specialized transitional facility.

We would also like to take this opportunity to recommend changes to additional sections of A.A.C. Title 9, Chapter 10, Article 13 to clarify and align the regulation with the delivery of patient care specific to a Behavioral Health Specialized Transitional Facility.

ACPTC does not employ behavioral health technicians to provide behavioral health services to residents. Instead, treatment units are staffed with residential program specialists for care, custody and control of the residents. These personnel do not perform any duties that require a license under Title 32 of the Arizona Revised Statutes. Duties include interacting with residents in a helping role, providing security and escort, participating in recreational activities, providing assistance with activities of daily living (ADLs) including assisting residents with personal hygiene and environmental hygiene. This personnel type does not meet the definition of a behavioral health technician as defined in A.A.C. R9-10-101(39) and, as such for clarity, it is recommended that the reference to behavioral health technicians be removed from the following sections of Article 13.

**A.A.C. R9-10-1302(H)(2)(b)**

H. A clinical director:

2. Shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:

b. Providing~~:~~

~~i. s~~Supervision to behavioral health paraprofessionals, according to R9-10-115(1); ~~and~~

~~ii. Clinical oversight to behavioral health technicians, according to R9-10-115(2);~~

**A.A.C. R9-10-1305(E)**

E. An administrator shall comply with the requirements for ~~behavioral health technicians and~~ behavioral health paraprofessionals in R9-10-115.

**A.A.C. R9-10-1305(G)(3)**

G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

3. Documentation of:

a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;

b. The individual's education and experience applicable to the individual's job duties;

c. The individual's completed orientation and in-service education as required by policies and procedures;

d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;

~~e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;~~

e~~f~~. Cardiopulmonary resuscitation training, if required for the individual according to this Article or policies and procedures;

f~~g~~. First aid training, if required for the individual according to this Article or policies and procedures; and

g~~h~~. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).

We would like to recommend A.A.C. R9-10-1307 be updated to align with the discharge process for ACPTC residents. Residents may be conditionally released to a less restrictive alternative through the privileges process; however, they remain under the care of ACPTC until the time of discharge. Additionally, It is rare that a resident of ACPTC is determined to have a Serious Mental Illness (SMI) and thus an outpatient treatment team or Regional Behavioral Health Authority (RHBA) to facilitate the transfer of care. As such, upon discharge many residents are released to the community and there is no health care provider or behavioral health professional identified to receive the discharge summary. To align with this process, we suggest that the language in A.A.C. R9-10-1307(D) be updated as follows:

**A.A.C. R9-10-1307(D)**

D A clinical director shall ensure that before a patient is discharged ~~or conditionally released to a less restrictive alternative~~:

~~1. The clinical director or the clinical director's designee, as specified in the behavioral health specialized transitional facility's discharge policies and procedures, receives the name of the health care provider or behavioral health professional to whom a copy of the patient's discharge summary will be sent; and~~

1~~2~~. The patient receives:

a. A referral for treatment or ancillary services that the resident may need after discharge, if applicable.

b. Written discharge~~follow-up~~ instructions including as applicable to the patient:

i. On-going behavioral health issues and physical health conditions;

ii. A list of the patient's medications and, for each medication, directions for

taking the medication, possible side-effects, and possible results of not taking the medication; and

iii. Counseling goals; and

c~~b~~. A supply of medications determined according to the policies and procedures

specified in R9-10- 1302(C)(1)(d).

We would also like to recommend A.A.C. R9-10-1310 be updated to align with the treatment planning process for ACPTC residents. A resident's treatment plan is developed by a multidisciplinary team and under the ultimate responsibility of the clinical director. Depending on what is ordered in the course of a resident's treatment, these orders may come from various providers and are stored in locations other than the resident's master treatment plan. It is duplicative and impractical to list each name on the treatment plan. We recommend this requirement be removed from the language.

**R9-10-1310(A)(1)(c)**

A. A clinical director shall ensure that:

1. A treatment plan is developed and implemented for the patient:

c. Including:

i. The physical health services, behavioral health services, and ancillary services to be provided to the patient until completion of the treatment plan;

ii. The type, frequency, and duration of counseling or other treatment ordered for the patient;

~~iii. The name of each individual who ordered medication, counseling, or other treatment for the patient;~~

~~iii~~iv~~.~~. The signature of the patient or the patient's representative and dated signed, or documentation of the refusal to sign;

iv. The date when the patient's treatment plan will be reviewed;

v~~i~~. If a discharge date has been determined, the treatment needed after discharge; and

vi~~i~~. The signature of the personnel member who developed the treatment plan and the date signed; and

Lastly, the individuals receiving care at ACPTC are termed “residents.” It is recommended that the Article refer to “residents” rather than “patients.”

Please contact me at 602-220-6123 or at katrina.trinchera@azdhs.gov should you have any questions regarding this correspondence.

Sincerely,

Katrina Trinchera, Chief Compliance Officer
Arizona State Hospital

C: Michael R. Sheldon, CEO

ARIZONA
DEPARTMENT OF
HEALTH SERVICES

February 20, 2025

Sent Via Electronic Mail: katrina.trinchera@azdhs.gov

Katrina Trinchera
Chief Compliance Officer
Arizona State Hospital
501 N 24th St
Phoenix, AZ 85008

Re: Public Comment Health Care Institution Rules; Response to Stakeholder Comment on Proposed Rules

Dear Ms. Trinchera:

Thank you for your comments on the Notice of Proposed Rulemaking for the Chapter 10, Article 13 rules. The Department appreciates your participation and input on these rules. Below, are the Department's responses to your comments:

**A.A.C. R9-10-1315(D) -** The proposed changes to this Section are intended to ease the burden of evacuation drills by exempting patients whose medical records document that evacuation from the behavioral health inpatient facility would cause harm. The current rules do not include this exemption, requiring all patients to participate in evacuation drills. Additionally, the term 'evacuation drill' aligns with Chapter 10 and appropriately reflects that evacuations may occur for reasons other than fire. The Department does not plan to make further changes to this provision.

**A.A.C. R9-10-1302(H)(2)(b), R9-10-1305(E), and R9-10-1305(G)(3) -** The Department has specific rulemaking authority, and the requested changes fall outside the scope of this rulemaking. While ACPTC does not currently employ behavioral health technicians (BHTs) to provide behavioral health services to residents, could this be a possibility in the future? The rules establish minimum standards, and if ACPTC were to hire BHTs at a later date, this rule would still be applicable.

**A.A.C. R9-10-1307(D) -** Amending the rules related to the discharge process is outside the scope of this rulemaking. The Department also acknowledges that it is uncommon for ACPTC residents to be determined to have a Serious Mental Illness and that some residents may be discharged to the community without an

identified health care provider or behavioral health professional. However, any modifications to discharge requirements would require further evaluation beyond this rulemaking effort. In addition, the language referring to "conditional release to a less restrictive alternative" is consistent with the statutory language in A.R.S. TItle 9, Chapter 37 and 40

**R9-10-1310(A)(1)(c) -** Removing the requirement of documenting the name of each individual who ordered medication, counseling, or other treatment for the patient would be inconsistent with other rules in Chapter 10 as well as national standard practices.

Lastly, changing the use of the term "patient" with "resident" when referring to individuals receiving care at ACPTC would create inconsistency and would not align with the defined terms in R9-10-101(164) and (195).

The Department appreciates your feedback and participation in this rulemaking process. If you have any further questions regarding this response, please contact the Office of Administrative Counsel and Rules at 602-542-1020.

Sincerely,

Lucinda Sallaway

Lucinda Sallaway, Senior Rules Analyst
Director's Office, Administrative Counsel and Rules
Arizona Department of Health Services

THE NELSON LAW GROUP ★ PLLC
LAW, CONSULTING, & GOVERNMENT SOLUTIONS

February 18, 2025

Mr. Thomas Salow
Assistant Director, Public Health Licensing
Arizona Department of Health Services
150 No. 18th Ave. Suite 500
Phoenix, AZ. 85007

Re: Public Comment by the Arizona Society of Anesthesiologists on Proposed Rulemaking, R9-10-911

Dear Mr. Salow:

On behalf of our client, the Arizona Society of Anesthesiologists (AzSA), I submit the following comment regarding the Arizona Department of Health Services' (ADHS) proposed revision to R9-10-911, as published in the January 17, 2025 Arizona Register.

AzSA recognizes ADHS' proposed revisions to A.A.C. R9-10-911, as required to implement revisions to ARS 36-405 made by the legislature in 2021.

AzSA affirmatively states, however, and encourages ADHS to acknowledge in its final draft of the rule, that nothing in the legislature's revision to ARS 36-405 or in ADHS's implementing language in AAC R9-10-911 may be read to amend or revise in any way the well-established scope of practice of certified registered nurse anesthetists in the state of Arizona, as set forth in ARS 32-1634.04.A.

This statute states:

> A. A certified registered nurse anesthetist may administer aesthetics under the direction of and in the presence of a physician or surgeon in connection with the preoperative, intraoperative or postoperative care of a patient or as part of a procedure performed by a physician or surgeon…

It is clear that no health care professional in the state of Arizona may exceed their scope of practice as established by the legislature. It is equally clear that ADHS does not have the authority to modify such professional licensure restrictions through its facility licensure rules.

We therefore encourage ADHS to acknowledge that any revision to R9-10-911 is subject to the provisions and limitations in ARS 32-1634.04.

Sincerely,

Joel Wakefield

Cc: Ying Tian, MD
President, Arizona Society of Anesthesiologists

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ARIZONA
DEPARTMENT OF
HEALTH SERVICES

February 20, 2025

Sent Via Electronic Mail: joel@nelsonlawsolutions.com

Joel Wakefield
Nelson Law Group
2501 No. 7th St.
Phoenix, Arizona 85006

Re: Public Comment Health Care Institution Rules; Response to Comment on Proposed Rules

Dear Mr. Wakefield:

Thank you for your comment on the proposed revisions to R9-10-911. The Department acknowledges your concerns and understands that facility licensing rules do not have the authority to alter the scope of practice. The proposed changes are intended to align with the statutory revisions to A.R.S. 36-405 while maintaining consistency with the existing scope of practice requirements.

The Department appreciates your feedback and participation in this rulemaking process. If you have any further questions regarding this response, please contact the Office of Administrative Counsel and Rules at 602-542-1020.

Sincerely,
Lucinda Sallaway

Lucinda Sallaway, Senior Rules Analyst
Director's Office, Administrative Counsel and Rules
Arizona Department of Health Services

# TITLE 9. HEALTH SERVICES

## CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of

October 1, 2022 through December 31, 2022



### Questions about these rules? Contact:

Department: Arizona Department of Health Services
Public Health Licensing & Policy and Intergovernmental Affairs
Address: 150 N. 18th Ave., Suite 400
Phoenix, AZ 85007
Website: https://www.azdhs.gov
Name: Thomas Salow, Assistant Director
Telephone: (602) 364-1935
Fax: (602) 364-3808
Email: Thomas.Salow@azdhs.gov

**PREFACE**

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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**RULES**
The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

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The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31



Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

**RULE HISTORY**
Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

**AUTHENTICATION OF PDF CODE CHAPTERS**
The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

**HOW TO USE THE CODE**
Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

**ARIZONA REVISED STATUTE REFERENCES**
The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

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The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

**PERSONAL USE/COMMERCIAL USE**
This Chapter is posted as a public courtesy online, and is for private use only. Those who wish to use the contents for resale or profit should contact the Office about Commercial Use fees. For information on commercial use fees review A.R.S. § 39-121.03 and 1 A.A.C. 1, R1-1-113.

*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

# TITLE 9. HEALTH SERVICES

## CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

Authority: A.R.S. §§ 36-132(A)(1), 36-136(G)

**Supp. 22-4**

***Editor's Note: The heading for 9 A.A.C. 10 changed from "Licensure" to "Licensing" per a request from the Department of Health Services (Supp. 03-4).***

***Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper (Supp. 01-2).***

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

***Editor's Note: This Chapter contains rules which were adopted, amended, and repealed under exemptions from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1993, Ch. 163, § 3(B); Laws 1996, Ch. 329, § 5; Laws 1998, Ch. 178 § 17, and Laws 1999, Ch. 311. Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit these rules to the Governor's Regulatory Review Council for review; the Department may not have submitted notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.***

## CHAPTER TABLE OF CONTENTS

### ARTICLE 1. GENERAL



### ARTICLE 2. HOSPITALS

*Article 2, consisting of Sections R9-10-201 through R9-10-233, adopted effective February 23, 1979.*

*Former Article 2, consisting of Sections R9-10-201 through R9-10-250, renumbered as Sections R9-10-301 through R9-10-335 as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days.*

## ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES

*Article 3, consisting of Sections R9-10-311 through R9-10-333, repealed at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).*

*Article 3, consisting of Sections R9-10-301 through R9-10-333, adopted effective February 4, 1981.*

*Former Article 3, consisting of Sections R9-10-301 through R9-10-335, repealed effective February 4, 1981.*

## ARTICLE 4. NURSING CARE INSTITUTIONS

*Article 4, consisting of Sections R9-10-411 through R9-10-438, repealed at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).*



## ARTICLE 6. HOSPICES

*Article 6, consisting of Sections R9-10-601 through R9-10-618, made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).*

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

*Article 6, consisting of Sections R9-10-611 through R9-10-624, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).*

Section



## ARTICLE 9. OUTPATIENT SURGICAL CENTERS

*Article 9, consisting of Sections R9-10-901 through R9-10-917 adopted effective February 17, 1995 (Supp. 95-1).*

*Article 9, consisting of Sections R9-10-911 through R9-10-925, repealed effective February 17, 1995 (Supp. 95-1).*

*Article 9, consisting of Sections R9-10-911 through R9-10-925, adopted effective October 20, 1982 (Supp. 82-5).*

Section

## ARTICLE 10. OUTPATIENT TREATMENT CENTERS

*Article 10, consisting of Sections R9-10-1001 through R9-10-1017, made new by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1).*

*Article 10, consisting of Sections R9-10-1011 through R9-10-1030, repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).*

*The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1).*

*Article 10, consisting of R9-10-1011 through R9-10-1030, repealed by summary action, interim effective date of July 21, 1995.*



## ARTICLE 11. ADULT DAY HEALTH CARE FACILITIES

*Article 11, consisting of Sections R9-10-1101 through R9-10-1109 adopted effective July 22, 1994 (Supp. 94-3).*

*Article 11, consisting of Sections R9-10-1111 through R9-10-1127 repealed effective July 22, 1994 (Supp. 94-3).*

## ARTICLE 12. HOME HEALTH AGENCIES

*Article 12, consisting of Sections R9-10-1201 through R9-10-1230, repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).*

*Article 12, consisting of Sections R9-10-1201 through R9-10-1230, adopted effective February 4, 1981.*

## ARTICLE 13. BEHAVIORAL HEALTH SPECIALIZED TRANSITIONAL FACILITY

*New Article 13, consisting of Sections R9-10-1301 through R9-10-1317, made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1314, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted as permanent rules effective November 25, 1992 (Supp. 92-4).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted as an emergency effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).*

*Article 13, consisting of Sections R9-10-1301 through R9-10-1306, adopted as an emergency effective March 29, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency expired.*

Section



## ARTICLE 14. SUBSTANCE ABUSE TRANSITIONAL FACILITIES

*Article 14, consisting of Sections R9-10-1401 through R9-10-1412, adopted effective February 1, 1994 (Supp. 94-1).*

Section

## ARTICLE 15. ABORTION CLINICS

*Article 15, consisting of Sections R9-10-1501 through R9-10-1515, were either amended, renumbered and repealed by final rulemaking which means the public had the opportunity to comment on the rules and they were reviewed and approved by the Governor's Regulatory Review Council. Section editor's notes referring to the adoption under an exemption have been removed in this Article (Supp. 18-4).*

*Selected Sections in Article 15 were subsequently amended by final rulemaking in Supp. 10-2 which means the public had the opportunity to comment on the rules and they were reviewed and approved by the Governor's Regulatory Review Council. Refer to the historical notes for more information (Supp. 18-4).*

*Article 15, consisting of Sections R9-10-1501 through R9-10-1514, adopted under an exemption from the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311, filed in the Office of the Secretary of State December 23, 1999 (Supp. 99-4).*

*Article 15, consisting of Sections R9-10-1501 through R9-10-1514, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).*

Section



## ARTICLE 16. BEHAVIORAL HEALTH RESPITE HOMES

*Article 16, consisting of Sections R9-10-1601 through R9-10-1611, made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).*

Section

## ARTICLE 17. UNCLASSIFIED HEALTH CARE INSTITUTIONS

*Article 17, consisting of Sections R9-10-1701 through R9-10-1713, adopted effective July 6, 1994 (Supp. 94-3).*

*Article 17, consisting of Sections R9-10-1711 through R9-10-1713, R9-10-1715 through R9-10-1723, and R9-10-1731 through R9-10-1734, repealed effective July 6, 1994 (Supp. 94-3).*



## ARTICLE 19. COUNSELING FACILITIES

*Article 19, consisting of Sections R9-10-1901 through R9-10-1911, made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).*



## ARTICLE 20. PAIN MANAGEMENT CLINICS

*Article 20, consisting of Sections R9-10-2001 through R9-10-2010, made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).*

## ARTICLE 21. RECOVERY CARE CENTERS

*New Article 21, consisting of Sections R9-10-2101 through R9-10-2118, renumbered from R1-10-501 through R1-1-518 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).*

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

## ARTICLE 22. NURSING-SUPPORTED GROUP HOMES

*Article 22, consisting of Sections R9-10-2201 through R9-10-2226, made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).*

Section

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

## ARTICLE 1. GENERAL

**R9-10-101. Definitions**

In addition to the definitions in A.R.S. §§ 36-401(A) and 36-439, the following definitions apply in this Chapter unless otherwise specified:

1. "Abortion clinic" has the same meaning as in A.R.S. § 36-449.01.
2. "Abuse" means:
   a. The same:
      i. For an individual 18 years of age or older, as in A.R.S. § 46-451; and
      ii. For an individual less than 18 years of age, as in A.R.S. § 8-201;
   b. A pattern of ridiculing or demeaning a patient;
   c. Making derogatory remarks or verbally harassing a patient; or
   d. Threatening to inflict physical harm on a patient.
3. "Accredited" has the same meaning as in A.R.S. § 36-422.
4. "Active malignancy" means a cancer for which:
   a. A patient is undergoing treatment, such as through:
      i. One or more surgical procedures to remove the cancer;
      ii. Chemotherapy, as defined in A.A.C. R9-4-401; or
      iii. Radiation treatment, as defined in A.A.C. R9-4-401;
   b. There is no treatment; or
   c. A patient is refusing treatment.
5. "Activities of daily living" means ambulating, bathing, toileting, grooming, eating, and getting in or out of a bed or a chair.
6. "Acuity" means a patient's need for medical services, nursing services, or behavioral health services based on the patient's medical condition or behavioral health issue.
7. "Acuity plan" means a method for establishing nursing personnel requirements by unit based on a patient's acuity.
8. "Adjacent" means not intersected by:
   a. Property owned, operated, or controlled by a person other than the applicant or licensee; or
   b. A public thoroughfare.
9. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
10. "Administrative office" means a location used by personnel for recordkeeping and record retention but not for providing medical services, nursing services, behavioral health services, or health-related services.
11. "Admission" or "admitted" means, after completion of an individual's screening or registration by a health care institution, the individual begins receiving physical health services or behavioral health services and is accepted as a patient of the health care institution.
12. "Adult" has the same meaning as in A.R.S. § 1-215.
13. "Adult behavioral health therapeutic home" means a residence that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to a case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issue and need for behavioral health services and may provide behavioral health services under the clinical oversight of a behavioral health professional.
14. "Adult residential care institution" means a subclass of behavioral health residential facility that only admits residents 18 years of age and older and provides recidivism reduction services.
15. "Adverse reaction" means an unexpected outcome that threatens the health or safety of a patient as a result of a medical service, nursing service, or health-related service provided to the patient.
16. "Affiliated counseling facility" means a counseling facility that shares administrative support with one or more other counseling facilities that operate under the same governing authority.
17. "Affiliated outpatient treatment center" means an outpatient treatment center authorized by the Department to provide behavioral health services that provides administrative support to a counseling facility or counseling facilities that operate under the same governing authority as the outpatient treatment center.
18. "Alternate licensing fee due date" means the last calendar day in a month each year, other than the anniversary date of a facility's health care institution license, by which a licensee is required to pay the applicable fees in R9-10-106.
19. "Ancillary services" means services other than medical services, nursing services, or health-related services provided to a patient.
20. "Anesthesiologist" means a physician granted clinical privileges to administer anesthesia.
21. "Applicant" means a governing authority requesting:
   a. Approval of a health care institution's architectural plans and specifications for construction or modification,
   b. Approval of a modification,
   c. Approval of an alternate licensing fee due date, or
   d. A health care institution license.
22. "Application packet" means the information, documents, and fees required by the Department for the:
   a. Approval of a health care institution's architectural plans and specifications for construction or modification,

b. Approval of a modification,
c. Approval of an alternate licensing fee due date, or
d. Licensing of a health care institution.

23. "Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.
24. "Assistance in the self-administration of medication" means restricting a patient's access to the patient's medication and providing support to the patient while the patient takes the medication to ensure that the medication is taken as ordered.
25. "Attending physician" means a physician designated by a patient to participate in or coordinate the medical services provided to the patient.
26. "Authenticate" means to establish authorship of a document or an entry in a medical record by:
    a. A written signature;
    b. An individual's initials, if the individual's written signature appears on the document or in the medical record;
    c. A rubber-stamp signature; or
    d. An electronic signature code.
27. "Authorized service" means specific medical services, nursing services, behavioral health services, or health-related services provided by a specific health care institution class or subclass for which the health care institution is required to obtain approval from the Department before providing the medical services, nursing services, or health-related services.
28. "Available" means:
    a. For an individual, the ability to be contacted and to provide an immediate response by any means possible;
    b. For equipment and supplies, physically retrievable at a health care institution; and
    c. For a document, retrievable by a health care institution or accessible according to the applicable time-frames in this Chapter.
29. "Behavioral care"
    a. Means limited behavioral health services, provided to a patient whose primary admitting diagnosis is related to the patient's need for physical health services, that include:
        i. Assistance with the patient's psychosocial interactions to manage the patient's behavior that can be performed by an individual without a professional license or certificate including:
            (1) Direction provided by a behavioral health professional, and
            (2) Medication ordered by a medical practitioner or behavioral health professional; or
        ii. Behavioral health services provided by a behavioral health professional on an intermittent basis to address the patient's significant psychological or behavioral response to an identifiable stressor or stressors; and
    b. Does not include court-ordered behavioral health services.
30. "Behavioral health facility" means a behavioral health inpatient facility, a behavioral health residential facility, a substance abuse transitional facility, a behavioral health specialized transitional facility, an outpatient treatment center that only provides behavioral health services, an adult behavioral health therapeutic home, a behavioral health respite home, or a counseling facility.
31. "Behavioral health inpatient facility" means a health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
    a. Have a limited or reduced ability to meet the individual's basic physical needs;
    b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
    c. Be a danger to self;
    d. Be a danger to others;
    e. Be persistently or acutely disabled, as defined in A.R.S. § 36-501; or
    f. Be gravely disabled.
32. "Behavioral health issue" means an individual's condition related to a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
33. "Behavioral health observation/stabilization services" means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:
    a. Requires nursing services,
    b. May require medical services, and
    c. May be a danger to others or a danger to self.
34. "Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:
    a. Under supervision by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
    b. Health-related services.
35. "Behavioral health professional" means:
    a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health, as defined in A.R.S. § 32-3251; or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health, as defined in A.R.S. § 32-3251, under direct supervision as defined in A.A.C. R4-6-101;

b. A psychiatrist as defined in A.R.S. § 36-501;

c. A psychologist as defined in A.R.S. § 32-2061;

d. A physician;

e. A behavior analyst as defined in A.R.S. § 32-2091; or

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

g. A registered nurse with:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services.

36. "Behavioral health residential facility" means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

a. Limits the individual's ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

37. "Behavioral health respite home" means a residence where respite care services, which may include assistance in the self-administration of medication, are provided to an individual based on the individual's behavioral health issue and need for behavioral health services.

38. "Behavioral health specialized transitional facility" means a health care institution that provides inpatient behavioral health services and physical health services to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37.

39. "Behavioral health technician" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:

a. With clinical oversight by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or

b. Health-related services.

40. "Benzodiazepine" means any one of a class of sedative-hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven-membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.

41. "Biohazardous medical waste" has the same meaning as in A.A.C. R18-13-1401.

42. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

43. "Case manager" means an individual assigned by an entity other than a health care institution to coordinate the physical health services or behavioral health services provided to a patient at the health care institution.

44. "Certification" means, in this Article, a written statement that an item or a system complies with the applicable requirements incorporated by reference in R9-10-104.01.

45. "Certified health physicist" means an individual recognized by the American Board of Health Physics as complying with the health physics criteria and examination requirements established by the American Board of Health Physics.

46. "Change in ownership" means conveyance of the ability to appoint, elect, or otherwise designate a health care institution's governing authority from an owner of the health care institution to another person.

47. "Chief administrative officer" or "administrator" means an individual designated by a governing authority to implement the governing authority's direction in a health care institution.

48. "Clinical laboratory services" means the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or impairment of a human being, or for the assessment of the health of a human being, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.

49. "Clinical oversight" means:

a. Monitoring the behavioral health services provided by a behavioral health technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures and, if applicable, a patient's treatment plan;

b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services;

c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services; and

d. Recommending training for a behavioral health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.

50. "Clinical privileges" means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.

51. "Collaborating health care institution" means a health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:
    a. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and
    b. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan.
52. "Common area" means licensed space in health care institution that is:
    a. Not a resident's bedroom or a residential unit,
    b. Not restricted to use by employees or volunteers of the health care institution, and
    c. Available for use by visitors and other individuals on the premises.
53. "Communicable disease" has the same meaning as in A.R.S. § 36-661.
54. "Conspicuously posted" means placed:
    a. At a location that is visible and accessible; and
    b. Unless otherwise specified in the rules, within the area where the public enters the premises of a health care institution.
55. "Consultation" means an evaluation of a patient requested by a medical staff member or personnel member.
56. "Contracted services" means medical services, nursing services, behavioral health services, health-related services, ancillary services, or environmental services provided according to a documented agreement between a health care institution and the person providing the medical services, nursing services, health-related services, ancillary services, or environmental services.
57. "Contractor" has the same meaning as in A.R.S. § 32-1101.
58. "Controlled substance" has the same meaning as in A.R.S. § 36-2501.
59. "Counseling" has the same meaning as "practice of professional counseling" in A.R.S. § 32-3251.
60. "Counseling facility" means a health care institution that only provides counseling, which may include:
    a. DUI screening, education, or treatment according to the requirements in 9 A.A.C. 20, Article 1; or
    b. Misdemeanor domestic violence offender treatment according to the requirements in 9 A.A.C. 20, Article 2.
61. "Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.
62. "Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.
63. "Crisis services" means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.
64. "Current" means up-to-date, extending to the present time.
65. "Daily living skills" means activities necessary for an individual to live independently and include meal preparation, laundry, house-cleaning, home maintenance, money management, and appropriate social interactions.
66. "Danger to others" has the same meaning as in A.R.S. § 36-501.
67. "Danger to self" has the same meaning as in A.R.S. § 36-501.
68. "Detoxification services" means behavioral health services and medical services provided to an individual to:
    a. Treat the individual's signs or symptoms of withdrawal from alcohol or other drugs, and
    b. Reduce or eliminate the individual's dependence on alcohol or other drugs.
69. "Diagnostic procedure" means a method or process performed to determine whether an individual has a medical condition or behavioral health issue.
70. "Dialysis" means the process of removing dissolved substances from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.
71. "Dialysis services" means medical services, nursing services, and health-related services provided to a patient receiving dialysis.
72. "Dialysis station" means a designated treatment area approved by the Department for use by a patient receiving dialysis or dialysis services.
73. "Dialyzer" means an apparatus containing semi-permeable membranes used as a filter to remove wastes and excess fluid from a patient's blood.
74. "Disaster" means an unexpected occurrence that adversely affects a health care institution's ability to provide services.
75. "Discharge" means a documented termination of services to a patient by a health care institution.
76. "Discharge instructions" means documented information relevant to a patient's medical condition or behavioral health issue provided by a health care institution to the patient or the patient's representative at the time of the patient's discharge.
77. "Discharge planning" means a process of establishing goals and objectives for a patient in preparation for the patient's discharge.
78. "Discharge summary" means a documented brief review of services provided to a patient, current patient status, and reasons for the patient's discharge.
79. "Disinfect" means to clean in order to prevent the growth of or to destroy disease-causing microorganisms.
80. "Documentation" or "documented" means information in written, photographic, electronic, or other permanent form.
81. "Drill" means a response to a planned, simulated event.
82. "Drug" has the same meaning as in A.R.S. § 32-1901.
83. "Electronic" has the same meaning as in A.R.S. § 44-7002.
84. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.

85. "Emergency" means an immediate threat to the life or health of a patient.
86. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
87. "Emergency services" means unscheduled medical services provided in a designated area to an outpatient in an emergency.
88. "End-of-life" means that a patient has a documented life expectancy of six months or less.
89. "Environmental services" means activities such as housekeeping, laundry, facility maintenance, or equipment maintenance.
90. "Equipment" means, in this Article, an apparatus, a device, a machine, or a unit that is required to comply with the specifications incorporated by reference in R9-10-104.01.
91. "Exploitation" has the same meaning as in A.R.S. § 46-451.
92. "Factory-built building" has the same meaning as in A.R.S. § 41-4001.
93. "Family" or "family member" means an individual's spouse, sibling, child, parent, grandparent, or another individual designated by the individual.
94. "Follow-up instructions" means information relevant to a patient's medical condition or behavioral health issue that is provided to the patient, the patient's representative, or a health care institution.
95. "Food services" means the storage, preparation, serving, and cleaning up of food intended for consumption in a health care institution.
96. "Full-time" means 40 hours or more every consecutive seven calendar days.
97. "Garbage" has the same meaning as in A.A.C. R18-13-302.
98. "General consent" means documentation of an agreement from an individual or the individual's representative to receive physical health services to address the individual's medical condition or behavioral health services to address the individual's behavioral health issues.
99. "General hospital" means a subclass of hospital that provides surgical services and emergency services.
100. "Gravely disabled" has the same meaning as "grave disability" in A.R.S. § 36-501.
101. "Habilitation services" means activities provided to an individual to assist the individual with habilitation, as defined in A.R.S. § 36-551.
102. "Hazard" or "hazardous" means a condition or situation where a patient or other individual may suffer physical injury.
103. "Health care directive" has the same meaning as in A.R.S. § 36-3201.
104. "Hemodialysis" means the process for removing wastes and excess fluids from a patient's blood by passing the blood through a dialyzer.
105. "Home health agency" has the same meaning as in A.R.S. § 36-151.
106. "Home health aide" means an individual employed by a home health agency to provide home health services under the direction of a registered nurse or therapist.
107. "Home health aide services" means those tasks that are provided to a patient by a home health aide under the direction of a registered nurse or therapist.
108. "Home health services" has the same meaning as in A.R.S. § 36-151.
109. "Hospice inpatient facility" means a subclass of hospice that provides hospice services to a patient on a continuous basis with the expectation that the patient will remain on the hospice's premises for 24 hours or more.
110. "Hospital" means a class of health care institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient.
111. "Immediate" means without delay.
112. "Incident" means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:
    a. On the premises of a health care institution, or
    b. Not on the premises of a health care institution but directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.
113. "Infection control" means to identify, prevent, monitor, and minimize infections.
114. "Infectious tuberculosis" has the same meaning as "infectious active tuberculosis" in A.A.C. R9-6-101.
115. "Informed consent" means:
    a. Advising a patient of a proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; and associated risks and possible complications; and
    b. Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure from the patient or the patient's representative.
116. "In-service education" means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.
117. "Interdisciplinary team" means a group of individuals consisting of a resident's attending physician, a registered nurse responsible for the resident, and other individuals as determined in the resident's comprehensive assessment or, if applicable, placement evaluation.
118. "Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" has the same meaning as in A.R.S. § 36-551.
119. "Interval note" means documentation updating a patient's:
    a. Medical condition after a medical history and physical examination is performed, or

b. Behavioral health issue after an assessment is performed.

120. "Isolation" means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.
121. "Leased facility" means a facility occupied or used during a set time period in exchange for compensation.
122. "License" means:
    a. Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or
    b. Written approval issued to an individual to practice a profession in this state.
123. "Licensed occupancy" means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.
124. "Licensee" means an owner approved by the Department to operate a health care institution.
125. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
126. "Medical condition" means the state of a patient's physical or mental health, including the patient's illness, injury, or disease.
127. "Medical director" means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.
128. "Medical history" means an account of a patient's health, including past and present illnesses, diseases, or medical conditions.
129. "Medical practitioner" means a physician, physician assistant, or registered nurse practitioner.
130. "Medical record" has the same meaning as "medical records" in A.R.S. § 12-2291.
131. "Medical staff" means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.
132. "Medical staff bylaws" means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.
133. "Medical staff member" means an individual who is part of the medical staff of a health care institution.
134. "Medication" means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:
    a. Biologicals as defined in A.A.C. R18-13-1401,
    b. Prescription medication as defined in A.R.S. § 32-1901, or
    c. Nonprescription drug as defined in A.R.S. § 32-1901.
135. "Medication administration" means restricting a patient's access to the patient's medication and providing the medication to the patient or applying the medication to the patient's body, as ordered by a medical practitioner.
136. "Medication error" means:
    a. The failure to administer an ordered medication;
    b. The administration of a medication not ordered; or
    c. The administration of a medication:
        i. In an incorrect dosage,
        ii. More than 60 minutes before or after the ordered time of administration unless ordered to do so, or
        iii. By an incorrect route of administration.
137. "Mental disorder" means the same as in A.R.S. § 36-501.
138. "Mobile clinic" means a movable structure that:
    a. Is not physically attached to a health care institution's facility;
    b. Provides medical services, nursing services, behavioral health services, or health related service to an outpatient under the direction of the health care institution's personnel; and
    c. Is not intended to remain in one location indefinitely.
139. "Monitor" or "monitoring" means to check systematically on a specific condition or situation.
140. "Neglect" has the same meaning:
    a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and
    b. For an individual 18 years of age or older, as in A.R.S. § 46-451.
141. "Nephrologist" means a physician who is board eligible or board certified in nephrology by a professional credentialing board.
142. "Nurse" has the same meaning as "registered nurse" or "practical nurse" as defined in A.R.S. § 32-1601.
143. "Nursing care institution administrator" means an individual licensed according to A.R.S. Title 36, Chapter 4, Article 6.
144. "Nursing personnel" means individuals authorized according to A.R.S. Title 32, Chapter 15 to provide nursing services.
145. "Observation chair" means a physical piece of equipment that:
    a. Is located in a designated area where behavioral health observation/stabilization services are provided,
    b. Allows an individual to fully recline, and
    c. Is used by the individual while receiving crisis services.
146. "Occupational therapist" has the same meaning as in A.R.S. § 32-3401.
147. "Occupational therapy assistant" has the same meaning as in A.R.S. § 32-3401.

148. "Ombudsman" means a resident advocate who performs the duties described in A.R.S. § 46-452.02.
149. "On-call" means a time during which an individual is available and required to come to a health care institution when requested by the health care institution.
150. "Opioid" means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of "opiate" in A.R.S. § 36-2501.
151. "Opioid agonist treatment medication" means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of opioid-related substance use disorder.
152. "Opioid antagonist" means a prescription medication, as defined in A.R.S. § 32-1901, that:
    a. Is approved by the U.S. Department of Health and Human Services, Food and Drug Administration; and
    b. When administered, reverses, in whole or in part, the pharmacological effects of an opioid in the body.
153. "Opioid treatment" means providing medical services, nursing services, behavioral health services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opioid-related substance use disorder.
154. "Order" means instructions to provide:
    a. Physical health services to a patient from a medical practitioner or as otherwise provided by law; or
    b. Behavioral health services to a patient from a behavioral health professional.
155. "Orientation" means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.
156. "Outing" means a social or recreational activity that:
    a. Occurs away from the premises,
    b. Is not part of a behavioral health inpatient facility's or behavioral health residential facility's daily routine, and
    c. Lasts longer than four hours.
157. "Outpatient surgical center" means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia services to a patient whose recovery, in the opinions of the patient's surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.
158. "Outpatient treatment center" means a class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients.
159. "Overall time-frame" means the same as in A.R.S. § 41-1072.
160. "Owner" means a person who appoints, elects, or designates a health care institution's governing authority.
161. "Pain management clinic" has the same meaning as in A.R.S. § 36-448.01.
162. "Participant" means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.
163. "Participant's representative" means the same as "patient's representative" for a participant.
164. "Patient" means an individual receiving physical health services or behavioral health services from a health care institution.
165. "Patient's representative" means:
    a. A patient's legal guardian;
    b. If a patient is less than 18 years of age and not an emancipated minor, the patient's parent;
    c. If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient's legal guardian; or
    d. A surrogate as defined in A.R.S. § 36-3201.
166. "Person" means the same as in A.R.S. § 1-215 and includes a governmental agency.
167. "Personnel member" means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.
168. "Pest control program" means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient's health and safety is not at risk.
169. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
170. "Physical examination" means to observe, test, or inspect an individual's body to evaluate health or determine cause of illness, injury, or disease.
171. "Physical health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's medical condition.
172. "Physical therapist" has the same meaning as in A.R.S. § 32-2001.
173. "Physical therapist assistant" has the same meaning as in A.R.S. § 32-2001.
174. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
175. "Placement evaluation" means the same as in A.R.S. § 36-551.
176. "Pre-petition screening" has the same meaning as "prepetition screening" in A.R.S. § 36-501.
177. "Premises" means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a patient.
178. "Prescribe" means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user's behalf, a specific dose of a specific medication in a specific quantity and route of administration.
179. "Professional credentialing board" means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.
180. "Progress note" means documentation by a medical staff member, nurse, or personnel member of:

a. An observed patient response to a physical health service or behavioral health service provided to the patient,
b. A patient's significant change in condition, or
c. Observed behavior of a patient related to the patient's medical condition or behavioral health issue.

181. "PRN" means *pro re nata* or given as needed.
182. "Project" means specific construction or modification of a facility stated on an architectural plans and specifications approval application.
183. "Provider" means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual's place of residence.
184. "Provisional license" means the Department's written approval to operate a health care institution issued to an applicant or licensee that is not in substantial compliance with the applicable laws and rules for the health care institution.
185. "Psychotropic medication" means a chemical substance that:
    a. Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and
    b. Is provided to a patient to address the patient's behavioral health issue.
186. "Quality management program" means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.
187. "Recovery care center" has the same meaning as in A.R.S. § 36-448.51.
188. "Referral" means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.
189. "Registered dietitian" means an individual approved to work as a dietitian by the American Dietetic Association's Commission on Dietetic Registration.
190. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
191. "Registered nurse practitioner" has the same meaning as A.R.S. § 32-1601.
192. "Regular basis" means at recurring, fixed, or uniform intervals.
193. "Rehabilitation services" means medical services provided to a patient to restore or to optimize functional capability.
194. "Research" means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.
195. "Resident" means an individual living in and receiving physical health services or behavioral health services, including rehabilitation services or habilitation services if applicable, from a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.
196. "Resident's representative" means the same as "patient's representative" for a resident.
197. "Respiratory care services" has the same meaning as "practice of respiratory care" as defined in A.R.S. § 32-3501.
198. "Respiratory therapist" has the same meaning as in A.R.S. § 32-3501.
199. "Respite capacity" means the total number of children who do not stay overnight for whom an outpatient treatment center or a behavioral health residential facility is authorized by the Department to provide respite services on the premises of the outpatient treatment center or behavioral health residential facility.
200. "Respite services" means respite care services provided to an individual who is receiving behavioral health services.
201. "Restraint" means any physical or chemical method of restricting a patient's freedom of movement, physical activity, or access to the patient's own body.
202. "Risk" means potential for an adverse outcome.
203. "Room" means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.
204. "Rural general hospital" means a subclass of hospital:
    a. Having 50 or fewer inpatient beds,
    b. Located more than 20 surface miles from a general hospital or another rural general hospital, and
    c. Requesting to be and being licensed as a rural general hospital rather than a general hospital.
205. "Satellite facility" has the same meaning as in A.R.S. § 36-422.
206. "Scope of services" means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.
207. "Seclusion" means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
208. "Sedative-hypnotic medication" means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.
209. "Self-administration of medication" means a patient having access to and control of the patient's medication and may include the patient receiving limited support while taking the medication.
210. "Sexual abuse" means the same as in A.R.S. § 13-1404(A).

211. "Sexual assault" means the same as in A.R.S. § 13-1406(A).
212. "Shift" means the beginning and ending time of a continuous work period established by a health care institution's policies and procedures.
213. "Short-acting opioid antagonist" means an opioid antagonist that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.
214. "Signature" means:
    a. A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or
    b. An electronic signature.
215. "Significant change" means an observable deterioration or improvement in a patient's physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.
216. "Single group license" means a license that includes authorization to operate health care institutions according to A.R.S. § 36-422(F) or (G).
217. "Speech-language pathologist" means an individual licensed according to A.R.S. Title 36, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.
218. "Special hospital" means a subclass of hospital that:
    a. Is licensed to provide hospital services within a specific branch of medicine; or
    b. Limits admission according to age, gender, type of disease, or medical condition.
219. "Student" means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.
220. "Substance abuse" means an individual's misuse of alcohol or other drug or chemical that:
    a. Alters the individual's behavior or mental functioning;
    b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
    c. Impairs, reduces, or destroys the individual's social or economic functioning.
221. "Substance abuse transitional facility" means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.
222. "Substance use disorder" means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.
223. "Substance use risk" means an individual's unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.
224. "Substantial" when used in connection with a modification means:
    a. An addition or removal of an authorized service;
    b. The addition or removal of a colocator;
    c. A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;
    d. A change in the physical plant, including facilities or equipment, that costs more than $300,000; or
    e. A change in the building where a health care institution is located that affects compliance with:
        i. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or
        ii. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.
225. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.
226. "Supportive services" has the same meaning as in A.R.S. § 36-151.
227. "Surgical procedure" means the excision of or incision in a patient's body for the:
    a. Correction of a deformity or defect;
    b. Repair of an injury; or
    c. Diagnosis, amelioration, or cure of disease.
228. "Swimming pool" has the same meaning as "semipublic swimming pool" in A.A.C. R18-5-201.
229. "System" means interrelated, interacting, or interdependent elements that form a whole.
230. "Tapering" means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.
231. "Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
232. "Telemedicine" has the same meaning as in A.R.S. § 36-3601.
233. "Therapeutic diet" means foods or the manner in which food is to be prepared that are ordered for a patient.
234. "Therapist" means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.
235. "Time-out" means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.
236. "Transfer" means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending health care institution.
237. "Transport" means a licensed health care institution:

a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or
b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.

238. "Treatment" means a procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.
239. "Treatment plan" means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.
240. "Unclassified health care institution" means a health care institution not classified or subclassified in statute or in rule.
241. "Vascular access" means the point on a patient's body where blood lines are connected for hemodialysis.
242. "Volunteer" means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.
243. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-102. Health Care Institution Classes and Subclasses; Requirements**

**A.** A person may apply for a license as one of the following classes or subclasses of health care institution:
1. General hospital,
2. Rural general hospital,
3. Special hospital,
4. Behavioral health inpatient facility,
5. Nursing care institution,
6. Intermediate care facility for individuals with intellectual disabilities,
7. Recovery care center,
8. Hospice inpatient facility,
9. Hospice service agency,
10. Behavioral health residential facility,
11. Adult residential care institution,
12. Assisted living center,
13. Assisted living home,
14. Adult foster care home,
15. Outpatient surgical center,
16. Outpatient treatment center,
17. Abortion clinic,
18. Adult day health care facility,
19. Home health agency,
20. Substance abuse transitional facility,
21. Behavioral health specialized transitional facility,
22. Counseling facility,
23. Adult behavioral health therapeutic home,
24. Behavioral health respite home,
25. Unclassified health care institution,
26. Pain management clinic, or
27. Nursing-supported group home.

**B.** A person shall apply for a license for the class or subclass that authorizes the provision of the highest level of physical health services or behavioral health services the proposed health care institution plans to provide.

**C.** The Department shall review a proposed health care institution's scope of services to determine whether the requested health care institution class or subclass is appropriate.

**D.** A health care institution shall comply with the requirements in Article 17 of this Chapter if:
1. There are no specific rules in another Article of this Chapter for the health care institution's class or subclass, or
2. The Department determines that the health care institution is an unclassified health care institution.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-103. Licensing Exceptions**

**A.** A health care institution license is required for each health care institution facility except:
1. A facility exempt from licensing under A.R.S. § 36-402, or
2. A health care institution's administrative office.

**B.** The Department does not require a separate health care institution license for:
1. A satellite facility of a hospital under A.R.S. § 36-422(F);
2. An accredited facility of an accredited hospital under A.R.S. § 36-422(G);
3. A facility operated by a licensed health care institution that is:
   a. Adjacent to and contiguous with the licensed health care institution premises; or
   b. Not adjacent to or contiguous with the licensed health care institution but connected to the licensed health care institution facility by an all-weather enclosure and:
      i. Owned by the health care institution, or
      ii. Leased by the health care institution with exclusive rights of possession;
4. A mobile clinic operated by a licensed health care institution; or
5. A facility located on grounds that are not adjacent to or contiguous with the health care institution premises where only ancillary services are provided to a patient of the health care institution.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-104. Approval of Architectural Plans and Specifications**

**A.** For approval of architectural plans and specifications for the construction or modification of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01, an applicant shall submit to the Department an application packet including:
1. An application in a Department-provided format that contains:
   a. For construction of a new health care institution:
      i. The health care institution's name, street address, city, state, zip code, telephone number, and e-mail address;
      ii. The name and mailing address of the health care institution's governing authority;
      iii. The requested health care institution class or subclass; and
      iv. If applicable, the requested licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations for the health care institution;
   b. For modification of a licensed health care institution that requires approval of architectural plans and specifications:
      i. The health care institution's license number,
      ii. The name and mailing address of the licensee,
      iii. The health care institution's class or subclass, and
      iv. The health care institution's existing licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations; and the requested licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations for the health care institution;
   c. The health care institution's contact person's name, street mailing address, city, state, zip code, telephone number, and e-mail address;
   d. The name, street mailing address, city, state, zip code, telephone number, and e-mail address of:
      i. The project architect; or
      ii. If the construction or modification of the health care institution does not require a project architect, the project engineer or other individual responsible for the completion of the construction or modification;
   e. A narrative description of the project;

f. The estimated total project cost including the costs of:
   i. Site acquisition,
   ii. General construction,
   iii. Architect fees,
   iv. Fixed equipment, and
   v. Movable equipment;
g. If providing or planning to provide medical services, nursing services, or health-related services that require compliance with specific physical plant codes and standards incorporated by reference in R9-10-104.01, the number of rooms or inpatient beds designated for providing the medical services, nursing services, or health-related services;
h. If providing or planning to provide behavioral health observation/stabilization services, the number of behavioral health observation/stabilization observation chairs designated for providing the behavioral health observation/stabilization services;
i. For construction of a new health care institution and if modification of a health care institution requires a project architect, a statement signed and sealed by the project architect, according to the requirements in 4 A.A.C. 30, Article 3, that the:
   i. Project architect has complied with A.A.C. R4-30-301; and
   ii. Architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;
j. If construction or modification of a health care institution requires a project engineer, a statement signed and sealed by the project engineer, according to the requirements in 4 A.A.C. 30, Article 3, that the project engineer has complied with A.A.C. R4-30-301; and
k. A statement signed by the governing authority or the licensee that the architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;

2. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following:
   a. A building permit for the construction or modification issued by the local governmental agency; or
   b. If a building permit issued by the local governmental agency is not required, zoning clearance issued by the local governmental agency that includes:
      i. The health care institution's name, street address, city, state, zip code, and county;
      ii. The health care institution's class or subclass and each type of medical services, nursing services, or health-related services to be provided; and
      iii. A statement signed by a representative of the local governmental agency stating that the address listed is zoned for the health care institution's class or subclass;
3. The following information that is as necessary to demonstrate that the project described on the application complies with applicable codes and standards incorporated by reference in R9-10-104.01:
   a. A table of contents containing:
      i. The architectural plans and specifications submitted;
      ii. The physical plant codes and standards incorporated by reference in R9-10-104.01 that apply to the project;
      iii. The physical plant codes and standards that are required by a local governmental agency, if applicable;
      iv. An index of the abbreviations and symbols used in the architectural plans and specifications; and
      v. The facility's specific International Building Code construction type and International Building Code occupancy type;
   b. If the facility is larger than 3,000 square feet and is or will be occupied by more than 20 individuals, the seal of an architect on the architectural plans and specifications according to the requirements in A.R.S. Title 32, Chapter 1 and 4 A.A.C. 30, Article 3;
   c. A site plan, drawn to scale, of the entire premises showing streets, property lines, facilities, parking areas, outdoor areas, fences, swimming pools, fire access roads, fire hydrants, and access to water mains;
   d. For each facility, on architectural plans and specifications:
      i. A floor plan, drawn to scale, for each level of the facility, showing the layout and dimensions of each room, the name and function of each room, means of egress, and natural and artificial lighting sources;
      ii. A diagram of a section of the facility, drawn to scale, showing the vertical cross-section view from foundation to roof and specifying construction materials;
      iii. Building elevations, drawn to scale, showing the outside appearance of each facility;
      iv. The materials used for ceilings, walls, and floors;
      v. The location, size, and fire rating of each door and each window and the materials and hardware used, including safety features such as fire exit door hardware and fireproofing materials;
      vi. A ceiling plan, drawn to scale, showing the layout of each light fixture, each fire protection device, and each element of the mechanical ventilation system;
      vii. An electrical floor plan, drawn to scale, showing the wiring diagram and the layout of each lighting fixture, each outlet, each switch, each electrical panel, and electrical equipment;
      viii. A mechanical floor plan, drawn to scale, showing the layout of heating, ventilation, and air conditioning systems;

ix. A plumbing floor plan, drawn to scale, showing the layout and materials used for water, sewer, and medical gas systems, including the water supply and plumbing fixtures;
x. A floor plan, drawn to scale, showing the communication system within the health care institution including the nurse call system, if applicable;
xi. A floor plan, drawn to scale, showing the automatic fire extinguishing, fire detection, and fire alarm systems; and
xii. Technical specifications or drawings describing installation of equipment or medical gas and the materials used for installation in the health care institution;

4. The estimated total project cost including the costs of:
   a. Site acquisition,
   b. General construction,
   c. Architect fees,
   d. Fixed equipment, and
   e. Movable equipment;
5. The following, as applicable:
   a. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following provided by the local governmental agency:
      i. A copy of the certificate of occupancy for the facility,
      ii. Documentation that the facility was approved for occupancy, or
      iii. Documentation that a certificate of occupancy for the facility is not available;
   b. A certification and a statement that the construction or modification of the facility is in substantial compliance with applicable licensing requirements in A.R.S. Title 36, Article 4 and this Chapter signed by the project architect, the contractor, and the owner;
   c. A written description of any work necessary to complete the construction or modification submitted by the project architect;
   d. If the construction or modification affects the health care institution's fire alarm system, a contractor certification and description of the fire alarm system in a Department-provided format provided by the Department;
   e. If the construction or modification affects the health care institution's automatic fire extinguishing system, a contractor certification of the automatic fire extinguishing system in a Department-provided format provided by the Department;
   f. If the construction or modification affects the health care institution's heating, ventilation, or air conditioning system, a copy of the heating, ventilation, air conditioning, and air balance tests and a contractor certification of the heating, ventilation, or air conditioning system;
   g. If draperies, cubicle curtains, or floor coverings are installed or replaced, a copy of the manufacturer's certification of flame spread for the draperies, cubicle curtains, or floor coverings;
   h. For a health care institution using inhalation anesthetics or nonflammable medical gas, a copy of the Compliance Certification for Inhalation Anesthetics or Nonflammable Medical Gas System required in the National Fire Codes incorporated by reference in R9-10-104.01;
   i. If a generator is installed, a copy of the installation acceptance required in the National Fire Codes incorporated by reference in R9-10-104.01;
   j. If equipment is installed, a certification from an engineer or from a technical representative of the equipment's manufacturer that the equipment has been installed according to the manufacturer's recommendations and, if applicable, calibrated;
   k. For a health care institution providing radiology, a written report from a certified health physicist of the location, type, and amount of radiation protection; and
   l. If a factory-built building is used by a health care institution:
      i. A copy of the installation permit and the copy of a certificate of occupancy for the factory-built building from the Office of Manufactured Housing; or
      ii. A written report from an individual registered as an architect or a professional structural engineer under 4 A.A.C. 30, Article 2, stating that the factory-built building complies with applicable design standards;
6. For construction of a new health care institution and for a modification of a health care institution that requires a project architect, a statement signed by the project architect that final architectural plans and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution;
7. For modification of a health care institution that does not require a project architect, a statement signed by the project engineer or other individual responsible for the completion of the modification that final architectural plans and specifications have been submitted to the person applying for a health care institution license or the licensee of the health care institution; and
8. The applicable fee required by R9-10-106.

**B.** Before an applicant submits an application for approval of architectural plans and specifications for the construction or modification of a health care institution, an applicant may request an architectural evaluation by providing the documents in subsection (A)(3) to the Department.

**C.** The Department may conduct on-site facility reviews during the construction or modification of a health care institution.

**D.** The Department shall approve or deny an application for approval of architectural plans and specifications of a health care institution in this Section according to R9-10-108.

**E.** In addition to obtaining an approval of a health care institution's architectural plans and specifications, a person shall obtain a health care institution license before operating the health care institution.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Publication error corrected in R9-10-104(A)(1) removing "provided by the Department;" publication error corrected in R9-10-104(B) removing "submitting;" with both amendments made at 25 A.A.R. 1583. Publication error corrected in R9-10-104(A), incorporated by reference Section updated as amended at 25 A.A.R. 3481 (Supp. 21-2).

**R9-10-104.01. Codes and Standards**

**A.** For a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in this Section, an applicant shall follow the requirements in subsection (B), except as follows:
1. Physical plant standards specified in applicable Articles of this Chapter shall govern over the codes and standards incorporated by reference in subsection (B); and
2. If a conflict occurs among the codes and standards incorporated by reference in subsection (B), the more restrictive codes and standards shall govern over the less restrictive.

**B.** The following physical plant health and safety codes and standards are incorporated by reference as modified, are on file with the Department, and include no future editions or amendments:
1. Guidelines for Design and Construction of Health Care Facilities (2018 ed.), published by the American Society for Healthcare Engineering and available from The Facility Guidelines Institute at www.fgiguidelines.org;
2. The following National Fire Codes (2012), published by and available from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269, and at www.nfpa.org/catalog:
   a. NFPA70 National Electrical Code,
   b. NFPA101 Life Safety Code, and
   c. 2012 Supplements;
3. ICC/A117.1-2017, American National Standard: Accessible and Usable Buildings and Facilities (2017), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at ﷺwww.iccsafe.org;
4. International Building Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]";
   b. Section 101.2 is modified by deleting the "Exception";
   c. Section 101.4.7 is deleted;
   d. Sections 103.1 through 103.3 are deleted;
   e. Sections 104.1 through 104.11.2 are deleted;
   f. Sections 105.1 through 105.7 are deleted;
   g. Sections 106.1 through 106.3 are deleted;
   h. Sections 107.1 through 107.5 are deleted;
   i. Sections 108.1 through 108.4 are deleted;
   j. Sections 109.1 through 109.6 are deleted;
   k. Sections 110.1 through 110.6 are deleted;
   l. Sections 111.1 through 111.4 are deleted;
   m. Sections 112.1 through 112.3 are deleted;
   n. Sections 113.1 through 113.3 are deleted;
   o. Sections 114.1 through 114.4 are deleted;
   p. Sections 115.1 through 115.3 are deleted;
   q. Sections 116.1 through 116.5 are deleted; and
   r. Appendices A, B, C, D, K, L, and M are deleted;
5. International Mechanical Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 103.1 through 103.4.1 are deleted,
   c. Sections 104.1 through 104.7 are deleted,
   d. Sections 105.1 through 105.5 are deleted,
   e. Sections 106.1 through 106.5.3 are deleted,
   f. Sections 107.1 through 107.6 are deleted,

g. Sections 108.1 through 108.7.3 are deleted,
h. Sections 109.1 through 109.7 are deleted,
i. Sections 110.1 through 110.4 are deleted, and
j. Appendix B is deleted;

6. International Plumbing Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 103.1 through 103.4.1 are deleted,
   c. Sections 104.1 through 104.7 are deleted,
   d. Sections 105.1 through 105.4.1 are deleted,
   e. Sections 106.1 through 106.6.3 are deleted,
   f. Sections 107.1 through 107.7 are deleted,
   g. Sections 108.1 through 108.7.3 are deleted,
   h. Sections 109.1 through 109.7 are deleted,
   i. Sections 110.1 through 110.4 are deleted, and
   j. Appendix A is deleted;
7. International Fire Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 102.3 and 102.5 are deleted,
   c. Sections 103.1 through 103.4.1 are deleted,
   d. Sections 104.1 through 104.11.3 are deleted,
   e. Sections 105.1 through 105.7.25 are deleted,
   f. Sections 106.1 through 106.5 are deleted,
   g. Sections 107.1 through 107.4 are deleted,
   h. Sections 109.1 through 109.3 are deleted,
   i. Sections 110.1 through 110.4.1 are deleted,
   j. Sections 111.1 through 111.4 are deleted,
   k. Section 112.1 through 112.4 is deleted,
   l. Section 113.1.is deleted, and
   m. Appendix A is deleted;
8. International Fuel Gas Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Section 101.2 is modified by deleting the "Exception",
   c. Sections 103.1 through 103.4.1 are deleted,
   d. Sections 104.1 through 104.7 are deleted,
   e. Sections 105.1 through 105.5 are deleted,
   f. Sections 106.1 through 106.6.3 are deleted,
   g. Sections 107.1 through 107.6 are deleted,
   h. Sections 108.1 through 108.7.3 are deleted,
   i. Sections 109.1 through 109.7 are deleted, and
   j. Sections 110.1 through 110.4 are deleted;
9. International Private Sewage Disposal Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
   a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]",
   b. Sections 103.1 through 103.4.1 are deleted,
   c. Sections 104.1 through 104.7 are deleted,
   d. Sections 105.1 through 105.5 are deleted,
   e. Sections 106.1 through 106.4.3 are deleted,
   f. Sections 107.1 through 107.9 are deleted,
   g. Sections 108.1 through 108.7.2 are deleted,
   h. Sections 109.1 through 109.7 are deleted, and
   i. Sections 110.1 through 110.4 are deleted.

**C.** The Department shall not assess any penalty or fee specified in the physical plant health and safety codes and standards that are incorporated by reference in this Section.

**Historical Note**
New Section made by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-105. License Application**

**A.** A person applying for an initial a health care institution license shall submit to the Department an application packet that contains:

1. An application in a Department-provided format provided by the Department including:
   a. The health care institution's:
      i. Name;
      ii. Street address, city, state, zip code;
      iii. Mailing address;
      iv. Telephone number, and;
      v. E-mail address;
      vi. Tax ID number; and
      vii. Class or subclass listed in R9-10-102 for which licensing is requested;
   b. Except for a home health agency, or hospice service agency, or behavioral health facility, whether the health care institution is located within 1/4 mile of agricultural land;
   c. Whether the health care institution is located in a leased facility;
   d. Whether the health care institution is ready for a licensing inspection by the Department;
   e. If the health care institution is not ready for a licensing inspection by the Department, the date the health care institution will be ready for a licensing inspection;
   f. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-10-108;
   g. Owner information including:
      i. The owner's name, mailing address, telephone number, and e-mail address;
      ii. Whether the owner is a sole proprietorship, a corporation, a partnership, a limited liability partnership, a limited liability company, or a governmental agency;
      iii. If the owner is a partnership or a limited liability partnership, the name of each partner;
      iv. If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;
      v. If the owner is a corporation, the name and title of each corporate officer;
      vi. If the owner is a governmental agency, the name and title of the individual in charge of the governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency;
      vii. Whether the owner or any person with 10% or more business interest in the health care institution has had a license to operate a health care institution denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license;
      viii. Whether the owner or any person with 10% or more business interest in the health care institution has had a health care professional license or certificate denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license or certificate; and
      ix. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;
   h. The name and mailing address of the governing authority;
   i. The chief administrative officer's:
      i. Name,
      ii. Title,
      iii. Highest educational degree, and
      iv. Work experience related to the health care institution class or subclass for which licensing is requested; and
   j. Signature required in A.R.S. § 36-422(B);
2. If the health care institution is located in a leased facility, a copy of the lease showing the rights and responsibilities of the parties and exclusive rights of possession of the leased facility;
3. If applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents;
4. If applicable, the name and mailing address of each owner or lessee of any agricultural land regulated under A.R.S. § 3-365 and a copy of the written agreement between the applicant and the owner or lessee of agricultural land as prescribed in A.R.S. § 36-421(D);
5. Except for a home health agency or a hospice service agency, one of the following:

a. If the health care institution or a part of the health care institution is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01:
   i. An application packet for approval of architectural plans and specifications in R9-10-104(A), or
   ii. Documentation of the Department's approval of the health care institution's architectural plans and specifications approval in R9-10-104 R9-10-104(D); or
b. If a no part of the health care institution or a part of the health care institution is not required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01:
   i. One of the following:
      (1) Documentation from the local jurisdiction of compliance with applicable local building codes and zoning ordinances; or
      (2) If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;
   ii. The licensed capacity requested by the applicant for the health care institution;
   iii. If applicable, the licensed occupancy requested by the applicant for the health care institution;
   iv. If applicable, the respite capacity requested by the applicant for the health care institution;
   v. A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and, if applicable, each swimming pool on the health care institution premises; and
   vi. A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device;

6. The health care institution's proposed scope of services; and
7. The applicable application fee required by R9-10-106.

**B.** In addition to the initial license application requirements in this Section, an applicant shall comply with the supplemental application requirements in specific rules in this Chapter for the health care institution class or subclass for which licensing is requested.

**C.** The Department shall approve or deny a license application in this Section according to R9-10-108.

**D.** A health care institution license is valid:
1. Unless, as specified in A.R.S. § 36-425(C):
   a. The Department revokes or suspends the license according to R9-10-112, or
   b. The license is considered void because the licensee did not pay the applicable fees in R9-10-106 according to R9-10-107; or
2. Until a licensee voluntarily surrenders the license to the Department when terminating the operation of the health care institution, according to R9-10-109(B).

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-106. Fees**

**A.** An applicant who submits to the Department architectural plans and specifications for the construction or modification of a health care institution shall also submit an architectural plans and specifications review fee as follows:
1. Fifty dollars for a project with a cost of $100,000 or less;
2. One hundred dollars for a project with a cost of more than $100,000 but less than $500,000; or
3. One hundred fifty dollars for a project with a cost of $500,000 or more.

**B.** An applicant submitting an application for a health care institution license shall submit to the Department an application fee of $50.

**C.** Except as provided in subsection (D) or (E), an applicant submitting an application for a health care institution license or a licensee submitting annual health care institution licensing fees shall submit to the Department the following licensing fee:
1. For an adult day health care facility, assisted living home, or assisted living center:
   a. For a facility with no licensed capacity, $280;
   b. For a facility with a licensed capacity of one to 59 beds, $280, plus the licensed capacity times $70;
   c. For a facility with a licensed capacity of 60 to 99 beds, $560, plus the licensed capacity times $70;
   d. For a facility with a licensed capacity of 100 to 149 beds, $840, plus the licensed capacity times $70; or
   e. For a facility with a licensed capacity of 150 beds or more, $1,400, plus the licensed capacity times $70;
2. For a behavioral health facility:
   a. For a facility with no licensed capacity, $375;
   b. For a facility with a licensed capacity of one to 59 beds, $375, plus the licensed capacity times $94;
   c. For a facility with a licensed capacity of 60 to 99 beds, $750, plus the licensed capacity times $94;
   d. For a facility with a licensed capacity of 100 to 149 beds, $1,125, plus the licensed capacity times $94; or

e. For a facility with a licensed capacity of 150 beds or more, $1,875, plus the licensed capacity times $94;

3. For a behavioral health facility providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(2), the licensed occupancy times $94;
4. For a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, or a nursing-supported group home:
   a. For a facility with a licensed capacity of one to 59 beds, $290, plus the licensed capacity times $73;
   b. For a facility with a licensed capacity of 60 to 99 beds, $580, plus the licensed capacity times $73;
   c. For a facility with a licensed capacity of 100 to 149 beds, $870, plus the licensed capacity times $73; or
   d. For a facility with a licensed capacity of 150 beds or more, $1,450, plus the licensed capacity times $73;
5. For a hospital, a home health agency, a hospice service agency, a hospice inpatient facility, an abortion clinic, a recovery care center, an outpatient surgical center, an outpatient treatment center that is not a behavioral health facility, a pain management clinic, or an unclassified health care institution:
   a. For a facility with no licensed capacity, $365;
   b. For a facility with a licensed capacity of one to 59 beds, $365, plus the licensed capacity times $91;
   c. For a facility with a licensed capacity of 60 to 99 beds, $730, plus the licensed capacity times $91;
   d. For a facility with a licensed capacity of 100 to 149 beds, $1,095, plus the licensed capacity times $91; or
   e. For a facility with a licensed capacity of 150 beds or more, $1,825, plus the licensed capacity times $91;
6. For a hospital providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times $91; and
7. For an outpatient treatment center that is not a behavioral health facility and provides:
   a. Dialysis services, in addition to the applicable fee in subsection (C)(5), the number of dialysis stations times $91; and
   b. Behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times $91.

**D.** In addition to the applicable fees in subsections (C)(5) and (C)(6), an applicant submitting an application for a single group hospital license or a licensee with a single group license submitting annual health care institution licensing fees shall submit to the Department an additional fee of $365 for each of the hospital's satellite facilities and, if applicable, the fees required in subsection (C)(7).

**E.** Subsections (C) and (D) do not apply to a health care institution operated by a state agency according to state or federal law or to an adult foster care home.

**F.** In addition to the applicable fees in subsections (C) and (D), a licensee shall submit a late payment fee of $250 if submitting annual licensing fees according to R9-10-107(E)(1) or (2)(d).

**G.** All fees are nonrefundable except as provided in A.R.S. § 41-1077.

**Historical Note**

New Section R9-10-106 renumbered from R9-10-122 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-107. Submission of Health Care Institution Licensing Fees**

**A.** An applicant for a health care institution license shall submit the applicable licensing fees in R9-10-106 to the Department:
1. Within 60 calendar days after the date of the written notice of approval in R9-10-108(C)(3); or
2. Within 90 calendar days after the date of the written notice of approval in R9-10-108(C)(3), with the payment of an additional late payment fee of $250.

**B.** The Department shall notify a licensee of the due date of the facility's health care institution licensing fees no later than 90 calendar days before the date the facility's health care institution licensing fee is due to the Department.

**C.** Except as specified in subsection (E), a licensee shall submit to the Department, no earlier than 60 calendar days before the anniversary date of the facility's health care institution license:
1. The following information in a Department-provided format:
   a. The licensee's name, and
   b. The facility's name and license number;
2. Verification of the information in the Department's current records for the health care institution;
3. If applicable, information or documentation required in another Article of this Chapter, specific to the health care institution, to be submitted with the relevant fees required in R9-10-106; and
4. The applicable annual licensing fees in R9-10-106.

**D.** If any information in the Department's current records for a health care institution is incorrect, before a licensee submits annual licensing fees according to subsection (C), the licensee shall comply with the applicable requirements in R9-10-109 or R9-10-110 to update the Department's records for the health care institution.

**E.** A licensee may submit to the Department the information in subsection (C)(1), verification in subsection (C)(2), applicable information or documentation in subsection (C)(3), and applicable annual licensing fees in R9-10-106:
1. Within 30 calendar days after the anniversary date of the facility's health care institution license, with the payment of the additional late payment fee in R9-10-106(F); or
2. If an alternate licensing fee due date has been established for the licensee according to subsections (F) and (G):
   a. By the anniversary date of the facility's health care institution license, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the alternate licensing fee due date;
   b. By the alternate licensing fee due date;
   c. If a new alternate licensing fee due date has been established, by the current alternate licensing fee due date, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the new alternate licensing fee due date; or
   d. Within 30 calendar days after the alternate licensing fee due date, with the payment of the additional late payment fee in R9-10-106(F).

**F.** Except as specified in subsection (H), a licensee may request a licensing fee due date for a facility that is different from the anniversary date of a facility's health care institution license by submitting an application for an alternate licensing fee due date to the Department, at least 30 calendar days before the anniversary date of the facility's health care institution license, that includes the following information in a Department-provided format:
1. The licensee's name and e-mail address,
2. The facility's name and license number,
3. The current licensing fee due date,
4. The proposed alternate licensing fee due date,
5. The reason the licensee is requesting an alternate licensing fee due date, and
6. The name of the health care institution's administrator's or individual representing the health care institution as designated in A.R.S. § 36-422 and the dated signature of the administrator or individual.

**G.** The Department shall review a request made according to subsection (F) according to R9-10-108.

**H.** A licensee may not request an alternate licensing fee due date according to subsection (F):
1. More frequently than once in each three-year period, or
2. For a facility for which the payment of licensing fees is not up-to-date.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-108. Time-frames**

**A.** The overall time-frame for each type of approval granted by the Department is listed in Table 1.1. The applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25% of the overall time-frame.

**B.** The administrative completeness review time-frame for each type of approval granted by the Department as prescribed in this Article is listed in Table 1.1. The administrative completeness review time-frame begins on the date the Department receives an application packet or a written request for an alternate licensing fee due date.
1. The application packet for a health care institution license is not complete until the applicant provides the Department with written notice that the health care institution is ready for a licensing inspection by the Department.
2. If the application packet or written request is incomplete, the Department shall provide a written notice to the applicant specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the missing document or information from the applicant.
3. When an application packet or written request is complete, the Department shall provide a written notice of administrative completeness to the applicant.
4. For an application packet for review of architectural plans and specifications, a health care institution license application packet, an application packet for a modification not requiring review of architectural plans and specifications, or a written request for an alternate licensing fee due date, the Department shall consider the application or written request withdrawn if the applicant fails to supply the missing documents or information included in the notice described in subsection (B)(2) within 60 calendar days after the date of the notice described in subsection (B)(2).
5. If the Department issues a license or grants an approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.

**C.** The substantive review time-frame is listed in Table 1.1 and begins on the date of the notice of administrative completeness.
1. The Department may conduct an onsite inspection of the facility:
   a. As part of the substantive review for approval of architectural plans and specifications;

b. As part of the substantive review for issuing a health care institution license; or
c. As part of the substantive review for approving a modification of a health care institution's license.

2. During the substantive review time-frame, the Department may make one comprehensive written request for additional information or documentation. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation. The time-frame for the Department to complete the substantive review is suspended from the date of a written request for additional information or documentation until the Department receives the additional information or documentation.
3. The Department shall send a written notice of approval to an applicant that is in substantial compliance with applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter.
4. After an applicant for a health care institution license receives the written notice of approval in subsection (C)(3), the applicant shall submit the applicable health care institution license fee in R9-10-106 according to R9-10-107(A).
5. After receiving the applicable health care institution licensing fee from an applicant according to subsection (C)(4) and R9-10-107(A), the Department shall send a health care institution license to the applicant.
6. The Department shall provide a written notice of denial that complies with A.R.S. § 41-1076 to an applicant who does not:
   a. For a health care institution license application or a request for approval of a modification of a health care institution requiring architectural plans and specifications, submit the information or documentation in subsection (C)(2) within 120 calendar days after the Department's written request to the applicant;
   b. For a request for approval of a modification of a health care institution not requiring architectural plans and specifications or a written request for an alternate licensing fee due date, submit the information or documentation in subsection (C)(2) within 30 calendar days after the Department's written request to the applicant;
   c. Comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; or
   d. If applicable, submit a fee required in R9-10-106 or R9-10-107.
7. An applicant may file a written notice of appeal with the Department within 30 calendar days after receiving the notice described in subsection (C)(6). The appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.
8. If a time-frame's last day falls on a Saturday, a Sunday, or an official state holiday, the Department shall consider the next working day to be the time-frame's last day.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 859, effective April 2, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**Table 1.1 Time-frames**

| Type of Approval | Statutory Authority | Overall Time-frame | Administrative Completeness Time-frame | Substantive Review Time-frame |
|---|---|---|---|---|
| Approval of architectural plans and specifications<br>R9-10-104 | A.R.S. §§ 36-405, 36-406(1)(b), and 36-421 | 105 calendar days | 45 calendar days | 60 calendar days |
| Health care institution license<br>R9-10-105 | A.R.S. §§ 36-405, 36-407, 36-421, 36-422, 36-424, and 36-425 | 120 calendar days | 30 calendar days | 90 calendar days |
| Approval of an alternate licensing fee due date<br>R9-10-107 | A.R.S. § 36-405 | 30 calendar days | 10 calendar days | 20 calendar days |
| Approval of a modification of a health care institution<br>R9-10-110 | A.R.S. §§ 36-405, 36-407, and 36-422 | 75 calendar days | 15 calendar days | 60 calendar days |

**Historical Note**

New Table 1 made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 859, effective April 2, 2005 (Supp. 05-1). Table 1 number amended to Table 1.1 and contents amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Table 1.1 amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Table 1.1 amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Table 1.1 heading added for clarity by the Division (21-2).

**R9-10-109. Changes Affecting a License**

**A.** A licensee shall ensure that:
1. The Department is notified in writing at least 30 calendar days before the effective date of:
   a. Except as provided in subsection (I), a change in the name of:
      i. A health care institution, or
      ii. The licensee;
   b. A change in the hours of operation:
      i. Of an administrative office, or
      ii. For providing physical health services or behavioral health services to patients of the health care institution;
   c. A change in the address of a health care institution that does not provide medical services, nursing services, behavioral health services, or health-related services on the premises; or
   d. A change in the geographic region to be served by the hospice service agency or home health agency; and
2. Documentation supporting the change is provided to the Department with the notification required in subsection (A)(1).

**B.** If a licensee intends to terminate the operation of a health care institution, the licensee shall ensure that the Department is notified in writing of:
1. The termination of the health care institution's operations, as required in A.R.S. § 36-422(D), at least 30 calendar days before the termination, and
2. The address and contact information for the location where the health care institution's medical records will be retained as required in A.R.S. § 12-2297.

**C.** A licensee shall ensure that the Department is notified in writing, according to A.R.S. § 36-425(I), of a change in the chief administrative officer of the health care institution.

**D.** If a health care institution is accredited by a nationally recognized accrediting organization, a licensee may submit to the Department the health care institution's current accreditation report.

**E.** Except as provided in A.R.S. § 36-424(B), if a licensee submits to the Department a health care institution's current accreditation report from a nationally recognized accrediting organization, the Department shall not conduct an onsite compliance inspection of the health care institution during the time the accreditation report is valid.

**F.** If a licensee is an adult behavioral health therapeutic home or a behavioral health respite home, the licensee shall ensure that:
1. The Department is notified in writing if the licensee does not have a written agreement with a collaborating health care institution, as required in R9-10-1603(A)(3) or R9-10-1803(A)(3) as applicable; and
2. The adult behavioral health therapeutic home or behavioral health respite home does not accept an individual as a resident or recipient, as applicable, or provide services to a resident or recipient, as applicable, until:
   a. The adult behavioral health therapeutic home or behavioral health respite home has a written agreement with a collaborating health care institution;
   b. The collaborating health care institution has approved the adult behavioral health therapeutic home's or behavioral health respite home's:
      i. Scope of services, and
      ii. Policies and procedures; and
   c. The collaborating health care institution has verified the provider's skills and knowledge.

**G.** If a licensee is an affiliated outpatient treatment center, the licensee shall ensure that if the affiliated outpatient treatment center:
1. Plans to begin providing administrative support to a counseling facility at a time other than during the affiliated outpatient treatment center's license application process, the following information for each counseling facility is submitted to the Department before the affiliated outpatient treatment center begins providing administrative support:
   a. The counseling facility's name,
   b. The license number assigned to the counseling facility by the Department, and
   c. The date the affiliated outpatient treatment center will begin providing administrative support to the counseling facility; or
2. No longer provides administrative support to a counseling facility previously identified by the affiliated outpatient treatment center as receiving administrative support from the affiliated outpatient treatment center, the following information for each counseling facility is submitted to the Department within 30 calendar days after the affiliated outpatient treatment center no longer provides administrative support:
   a. The counseling facility's name,
   b. The license number assigned to the counseling facility by the Department, and
   c. The date the affiliated outpatient treatment center stopped providing administrative support to the counseling facility.

**H.** If a licensee is a counseling facility, the licensee shall ensure that if the counseling facility:

1. Plans to begin receiving administrative support from an affiliated outpatient treatment center at a time other than during the counseling facility's license application process, the following information for the affiliated outpatient treatment center is submitted to the Department before the counseling facility begins receiving administrative support:
   a. The affiliated outpatient treatment center's name,
   b. The license number assigned to the affiliated outpatient treatment center by the Department, and
   c. The date the counseling facility will begin receiving administrative support;
2. No longer receives administrative support from an affiliated outpatient treatment center previously identified by the counseling facility as providing administrative support to the counseling facility, the following information for the affiliated outpatient treatment center is submitted to the Department within 30 calendar days after the counseling facility no longer receives administrative support from the affiliated outpatient treatment center:
   a. The affiliated outpatient treatment center's name,
   b. The license number assigned to the affiliated outpatient treatment center by the Department, and
   c. The date the counseling facility stopped receiving administrative support from the affiliated outpatient treatment center;
3. Plans to begin sharing administrative support with an affiliated counseling facility at a time other than during the counseling facility's license application process, the following information for each affiliated counseling facility sharing administrative support with the counseling facility is submitted to the Department before the counseling facility and affiliated counseling facility begin sharing administrative support:
   a. The affiliated counseling facility's name,
   b. The license number assigned to the affiliated counseling facility by the Department, and
   c. The date the counseling facility and the affiliated counseling facility will begin sharing administrative support; or
4. No longer shares administrative support with an affiliated counseling facility previously identified by the counseling facility as sharing administrative support with the counseling facility, the following information is submitted for each affiliated counseling facility within 30 calendar days after the counseling facility and affiliated counseling facility no longer share administrative support:
   a. The affiliated counseling facility's name,
   b. The license number assigned to the affiliated counseling facility by the Department, and
   c. The date the counseling facility and affiliated counseling facility will no longer be sharing administrative support.

**I.** A governing authority shall submit a license application required in R9-10-105 for:
1. A change in ownership of a health care institution;
2. A change in the address or location of a health care institution that provides medical services, nursing services, health-related services, or behavioral health services on the premises; or
3. A change in a health care institution's class or subclass.

**J.** A governing authority is not required to submit the documentation required in R9-10-105(A)(5) for a license application if:
1. The health care institution has not ceased operations for more than 30 calendar days,
2. A modification has not been made to the health care institution,
3. The services the health care institution is authorized by the Department to provide are not changed, and
4. The location of the health care institution's premises is not changed.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

**R9-10-110. Modification of a Health Care Institution**

**A.** A licensee shall submit a request for approval of a modification of a health care institution when planning to make:
1. An addition or removal of an authorized service;
2. An addition or removal of a colocator;
3. A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;
4. A change in the physical plant, including facilities or equipment, that costs more than $300,000; or
5. A change in the building where a health care institution is located that affects compliance with:
   a. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or
   b. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.

**B.** A licensee of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01 shall submit an application packet, according to R9-10-104(A), for approval of architectural plans and specifications for a modification of the health care institution described in subsections (A)(3) through (5).

**C.** A licensee of a health care institution shall submit a written request an application packet for a modification of the health care institution in a Department-provided format that contains:
1. The following information in a Department-provided format:
   a. The health care institution's name, mailing address, e-mail address, and license number;
   b. A narrative description of the modification, including as applicable:
      i. The services the licensee is requesting be added or removed as an authorized service;
      ii. The name and license number of an associated licensed provider being added or removed as a colocator;
      iii. The name and professional license number of an exempt health care provider being added or removed as a colocator;
      iv. If an associated licensed provider or exempt health care provider is being added as a colocator, the proposed scope of services;
      v. The current and proposed licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations;
      vi. The change being made in the physical plant; and
      vii. The change being made that affects compliance with applicable physical plant codes and standards incorporated by reference in R9-10-104.01; and
   c. The name and e-mail address of the health care institution's administrator's or individual representing the health care institution as designated in according to A.R.S. § 36-422 and the dated signature of the administrator or individual; and
2. Documentation that demonstrates that the requested modification complies with applicable requirements in this Chapter, including as applicable:
   a. A floor plan showing the location of each colocator's proposed treatment area and the areas of the collaborating outpatient treatment center's premises shared with a colocator;
   b. For a change in the licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations or a modification of the physical plant:
      i. A floor plan showing, for each story of the facility affected by the modification, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device; or
      ii. For a health care institution or part of the health care institution that is required to comply with the physical plant codes and standards incorporated by reference in R9-10-104.01 or the building, documentation of the Department's approval of the health care institution's architectural plans and specifications in R9-10-104(D); and
   c. Any other documentation to support the requested modification; and
3. If applicable, a copy of the written agreement the associated licensed provider or exempt health care provider has with the collaborating outpatient treatment center.

**D.** The Department shall approve or deny a request for a modification described in subsection (C) according to R9-10-108.

**E.** A licensee shall not implement a modification described in subsection (C) until an approval or amended license is issued by the Department.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-110 renumbered to Section R9-10-111; new Section R9-10-110 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-111. Enforcement Actions**

**A.** If the Department determines that an applicant or licensee is violating applicable statutes and rules and the violation poses a direct risk to the life, health, or safety of a patient, the Department may:
1. Issue a provisional license to the applicant or licensee under A.R.S. § 36-425,
2. Assess a civil penalty under A.R.S. § 36-431.01,
3. Impose an intermediate sanction under A.R.S. § 36-427,
4. Remove a licensee and appoint another person to continue operation of the health care institution pending further action under A.R.S. § 36-429,
5. Suspend or revoke a license under A.R.S. § 36-427 and R9-10-112,
6. Deny a license under A.R.S. § 36-425 and R9-10-112, or
7. Issue an injunction under A.R.S. § 36-430.

**B.** In determining which action in subsection (A) is appropriate, the Department shall consider the direct risk to the life, health, or safety of a patient in the health care institution based on:
1. Repeated violations of statutes or rules,
2. Pattern of violations,
3. Types of violation,
4. Severity of violation, and
5. Number of violations.

**Historical Note**

Amended effective February 4, 1981 (Supp. 81-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 97, effective January 1, 2014 (Supp. 13-4). Section R9-10-111 renumbered to Section R9-10-112; new Section R9-10-111 renumbered from R9-10-110 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-112. Denial, Revocation, or Suspension of License**

**A.** The Department may deny, revoke, or suspend a license to operate a health care institution if an applicant, a licensee, or a controlling person of the health care institution:
1. Provides false or misleading information to the Department;
2. Has had in any state or jurisdiction any of the following:
   a. An application or license to operate a health care institution denied, suspended, or revoked, unless the denial was based on failure to complete the licensing process or to pay a required licensing fee within a required time-frame; or
   b. A health care professional license or certificate denied, revoked, or suspended;
3. Does not comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; or
4. Has operated a health care institution, within the preceding ten years, in violation of A.R.S. Title 36, Chapter 4 or this Chapter, that posed a direct risk to the life, health, or safety of a patient.

**B.** The Department shall suspend or revoke a hospital's license if the Department receives, pursuant to A.R.S. § 36-2901.08(H), notice from the Arizona Health Care Cost Containment System that the hospital's provider agreement registration with the Arizona Health Care Cost Containment System has been suspended or revoked.

**Historical Note**

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 9 A.A.R. 526, effective April 1, 2003 (Supp. 03-1). Section R9-10-112 renumbered to R9-10-113; new Section R9-10-112 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-112 renumbered to Section R9-10-113; new Section R9-10-112 renumbered from R9-10-111 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-113. Tuberculosis Screening**

**A.** If a health care institution is subject to the requirements of this Section, as specified in an Article in this Chapter, the health care institution's chief administrative officer shall ensure that the health care institution establishes, documents, and implements tuberculosis infection control activities that:
1. Are consistent with recommendations in Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, published by the U.S. Department of Health and Human Services, Atlanta, GA 30333, available at https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm, incorporated by reference, on file with the Department, and including no future editions or amendments; and
2. Include:
   a. For each individual who is employed by the health care institution, provides volunteer services for the health care institution, or is admitted to the health care institution and who is subject to the requirements of this Section, baseline screening, on or before the date specified in the applicable Article of this Chapter, that consists of:
      i. Assessing risks of prior exposure to infectious tuberculosis,
      ii. Determining if the individual has signs or symptoms of tuberculosis, and
      iii. Obtaining documentation of the individual's freedom from infectious tuberculosis according to subsection (B)(1);
   b. If an individual may have a latent tuberculosis infection, as defined in A.A.C. R9-6-1201:
      i. Referring the individual for assessment or treatment; and
      ii. Annually obtaining documentation of the individual's freedom from symptoms of infectious tuberculosis, signed by a medical practitioner, occupation health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101;
   c. Annually providing training and education related to recognizing the signs and symptoms of tuberculosis to individuals employed by or providing volunteer services for the health care institution;
   d. Annually assessing the health care institution's risk of exposure to infectious tuberculosis;
   e. Reporting, as specified in A.A.C. R9-6-202, an individual who is suspected of exposure to infectious tuberculosis; and
   f. If an exposure to infectious tuberculosis occurs in the health care institution, coordinating and sharing information with the local health agency, as defined in A.A.C. R9-6-101, for identifying, locating, and investigating contacts, as defined in A.A.C. R9-6-101.

**B.** A health care institution's chief administrative officer shall:

1. For an individual for whom baseline screening and documentation of freedom from infectious tuberculosis is required by an Article in this Chapter, as specified in subsection (A)(2)(a), obtain one of the following as evidence of freedom from infectious tuberculosis:
   a. Documentation of a negative Mantoux skin test or other tuberculosis screening test that:
      i. Is recommended by the U.S. Centers for Disease Control and Prevention (CDC),
      ii. Was administered within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution, and
      iii. Includes the date and the type of tuberculosis screening test;
   b. If the individual had a history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, compliance with subsection (A)(2)(b); or
   c. If the individual had a positive Mantoux skin test or other tuberculosis screening test according to subsection (B)(1)(a) and does not have history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, a written statement:
      i. That the individual is free from infectious tuberculosis, signed by a medical practitioner or local health agency, as defined in A.A.C. R9-6-101; and
      ii. Dated within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution; and
2. As part of the annual assessment of the health care institution's risk of exposure to infectious tuberculosis according to subsection (A)(2)(d), ensure that documentation is obtained for each individual required to be screened for infectious tuberculosis that:
   a. Indicates the individual's freedom from symptoms of infectious tuberculosis; and
   b. Is signed by a medical practitioner, occupation health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101.

**Historical Note**

Former Section R9-10-113 repealed, new Section R9-10-113 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section R9-10-113 renumbered from R9-10-112 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-113 renumbered to Section R9-10-114; new Section R9-10-113 renumbered from R9-10-112 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-10-114. Clinical Practice Restrictions for Hemodialysis Technician Trainees**

**A.** The following definitions apply in this Section:
1. "Assess" means collecting data about a patient by:
   a. Obtaining a history of the patient,
   b. Listening to the patient's heart and lungs, and
   c. Checking the patient for edema.
2. "Blood-flow rate" means the quantity of blood pumped into a dialyzer per minute of hemodialysis.
3. "Blood lines" means the tubing used during hemodialysis to carry blood between a vascular access and a dialyzer.
4. "Central line catheter" means a type of vascular access created by surgically implanting a tube into a large vein.
5. "Clinical practice restriction" means a limitation on the hemodialysis tasks that may be performed by a hemodialysis technician trainee.
6. "Conductivity test" means a determination of the electrolytes in a dialysate.
7. "Dialysate" means a mixture of water and chemicals used in hemodialysis to remove wastes and excess fluid from a patient's body.
8. "Dialysate-flow rate" means the quantity of dialysate pumped per minute of hemodialysis.
9. "Directly observing" or "direct observation" means a medical person stands next to an inexperienced hemodialysis technician trainee and watches the inexperienced hemodialysis technician trainee perform a hemodialysis task.
10. "Direct supervision" has the same meaning as "supervision" in A.R.S. § 36-401.
11. "Electrolytes" means chemical compounds that break apart into electrically charged particles, such as sodium, potassium, or calcium, when dissolved in water.
12. "Experienced hemodialysis technician trainee" means an individual who has passed all didactic, skills, and competency examinations provided by a health care institution that measure the individual's knowledge and ability to perform hemodialysis.
13. "Fistula" means a type of vascular access created by a surgical connection between an artery and vein.
14. "Fluid-removal rate" means the quantity of wastes and excess fluid eliminated from a patient's blood per minute of hemodialysis to achieve the patient's prescribed weight, determined by:
   a. Dialyzer size,
   b. Blood-flow rate,
   c. Dialysate-flow rate, and

d. Hemodialysis duration.

15. "Germicide-negative test" means a determination that a chemical used to kill microorganisms is not present.
16. "Germicide-positive test" means a determination that a chemical used to kill microorganisms is present.
17. "Graft" means a vascular access created by a surgical connection between an artery and vein using a synthetic tube.
18. "Hemodialysis machine" means a mechanical pump that controls:
    a. The blood-flow rate,
    b. The mixing and temperature of dialysate,
    c. The dialysate-flow rate,
    d. The addition of anticoagulant, and
    e. The fluid-removal rate.
19. "Hemodialysis technician" has the same meaning as in A.R.S. § 36-423(A).
20. "Hemodialysis technician trainee" means an individual who is working in a health care institution to assist in providing hemodialysis and who is not certified as a hemodialysis technician according to A.R.S. § 36-423(A).
21. "Inexperienced hemodialysis technician trainee" means an individual who has not passed all didactic, skills, and competency examinations provided by a health care institution that measure the individual's knowledge and ability to perform hemodialysis.
22. "Medical person" means:
    a. A physician who is experienced in dialysis;
    b. A registered nurse practitioner who is experienced in dialysis;
    c. A nurse who is experienced in dialysis;
    d. A hemodialysis technician who meets the requirements in A.R.S. § 36-423(A) approved by the governing authority; and
    e. An experienced hemodialysis technician trainee approved by the governing authority.
23. "Not established" means not approved by a patient's nephrologist for use in hemodialysis.
24. "Patient" means an individual who receives hemodialysis.
25. "pH test" means a determination of the acidity of a dialysate.
26. "Preceptor course" means a health care institution's instruction and evaluation provided to a nurse, hemodialysis technician, or hemodialysis technician trainee that enables the nurse, hemodialysis technician, or hemodialysis technician trainee to provide direct observation and education to hemodialysis technician trainees.
27. "Respond" means to mute, shut off, reset, or troubleshoot an alarm.
28. "Safety check" means successful completion of tests recommended by the manufacturer of a hemodialysis machine, a dialyzer, or a water system used for hemodialysis before initiating a patient's hemodialysis.
29. "Water-contaminant test" means a determination of the presence of chlorine or chloramine in a water system used for hemodialysis.

**B.** An experienced hemodialysis technician trainee may:
1. Perform hemodialysis under direct supervision, and
2. Provide direct observation to another hemodialysis technician trainee only after completing the health care institution's preceptor course approved by the governing authority.

**C.** An experienced hemodialysis technician trainee shall not access a patient's:
1. Fistula that is not established, or
2. Graft that is not established.

**D.** An inexperienced hemodialysis technician trainee may perform the following hemodialysis tasks only under direct observation:
1. Access a patient's central line catheter;
2. Respond to a hemodialysis-machine alarm;
3. Draw blood for laboratory tests;
4. Perform a water-contaminant test on a water system used for hemodialysis;
5. Inspect a dialyzer and perform a germicide-positive test before priming a dialyzer;
6. Set up a hemodialysis machine and blood lines before priming a dialyzer;
7. Prime a dialyzer;
8. Test a hemodialysis machine for germicide presence;
9. Perform a hemodialysis machine safety check;
10. Prepare a dialysate;
11. Perform a conductivity test and a pH test on a dialysate;
12. Assess a patient;
13. Check and record a patient's vital signs, weight, and temperature;
14. Determine the amount and rate of fluid removal from a patient;
15. Administer local anesthetic at an established fistula or graft, administer anticoagulant, or administer replacement saline solution;
16. Perform a germicide-negative test on a dialyzer before initiating hemodialysis;
17. Initiate or discontinue a patient's hemodialysis;
18. Adjust blood-flow rate, dialysate-flow rate, or fluid-removal rate during hemodialysis; or

19. Prepare a blood, water, or dialysate culture to determine microorganism presence.

**E.** An inexperienced hemodialysis technician trainee shall not:
1. Access a patient's:
   a. Fistula that is not established, or
   b. Graft that is not established; or
2. Provide direct observation.

**F.** When a hemodialysis technician trainee performs hemodialysis tasks for a patient, the patient's medical record shall include:
1. The name of the hemodialysis technician trainee;
2. The date, time, and hemodialysis task performed;
3. The name of the medical person directly observing or the nurse or physician directly supervising the hemodialysis technician trainee; and
4. The initials or signature of the medical person directly observing or the nurse or physician directly supervising the hemodialysis technician trainee.

**G.** If the Department determines that a health care institution is not in substantial compliance with this Section, the Department may take enforcement action according to R9-10-111.

**Historical Note**

Former Section R9-10-114 repealed, new Section R9-10-114 adopted effective February 4, 1981 (Supp. 81-1). Amended by adding paragraph (7) as an emergency effective November 17, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Amended by adding paragraph (7) as a permanent amendment effective August 2, 1984 (Supp. 84-4). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section R9-10-114 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-114 renumbered to Section R9-10-115; new Section R9-10-114 renumbered from R9-10-113 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians**

If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented that:
   a. Delineate the services a behavioral health paraprofessional is allowed to provide at or for the health care institution;
   b. Cover supervision of a behavioral health paraprofessional, including documentation of supervision;
   c. Establish the qualifications for a behavioral health professional providing supervision to a behavioral health paraprofessional;
   d. Delineate the services a behavioral health technician is allowed to provide at or for the health care institution;
   e. Cover clinical oversight for a behavioral health technician, including documentation of clinical oversight;
   f. Establish the qualifications for a behavioral health professional providing clinical oversight to a behavioral health technician;
   g. Delineate the methods used to provide clinical oversight, including when clinical oversight is provided on an individual basis or in a group setting; and
   h. Establish the process by which information pertaining to services provided by a behavioral health technician is provided to the behavioral health professional who is responsible for the clinical oversight of the behavioral health technician;
2. A behavioral health paraprofessional receives supervision according to policies and procedures;
3. Clinical oversight is provided to a behavioral health technician to ensure that patient needs are met based on, for each behavioral health technician:
   a. The scope and extent of the services provided,
   b. The acuity of the patients receiving services, and
   c. The number of patients receiving services;
4. A behavioral health technician receives clinical oversight at least once during each two week period, if the behavioral health technician provides services related to patient care at the health care institution during the two week period;
5. When clinical oversight is provided electronically:
   a. The clinical oversight is provided verbally with direct and immediate interaction between the behavioral health professional providing and the behavioral health technician receiving the clinical oversight,
   b. A secure connection is used, and
   c. The identities of the behavioral health professional providing and the behavioral health technician receiving the clinical oversight are verified before clinical oversight is provided; and
6. A behavioral health professional provides supervision to a behavioral health paraprofessional or clinical oversight to behavioral health technician within the behavioral health professional's scope of practice established in the applicable licensing requirements under A.R.S. Title 32.

**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Amended by final rulemaking 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-115 renumbered to Section R9-10-116; new Section R9-10-115 renumbered from R9-10-114 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-116. Nutrition and Feeding Assistant Training Programs**

**A.** For the purposes of this Section, "agency" means an entity other than a nursing care institution that provides the nutrition and feeding assistant training required in A.R.S. § 36-413.

**B.** An agency shall apply for approval to operate a nutrition and feeding assistant training program by submitting:
1. An application in a Department-provided format that contains:
   a. The name of the agency;
   b. The name, telephone number, and e-mail address of the individual in charge of the proposed nutrition and feeding assistant training program;
   c. The address where the nutrition and feeding assistant training program records are maintained;
   d. A description of the training course being offered by the nutrition and feeding assistant training program including for each topic in subsection (I):
      i. The information presented for each topic,
      ii. The amount of time allotted to each topic,
      iii. The skills an individual is expected to acquire for each topic, and
      iv. The testing method used to verify an individual has acquired the stated skills for each topic;
   e. Whether the agency agrees to allow the Department to submit supplemental requests for information as specified in subsection (F)(2); and
   f. The signature of the individual in charge of the proposed nutrition and feeding assistant training program and the date signed; and
2. A copy of the materials used for providing the nutrition and feeding assistant training program.

**C.** For an application for an approval of a nutrition and feeding assistant training program, the administrative review time-frame is 30 calendar days, the substantive review time-frame is 30 calendar days, and the overall time-frame is 60 calendar days.

**D.** Within 30 calendar days after the receipt of an application in subsection (B), the Department shall:
1. Issue an approval of the agency's nutrition and feeding assistant training program;
2. Provide a notice of administrative completeness to the agency that submitted the application; or
3. Provide a notice of deficiencies to the agency that submitted the application, including a list of the information or documents needed to complete the application.

**E.** If the Department provides a notice of deficiencies to an agency:
1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the agency;
2. If the agency does not submit the missing information or documents to the Department within 30 calendar days, the Department shall consider the application withdrawn; and
3. If the agency submits the missing information or documents to the Department within 30 calendar days, the substantive review time-frame begins on the date the Department receives the missing information or documents.

**F.** Within the substantive review time-frame, the Department:
1. Shall issue or deny an approval of a nutrition and feeding assistant training program; and
2. May make one written comprehensive request for more information, unless the Department and the agency agree in writing to allow the Department to submit supplemental requests for information.

**G.** If the Department issues a written comprehensive request or a supplemental request for information:
1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives the information requested, and
2. The agency shall submit to the Department the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

**H.** The Department shall issue:
1. An approval for an agency to operate a nutrition and feeding assistant training program if the Department determines that the agency and the application comply with A.R.S. § 36-413 and this Section; or
2. A denial for an agency that includes the reason for the denial and the process for appeal of the Department's decision if:
   a. The Department determines that the agency does not comply with A.R.S. § 36-413 and this Section; or

b. The agency does not submit information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

**I.** An individual in charge of a nutrition and feeding assistant training program shall ensure that:
1. The materials and coursework for the nutrition and feeding assistant training program demonstrate the inclusion of the following topics:
   a. Feeding techniques;
   b. Assistance with feeding and hydration;
   c. Communication and interpersonal skills;
   d. Appropriate responses to resident behavior;
   e. Safety and emergency procedures, including the Heimlich maneuver;
   f. Infection control;
   g. Resident rights;
   h. Recognizing a change in a resident that is inconsistent with the resident's normal behavior; and
   i. Reporting a change in subsection (I)(1)(h) to a nurse at a nursing care institution;
2. An individual providing the training course is:
   a. A physician,
   b. A physician assistant,
   c. A registered nurse practitioner,
   d. A registered nurse,
   e. A registered dietitian,
   f. A licensed practical nurse,
   g. A speech-language pathologist, or
   h. An occupational therapist; and
3. An individual taking the training course completes:
   a. At least eight hours of classroom time, and
   b. Demonstrates that the individual has acquired the skills the individual was expected to acquire.

**J.** An individual in charge of a nutrition and feeding assistant training program shall issue a certificate of completion to an individual who completes the training course and demonstrates the skills the individual was expected to acquire as a result of completing the training course that contains:
1. The name of the agency approved to operate the nutrition and feeding assistant training program;
2. The name of the individual completing the training course;
3. The date of completion;
4. The name, signature, and professional license of the individual providing the training course; and
5. The name and signature of the individual in charge of the nutrition and feeding assistant training program.

**K.** The Department may deny, revoke, or suspend an approval to operate a nutrition and feeding assistant training program if an agency operating or applying to operate a nutrition and feeding assistance training program:
1. Provides false or misleading information to the Department;
2. Does not comply with the applicable statutes and rules;
3. Issues a training completion certificate to an individual who did not:
   a. Complete the nutrition and feeding assistant training program, or
   b. Demonstrate the skills the individual was expected to acquire; or
4. Does not implement the nutrition and feeding assistant training program as described in or use the materials submitted with the agency's application.

**L.** In determining which action in subsection (K) is appropriate, the Department shall consider the following:
1. Repeated violations of statutes or rules,
2. Pattern of non-compliance,
3. Types of violations,
4. Severity of violations, and
5. Number of violations.

**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-116 renumbered to Section R9-10-117; new Section R9-10-116 renumbered from R9-10-115 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-117. Repealed**

**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-117 renumbered to Section R9-10-118; new Section R9-10-117 renumbered from R9-10-116 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Repealed by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

**R9-10-118. Collaborating Health Care Institution**

**A.** An administrator of a collaborating health care institution shall ensure that:

1. A list is maintained of adult behavioral health therapeutic homes and behavioral health respite homes for which the collaborating health care institution serves as a collaborating health care institution;
2. For each adult behavioral health therapeutic home or behavioral health respite home in subsection (A)(1), the collaborating health care institution maintains the following information:
   a. A copy of the documented agreement that establishes the responsibilities of the adult behavioral health therapeutic home or behavioral health respite home and the collaborating health care institution consistent with the requirements in this Chapter;
   b. For the adult behavioral health therapeutic home or behavioral health respite home, the following information:
      i. Provider's name;
      ii. Street address;
      iii. License number;
      iv. Whether the residence is an adult behavioral health therapeutic home or a behavioral health respite home;
      v. If the residence is a behavioral health respite home, whether the behavioral health respite home provides respite care services to:
         (1) Individuals 18 years of age or older, or
         (2) Individuals less than 18 years of age;
      vi. The beginning and ending dates of the documented agreement in subsection (A)(2)(a); and
      vii. The name and contact information for the individual assigned by the collaborating health care institution to monitor the adult behavioral health therapeutic home or behavioral health respite home;
   c. For the adult behavioral health therapeutic home or behavioral health respite home, a copy of the following that have been approved by the collaborating health care institution:
      i. Scope of services,
      ii. Policies and procedures, and
      iii. Documentation of the review and update of policies and procedures;
   d. A description of the required skills and knowledge for a provider, based on the scope of services of the adult behavioral health therapeutic home or behavioral health respite home, as established by the collaborating health care institution; and
   e. For a provider in the adult behavioral health therapeutic home or behavioral health respite home, documentation of:
      i. The provider's skills and knowledge;
      ii. If applicable, the provider's completion of training in assistance in the self-administration of medication;
      iii. Verification of the provider's skills and knowledge; and
      iv. If the provider is required to have clinical oversight according to R9-10-1805(C), the provider's receiving clinical oversight;
3. A provider's skills and knowledge are verified by a personnel member according to policies and procedures;
4. A provider who provides behavioral health services receives clinical oversight, required in R9-10-1805(C), from a behavioral health professional; and
5. A provider, other than a provider who is a medical practitioner or nurse, receives training in assistance in the self-administration of medication:
   a. From a medical practitioner or registered nurse or from a personnel member of the collaborating health care institution trained by a medical practitioner or registered nurse;
   b. That includes:
      i. A demonstration of the provider's skills and knowledge necessary to provide assistance in the self-administration of medication,
      ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
      iii. The process for notifying the appropriate entities when an emergency medical intervention is needed; and
   c. That is documented.

**B.** For a patient referred to an adult behavioral health therapeutic home or a behavioral health respite home, an administrator shall ensure that:

1. A resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home does not present a threat to the referred patient, based on the resident's or recipient's developmental levels, social skills, verbal skills, and personal history;
2. The referred patient does not present a threat to a resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home based the referred patient's developmental levels, social skills, verbal skills, and personal history;
3. The referred patient requires services within the adult behavioral health therapeutic home's or behavioral health respite home's scope of services;
4. A provider of the adult behavioral health therapeutic home or behavioral health respite home has the verified skills and knowledge to provide behavioral health services to the referred patient;
5. A treatment plan for the referred patient, which includes information necessary for a provider to meet the referred patient's needs for behavioral health services, is completed and forwarded to the provider before the referred patient is accepted as a resident or recipient;
6. A patient's treatment plan is reviewed and updated at least once every 12 months, and a copy of the patient's updated treatment plan is forwarded to the patient's provider;
7. If documentation of a significant change in a patient's behavioral, physical, cognitive, or functional condition and the action taken by a provider to address patient's changing needs is received by the collaborating health care institution, a behavioral health professional or behavioral health technician reviews the documentation and:
    a. Documents the review; and
    b. If applicable:
        i. Updates the patient's treatment plan, and
        ii. Forwards the updated treatment plan to the provider within 10 working days after receipt of the documentation of a significant change;
8. If the review and updated treatment plan required in subsection (B)(7) is performed by a behavioral health technician, a behavioral health professional reviews and signs the review and updated treatment plan to ensure the patient is receiving the appropriate behavioral health services; and
9. In addition to the requirements for a medical record for a patient in this Chapter, a referred patient's medical record contains:
    a. The provider's name and the street address and license number of the adult behavioral health therapeutic home or behavioral health respite home to which the patient is referred,
    b. A copy of the treatment plan provided to the adult behavioral health therapeutic home or behavioral health respite home,
    c. Documentation received according to and required by subsection (B)(7),
    d. Any information about the patient received from the adult behavioral health therapeutic home or behavioral health respite home, and
    e. Any follow-up actions taken by the collaborating health care institution related to the patient.

**C.** For a patient referred to an adult behavioral health therapeutic home, an administrator shall ensure that the collaborating health care institution has documentation in the patient's medical record of evidence of freedom from infectious tuberculosis that meets the requirements in R9-10-113.

**Historical Note**

New Section R9-10-118 renumbered from R9-10-117 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). The word twelve has been changed to the numeral 12 in subsection (B)(6) for consistency in Chapter style and format (Supp. 21-2).

**R9-10-119. Abortion Reporting**

**A.** A licensed health care institution where abortions are performed shall submit to the Department, in a Department-provided format and according to A.R.S. § 36-2161(D) and (E), a report that contains the information required in A.R.S. § 36-2161(A) and the following:
1. The final disposition of the fetal tissue from the abortion; and
2. Except as provided in subsection (B), if custody of the fetal tissue is transferred to another person or persons:
    a. The name and address of the person or persons accepting custody of the fetal tissue,
    b. The amount of any compensation received by the licensed health care institution for the transferred fetal tissue, and
    c. Whether a patient provided informed consent for the transfer of custody of the fetal tissue.

**B.** A licensed health care institution where abortions are performed is not required to include the information specified in subsections (A)(2)(a) through (c) in the report required in subsection (A) if the licensed health care institution where abortions are performed:
1. Transfers custody of the fetal tissue:
    a. To a funeral establishment, as defined in A.R.S. § 32-1301;
    b. To a crematory, as defined in A.R.S. § 32-1301; or
    c. According to requirements in A.A.C. R18-13-1406, A.A.C. R18-13-1407, and A.A.C. R18-13-1408; or
2. Complies with requirements in A.A.C. R18-13-1405.

**C.** For purposes of this Section, the following definition applies: "Fetal tissue" means cells, or groups of cells with a specific function, obtained from an aborted human embryo or fetus.

**Historical Note**

New Section made by emergency rulemaking at 21 A.A.R. 1787, effective August 14, 2015 for 180 days (Supp. 15-3). Emergency expired February 10, 2016. Section amended by emergency rulemaking at 22 A.A.R. 420, effective February 11, 2016, for an additional 180 days; filed in the Office February 8, 2016 (Supp. 16-1). New Section made by final rulemaking at 22 A.A.R. 1343, with an immediate effective date upon filing under A.R.S. § 41-1032(A)(1) and (4) of May 5, 2016 (Supp. 16-2). Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

**R9-10-120. Opioid Prescribing and Treatment**

**A.** This Section does not apply to a health care institution licensed under Article 20 of this Chapter.

**B.** In addition to the definitions in A.R.S. §§ 32-3248.01 and 36-401(A) and R9-10-101, the following definitions apply in this Section:

1. "Episode of care" means medical services, nursing services, or health-related services provided by a health care institution to a patient for a specific period of time, ending in discharge, the completion of the patient's treatment plan, or 90 days from the start of service provision to the patient, whichever is later.
2. "Order" means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.

**C.** An administrator of a health care institution where opioids are prescribed or ordered as part of treatment shall:

1. Establish, document, and implement policies and procedures for prescribing or ordering an opioid as part of treatment, to protect the health and safety of a patient, that:
   a. Cover which personnel members may prescribe or order an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
   b. As applicable and except when contrary to medical judgment for a patient, are consistent with A.R.S. § 32-3248.01 and the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
      i. Centers for Disease Control and Prevention, or
      ii. U.S. Department of Veterans Affairs and the U.S. Department of Defense;
   c. As applicable, include how, when, and by whom:
      i. A patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
      ii. An assessment is conducted of a patient's substance use risk;
      iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient's representative;
      iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient's representative;
      v. Informed consent is obtained from a patient or the patient's representative and, if applicable, in what situations, described in subsection (G), (H), or (I), informed consent would not be obtained before an opioid is prescribed or ordered for a patient;
      vi. A patient receiving an opioid is monitored; and
      vii. The actions taken according to subsections (C)(1)(c)(i) through (vi) are documented;
   d. Address conditions that may impose a higher risk to a patient when prescribing or ordering an opioid as part of treatment, including:
      i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
      ii. History of substance use disorder,
      iii. Co-occurring behavioral health issue, or
      iv. Pregnancy;
   e. Cover the criteria for co-prescribing a short-acting opioid antagonist for a patient who is not an inpatient, as defined in R9-10-201;
   f. Include that, if continuing control of a patient's pain after discharge is medically indicated due to the patient's medical condition, a method for continuing pain control will be addressed as part of discharge planning;
   g. Include the frequency of the following for a patient being prescribed an opioid for longer than a 30-calendar-day period:
      i. Face-to-face interactions with the patient,
      ii. Conducting an assessment of a patient's substance use risk,
      iii. Renewal of a prescription for an opioid without a face-to-face interaction with the patient, and
      iv. Monitoring the effectiveness of the treatment;
   h. If applicable according to A.R.S. § 36-2608, include documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
   i. As applicable and consistent with A.R.S. § 32-3248.01, cover the criteria and procedures for tapering opioid prescription or ordering as part of treatment; and
   j. Cover the criteria and procedures for offering or referring a patient for treatment for substance use disorder;

2. Include in the plan for the health care institution's quality management program a process for:
   a. Review of known incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
   b. Surveillance and monitoring of adherence to the policies and procedures in subsection (C)(1);
3. Except as prohibited by 42 CFR, Chapter I, Subchapter A, Part 2, or as provided in subsection (H)(1), ensure that, if a patient's death may be related to an opioid prescribed or ordered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the health care institution learns of the patient's death; and
4. Ensure that informed consent, if required from a patient or the patient's representative, includes:
   a. The patient's:
      i. Name,
      ii. Date of birth or other patient identifier, and
      iii. Condition for which opioids are being prescribed;
   b. That an opioid is being prescribed or ordered;
   c. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
   d. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;
   e. Alternatives to a prescribed or ordered opioid;
   f. The name and signature of the individual explaining the use of an opioid to the patient; and
   g. The signature of the patient or the patient's representative and the date signed.

**D.** Except as provided in subsection (H) or (I), an administrator of a health care institution where opioids are prescribed as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to prescribe an opioid in treating a patient:
1. Before prescribing an opioid for a patient of the health care institution:
   a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted during the patient's same episode of care;
   b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
   c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted during the same episode of care by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
   d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
   e. If applicable, explains alternatives to a prescribed opioid; and
   f. Obtains informed consent from the patient or the patient's representative that meets the requirements in subsection (C)(4), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:
      i. Is also prescribed or ordered a sedative-hypnotic medication, or
      ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;
2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
   a. The patient's diagnosis;
   b. The patient's medical history, including co-occurring disorders;
   c. The opioid to be prescribed;
   d. Other medications or herbal supplements being taken by the patient;
   e. If applicable:
      i. The effectiveness of the patient's current treatment,
      ii. The duration of the current treatment, and
      iii. Alternative treatments tried by or planned for the patient;
   f. The expected benefit of the treatment and, if applicable, the benefit of the new treatment compared with continuing the current treatment; and
   g. Other factors relevant to the patient's being prescribed an opioid; and
3. If applicable, specifies in the patient's discharge plan how medically indicated pain control will occur after discharge to meet the patient's needs.

**E.** Except as provided in subsection (G) or (H), an administrator of a health care institution where opioids are ordered for administration to a patient in the health care institution as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to order an opioid in treating a patient:
1. Before ordering an opioid for a patient of the health care institution:
   a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted:

i. During the patient's same episode of care; or
ii. Within the previous 30 calendar days, at a health care institution transferring the patient to the health care institution or by the medical practitioner who referred the patient for admission to the health care institution;

b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;

c. If medically appropriate based on the physical examination in subsection (E)(1)(a) and the patient's medical history, assesses the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted within the previous 30 calendar days by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;

d. Ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative according to policies and procedures; and

e. If applicable, explains alternatives to an ordered opioid; and

2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:

a. The patient's diagnosis;
b. The patient's medical history, including co-occurring disorders;
c. The opioid being ordered and the reason for the order;
d. Other medications or herbal supplements being taken by the patient; and
e. If applicable:
i. The effectiveness of the patient's current treatment,
ii. The duration of the current treatment,
iii. Alternative treatments tried by or planned for the patient,
iv. The expected benefit of a new treatment compared with continuing the current treatment, and
v. Other factors relevant to the patient's being ordered an opioid.

**F.** For a health care institution where opioids are administered as part of treatment or where a patient is provided assistance in the self-administration of medication for a prescribed opioid, including a health care institution in which an opioid may be prescribed or ordered as part of treatment, an administrator, a manager as defined in R9-10-801, or a provider, as applicable to the health care institution, shall:

1. Establish, document, and implement policies and procedures for administering an opioid as part of treatment or providing assistance in the self-administration of medication for a prescribed opioid, to protect the health and safety of a patient, that:

a. Cover which personnel members may administer an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
b. Cover which personnel members may provide assistance in the self-administration of medication for a prescribed opioid and the required knowledge and qualifications of these personnel members;
c. Include how, when, and by whom a patient's need for opioid administration is assessed;
d. Include how, when, and by whom a patient receiving an opioid is monitored; and
e. Cover how, when, and by whom the actions taken according to subsections (F)(1)(c) and (d) are documented;

2. Include in the plan for the health care institution's quality management program a process for:

a. Review of incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
b. Surveillance and monitoring of adherence to the policies and procedures in subsection (F)(1);

3. Except as prohibited by 42 CFR, Chapter I, Subchapter A, Part 2, or as provided in subsection (H)(1), ensure that, if a patient's death may be related to an opioid administered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the patient's death; and

4. Except as provided in subsection (H), ensure that an individual authorized by policies and procedures to administer an opioid in treating a patient or to provide assistance in the self-administration of medication for a prescribed opioid:

a. Before administering an opioid or providing assistance in the self-administration of medication for a prescribed opioid in compliance with an order as part of the treatment for a patient, identifies the patient's need for the opioid;
b. Monitors the patient's response to the opioid; and
c. Documents in the patient's medical record:
i. An identification of the patient's need for the opioid before the opioid was administered or assistance in the self-administration of medication for a prescribed opioid was provided, and
ii. The effect of the opioid administered or for which assistance in the self-administration of medication for a prescribed opioid was provided.

**G.** A medical practitioner authorized by a health care institution's policies and procedures to order an opioid in treating a patient is exempt from the requirements in subsection (E), if:

1. The health care institution's policies and procedures, required in subsection (C)(1) or the applicable Article in 9 A.A.C. 10, contain procedures for:

a. Providing treatment without obtaining the consent of a patient or the patient's representative,
b. Ordering and administering opioids in an emergency situation, and
c. Complying with the requirements in subsection (E) after the emergency is resolved;

2. The order for the administration of an opioid is:
a. Part of the treatment for a patient in an emergency, and
b. Issued in accordance with policies and procedures; and

3. The emergency situation is documented in the patient's medical record.

**H.** The requirements in subsections (D), (E), and (F)(4), as applicable, do not apply to a health care institution's:

1. Prescribing, ordering, or administration of an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy;
2. Prescribing an opioid as part of treatment for a patient when changing the type or dosage of an opioid, which had previously been prescribed by a medical practitioner of the health care institution for the patient according to the requirements in subsection (D):
a. Before a pharmacist dispenses the opioid for the patient; or
b. If changing the opioid because of an adverse reaction to the opioid experienced by the patient, within 72 hours after the opioid was dispensed for the patient by a pharmacist;
3. Ordering an opioid as part of treatment for no longer than three calendar days for a patient remaining in the health care institution and receiving continuous medical services or nursing services from the health care institution; or
4. Ordering an opioid as part of treatment:
a. For a patient receiving a surgical procedure or other invasive procedure; or
b. When changing the type, dosage, or route of administration of an opioid, which had previously been ordered by a medical practitioner of the health care institution for a patient according to the requirements in subsection (E), to meet the patient's needs.

**I.** The requirements in subsections (D)(1)(c) through (f) do not apply to a health care institution's prescribing an opioid as part of treatment for a patient with chronic, intractable pain who has had an established health professional-patient relationship with the prescribing medical practitioner for at least 90 days before the opioid is prescribed.

**Historical Note**

New Section made by emergency rulemaking at 23 A.A.R. 2203, effective July 28, 2017, for 180 days (Supp. 17-3). Emergency expired; new Section renewed by emergency rulemaking at 24 A.A.R. 303, effective January 25, 2018, for 180 days; new Section made by final rulemaking at 24 A.A.R. 657, with an immediate effective date of March 6, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by final expedited rulemaking at 28 A.A.R. 3568 (November 18, 2022), with an immediate effective date November 2, 2022 (Supp. 22-4).

**R9-10-121. Disease Prevention and Control**

**A.** This Section applies:

1. When the Governor has declared a state of emergency, as defined in A.R.S. § 26-301, to address a situation described under A.R.S. § 36-787; and
2. To health care institutions licensed under Article 4, 5, or 8 of this Chapter.

**B.** The following definitions apply in this Section:

1. "Communicable disease" has the same meaning as in A.A.C. R9-6-101.
2. "Infection" has the same meaning as in A.A.C. R9-6-101.
3. "Respiratory symptoms" means coughing, shortness of breath, or wheezing not known to be caused by asthma or another chronic lung-related disease.

**C.** An administrator or manager, as applicable, shall ensure that policies and procedures are established, documented, and implemented, to protect the health and safety of a resident, that:

1. Cover screening and triage of personnel members, employees, visitors, and, except as provided in subsection (E), any other individuals entering the facility;
2. Cover the manner and frequency of assessing residents to determine a change in a resident's medical condition;
3. Establish disinfection protocols and schedules for frequently touched surfaces; and
4. Specify requirements for distancing residents who exhibit symptoms of a communicable disease from other residents to reduce the chance for infection of another individual.

**D.** An administrator or manager, as applicable, shall ensure that:

1. Except as provided in subsection (E), before entering the facility, each individual, including a personnel member, employee, or visitor, is screened for fever or respiratory symptoms indicative of a communicable disease;
2. If an individual refuses to be screened, the individual is excluded from entry to the facility;
3. If an individual is determined to have a fever or respiratory symptoms, the individual is excluded from entry to the facility until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner;
4. If an individual, other than a resident, develops a fever or respiratory symptoms while in the facility, the individual is required to leave the facility and not return until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner; and

5. If insufficient personnel members are available to meet the needs of all residents in the facility, the administrator or manager, as applicable, implements the disaster plan required in R9-10-424, R9-10-523, or R9-10-818, as applicable, which may include moving a resident to a different facility.

**E.** An administrator or manager, as applicable, may allow an emergency medical care technician, as defined in A.R.S. § 36-2201, to enter the facility without screening if the emergency medical care technician is responding to a call for providing emergency medical services, as defined in A.R.S. § 36-2201, to a resident or other individual in the facility.

**F.** An administrator or manager, as applicable, shall ensure that:

1. An assessment of a resident includes whether the resident has a fever or respiratory symptoms indicative of a communicable disease and is documented in the resident's medical record; and
2. If a resident is found to have a fever or respiratory symptoms indicative of a communicable disease:
   a. The resident is evaluated by a medical practitioner within 24 hours to determine what services need to be provided to the resident and what precautions need to be taken by the facility, and the evaluation is documented in the resident's medical record;
   b. To reduce the chance for infection of another individual, the resident is:
      i. Kept at a distance of at least six feet from other residents; or
      ii. If not possible to keep the resident at a distance from other residents, required to wear a facemask;
   c. A personnel member:
      i. Takes precautions, which may include the use of gloves and a facemask or other personal protection equipment, while providing services to the resident; and
      ii. Removes and, if applicable, disposes of the personal protection equipment and washes the personnel member's hands with soap and water for at least 20 seconds or, if soap and water are not available, uses a hand sanitizer containing at least 60% alcohol immediately after providing services to the resident and before providing services to another resident;
   d. Linens, dishes, utensils, and other items used by the resident are:
      i. Kept separate from similar items used by a resident who does not have a fever or respiratory symptoms indicative of a communicable disease, and
      ii. Disinfected or disposed of in a manner to reduce the chance for infection of another individual; and
   e. Surfaces touched by the resident are disinfected before another individual touches the surface.

**G.** An administrator or manager, as applicable, shall ensure that door handles, tables, chair backs and arm rests, light switches, and other frequently touched surfaces are cleaned and disinfected, according to policies and procedures, with:

1. An alcohol solution containing at least 70% alcohol;
2. A bleach solution containing four teaspoons of bleach per quart of water; or
3. An EPA-approved household disinfectant specified in a list, which is incorporated by reference, available at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19, and does not include any later amendments or editions of the incorporated matter.

**Historical Note**

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by emergency rulemaking at 26 A.A.R. 509, with an immediate effective date of March 16, 2020, for 180 days (Supp. 19-1). Emergency expired. New Section made by final rulemaking at 26 A.A.R. 2793, with an immediate effective date of October 7, 2020 (Supp. 20-4).

**R9-10-122. Repealed**

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 2145, effective May 1, 2001 (Supp. 01-2). Amended by final rulemaking at 8 A.A.R. 3578, effective July 26, 2002 (Supp. 02-3). Amended by exempt rulemaking at 14 A.A.R. 3958, effective September 26, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 2100, effective January 1, 2010 (Supp. 09-4). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-123. Repealed**

**Historical Note**

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

**R9-10-124. Repealed**

**Historical Note**

Former Section R9-10-124 repealed, new Section R9-10-124 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by

final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3).

## ARTICLE 2. HOSPITALS

**R9-10-201. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article unless otherwise specified:

1. "Adult" means an individual the hospital designates as an adult based on the hospital's criteria.
2. "Aftercare" means assistance provided to a patient by another individual in the patient's residence, which is not part of a health care institution, following care provided at a hospital, and may include:
   a. Assisting the patient with activities of daily living, and
   b. Following the discharge instructions provided by the hospital.
3. "Aftercare provider" means an individual who:
   a. May be a friend or relative of a patient or be the patient's representative,
   b. Is designated by the patient or the patient's representative to perform aftercare tasks, and
   c. Is not compensated for performing aftercare tasks for the patient.
4. "Care plan" means a documented guide for providing nursing services and rehabilitation services to a patient that includes measurable objectives and the methods for meeting the objectives.
5. "Continuing care nursery" means a nursery where medical services and nursing services are provided to a neonate who does not require intensive care services.
6. "Critically ill inpatient" means an inpatient whose severity of medical condition requires the nursing services of specially trained registered nurses for:
   a. Continuous monitoring and multi-system assessment,
   b. Complex and specialized rapid intervention, and
   c. Education of the inpatient or inpatient's representative.
7. "Device" has the same meaning as in A.R.S. § 32-1901.
8. "Diet" means food and drink provided to a patient.
9. "Diet manual" means a written compilation of diets.
10. "Dietary services" means providing food and drink to a patient according to an order.
11. "Diversion" means notification to an emergency medical services provider, as defined in A.R.S. § 36-2201, that a hospital is unable to receive a patient from an emergency medical services provider.
12. "Drug formulary" means a written list of medications available and authorized for use developed according to R9-10-218.
13. "Gynecological services" means medical services for the diagnosis, treatment, and management of conditions or diseases of the female reproductive organs or breasts.
14. "Hospital services" means medical services, nursing services, and health-related services provided in a hospital.
15. "Infection control risk assessment" means determining the probability for transmission of communicable diseases.
16. "Inpatient" means an individual who:
   a. Is admitted to a hospital as an inpatient according to policies and procedures,
   b. Is admitted to a hospital with the expectation that the individual will remain and receive hospital services for 24 consecutive hours or more, or
   c. Receives hospital services for 24 consecutive hours or more.
17. "Intensive care services" means hospital services provided to a critically ill inpatient who requires the services of specially trained nursing and other personnel members as specified in policies and procedures.
18. "Medical staff regulations" means standards, approved by the medical staff, that govern the day-to-day conduct of the medical staff members.
19. "Multi-organized service unit" means an inpatient unit in a hospital where more than one organized service may be provided to a patient in the inpatient unit.
20. "Neonate" means an individual:
   a. From birth until discharge following birth, or
   b. Who is designated as a neonate by hospital criteria.
21. "Nurse anesthetist" means a registered nurse who meets the requirements of A.R.S. § 32-1601 and who has clinical privileges to administer anesthesia.
22. "Nurse executive" means a registered nurse accountable for the direction of nursing services provided in a hospital.
23. "Nursery" means an area in a hospital designated only for neonates.
24. "Nurse supervisor" means a registered nurse accountable for managing nursing services provided in an organized service in a hospital.
25. "Nutrition assessment" means a process for determining a patient's dietary needs using information contained in the patient's medical record.
26. "On duty" means that an individual is at work and performing assigned responsibilities.
27. "Organized service" means specific medical services, such as surgical services or emergency services, provided in an area of a hospital designated for the provision of those medical services.

28. "Outpatient" means an individual who:
    a. Is admitted to a hospital with the expectation that the individual will receive hospital services for less than 24 consecutive hours; or
    b. Except as provided in subsection (17) receives, hospital services for less than 24 consecutive hours.
29. "Pathology" means an examination of human tissue for the purpose of diagnosis or treatment of an illness or disease.
30. "Patient care" means hospital services provided to a patient by a personnel member or a medical staff member.
31. "Pediatric" means pertaining to an individual designated by a hospital as a child based on the hospital's criteria.
32. "Perinatal services" means medical services for the treatment and management of obstetrical patients and neonates.
33. "Post-anesthesia care unit" means a designated area for monitoring a patient following a medical procedure for which anesthesia was administered to the patient.
34. "Private duty staff" means an individual, excluding a personnel member, compensated by a patient or the patient's representative.
35. "Psychiatric services" means the diagnosis, treatment, and management of a mental disorder.
36. "Social services" means assistance, other than medical services or nursing services, provided by a personnel member to a patient to assist the patient to cope with concerns about the patient's illness or injury while in the hospital or the anticipated needs of the patient after discharge.
37. "Specialty" means a specific branch of medicine practiced by a licensed individual who has obtained education or qualifications in the specific branch in addition to the education or qualifications required for the individual's license.
38. "Surgical services" means medical services involving a surgical procedure.
39. "Transfusion" means the introduction of blood or blood products from one individual into the body of another individual.
40. "Unit" means a designated area of an organized service.
41. "Vital record" has the same meaning as in A.R.S. § 36-301.
42. "Well-baby bassinet" means a receptacle used for holding a neonate who does not require treatment and whose anticipated discharge is within 96 hours after birth.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 2797, with an effective date of January 1, 2021 (Supp. 20-4).

**R9-10-202. Supplemental Application, Notification, and Documentation Submission Requirements**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and Article 1 of this Chapter, an applicant for a hospital license shall include:
1. On the application the requested licensed capacity for the hospital, including:
    a. The number of inpatient beds for each organized service, not including well-baby bassinets; and
    b. If applicable, the number of inpatient beds for each multi-organized service unit;
2. On the application, if applicable, the requested licensed occupancy for providing behavioral health observation/stabilization services to:
    a. Individuals who are under 18 years of age, and
    b. Individuals 18 years of age and older; and
3. A list, in a Department-provided format, of medical staff specialties and subspecialties.

**B.** For a single group license authorized in A.R.S. § 36-422(F), in addition to the requirements in subsection (A), a governing authority applying for a license shall submit the following to the Department, in a Department-provided format, for each satellite facility under the single group license:
1. The name, address, e-mail address, and telephone number of the satellite facility;
2. The class or subclass of the satellite facility, according to R9-10-102;
3. The name and e-mail address of the administrator;
4. A list of services to be provided at the satellite facility; and
5. The hours of operation during which the satellite facility provides medical services, nursing services, behavioral health services, or health-related services.

**C.** For a single group license authorized in A.R.S. § 36-422(G), in addition to the requirements in subsection (A), a governing authority applying for a license shall submit the following to the Department in a Department-provided format for each accredited satellite facility under the single group license:
1. The name, address, e-mail address, and telephone number of the accredited satellite facility;
2. The class or subclass of the accredited satellite facility, according to R9-10-102;
3. The name and e-mail address of the administrator;
4. A list of services to be provided at the accredited satellite facility;

5. The hours of operation during which the accredited satellite facility provides medical services, nursing services, behavioral health services, or health-related services; and
6. A copy of the accredited satellite facility's current accreditation report.

**D.** A licensee with a single group license shall submit to the Department, with the relevant fees required in R9-10-106(D) and in a Department-provided format, the following, as applicable:
1. The information required in subsections (B)(1) through (5), or
2. The information and documentation required in subsections (C)(1) through (6).

**E.** A governing authority shall:
1. Notify the Department:
   a. At least 30 calendar days before a satellite facility or an accredited satellite facility on a single group license terminates operations;
   b. Within 30 calendar days after adding a satellite facility or an accredited satellite facility under a single group license and provide, as applicable:
      i. The information required in subsections (B)(1) through (5), or
      ii. The information and documentation required in subsections (C)(1) through (6); and
   c. At least 60 calendar days before a satellite facility or an accredited satellite facility licensed under a single group license anticipates providing medical services, nursing services, behavioral health services, or health-related services under a license separate from the single group license; and
2. Upon notifying the Department according to subsection (E)(1)(c), submit an application, according to the requirements in 9 A.A.C. 10, Article 1, at least 60 calendar days but not more than 120 calendar days before a satellite facility or an accredited satellite facility licensed under a single group license anticipates providing medical services, nursing services, behavioral health services, or health-related services under a license separate from the single group license.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-203. Administration**

**A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of a hospital;
2. Establish, in writing:
   a. A hospital's scope of services,
   b. Qualifications for an administrator,
   c. Which organized services are to be provided in the hospital, and
   d. The organized services that are to be provided in a multi-organized service unit according to R9-10-228(A);
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Grant, deny, suspend, or revoke a clinical privilege of a medical staff member or delegate authority to an individual to grant or suspend a clinical privilege for a limited time, according to medical staff bylaws;
5. Adopt a quality management program according to R9-10-204;
6. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
7. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
   a. Expected not to be present on a hospital's premises for more than 30 calendar days, or
   b. Not present on a hospital's premises for more than 30 calendar days;
8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) if there is a change of administrator and identify the name and qualifications of the new administrator; and
9. For a health care institution under a single group license, ensure that the health care institution complies with the applicable requirements in this Chapter for the class or subclass of the health care institution.

**B.** An administrator:
1. Is directly accountable to the governing authority of a hospital for the daily operation of the hospital and hospital services and environmental services provided by or at the hospital;
2. Has the authority and responsibility to manage the hospital; and
3. Except as provided in subsection (A)(7), shall designate, in writing, an individual who is present on a hospital's premises and available and accountable for hospital services and environmental services when the administrator is not present on the hospital's premises.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:

a. Cover job descriptions, duties, and qualifications, including required skills and knowledge for personnel members, employees, volunteers, and students;
b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
c. Include how a personnel member may submit a complaint relating to patient care;
d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
e. Cover cardiopulmonary resuscitation training required in R9-10-206(5) including:
   i. The method and content of cardiopulmonary resuscitation training,
   ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
   iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
   iv. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
f. Cover use of private duty staff, if applicable;
g. Cover diversion, including:
   i. The criteria for initiating diversion;
   ii. The categories or levels of personnel or medical staff that may authorize or terminate diversion;
   iii. The method for notifying emergency medical services providers of initiation of diversion, the type of diversion, and termination of diversion; and
   iv. When the need for diversion will be reevaluated;
h. Include a method to identify a patient to ensure the patient receives hospital services as ordered;
i. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
j. Cover health care directives;
k. Cover medical records, including electronic medical records;
l. Cover quality management, including incident reports and supporting documentation;
m. Cover contracted services;
n. Cover tissue and organ procurement and transplant; and
o. Cover when an individual may visit a patient in a hospital, including visiting a neonate in a nursery, if applicable;

2. Policies and procedures for hospital services are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, transport, and transfer;
   b. Cover discharge planning and discharge, including the requirements in R9-10-225(B) for an inpatient who was admitted after a suicide attempt or who exhibits suicidal ideation;
   c. Cover the provision of hospital services;
   d. Cover acuity, including a process for obtaining sufficient nursing personnel to meet the needs of patients;
   e. Include when general consent and informed consent are required;
   f. Include the age criteria for providing hospital services to pediatric patients;
   g. Cover dispensing, administering, and disposing of medication;
   h. Cover prescribing a controlled substance to minimize substance abuse by a patient;
   i. Cover infection control;
   j. Cover restraints that:
      i. Require an order, including the frequency of monitoring and assessing the restraint; or
      ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a patient's sudden, intense, or out-of-control behavior;
   k. Cover seclusion of a patient including:
      i. The requirements for an order, and
      ii. The frequency of monitoring and assessing a patient in seclusion;
   l. Cover communicating with a midwife when the midwife's client begins labor and ends labor;
   m. Cover telemedicine, if applicable; and
   n. Cover environmental services that affect patient care;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members;
5. The licensed capacity in an organized service is not exceeded, except for an emergency admission of a patient;
6. A patient is only admitted to an organized service that has exceeded the organized service's licensed capacity after a medical staff member reviews the medical history of the patient and determines that the patient's admission is an emergency; and
7. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a hospital, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the hospital.

**D.** An administrator of a special hospital shall ensure that:

1. Medical services are available to an inpatient in an emergency based on the inpatient's medical conditions and the scope of services provided by the special hospital; and
2. A physician or nurse, qualified in cardiopulmonary resuscitation, is on the hospital premises.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4004, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-204. Quality Management**

**A.** A governing authority shall ensure that an ongoing quality management program is established that:
1. Complies with the requirements in A.R.S. § 36-445; and
2. Evaluates the quality of hospital services and environmental services related to patient care.

**B.** An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate hospital services and environmental services related to patient care;
   c. A method to evaluate the data collected to identify a concern about the delivery of hospital services or environmental services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of hospital services or environmental services related to patient care;
   e. A method to identify and document each occurrence of exceeding licensed capacity, as described in R9-10-203(C)(5), and to evaluate the occurrences of exceeding licensed capacity, including the actions taken for resolving occurrences of exceeding licensed capacity; and
   f. The frequency of submitting a documented report required in subsection (B)(2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of hospital services or environmental services related to patient care, and
   b. Any changes made or actions taken as a result of the identification of a concern about the delivery of hospital services or environmental services related to patient care;
3. The acuity plan required in R9-10-214(C)(2) is reviewed and evaluated at least once every 12 months and the results are documented and reported to the governing authority;
4. The reports required in subsections (B)(2) and (3) and the supporting documentation for the reports are maintained for at least 12 months after the date the report is submitted to the governing authority; and
5. Except for information or documentation that is confidential under federal or state law, a report or documentation required in this Section is provided to the Department for review within two hours after the Department's request.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-205. Contracted Services**

An administrator shall ensure that:
1. Contracted services are provided according to the requirements in this Article, and
2. A documented list of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-206. Personnel**

An administrator shall ensure that:
1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:

i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and

b. Include:
i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
a. Before the personnel member provides physical health services or behavioral health services, and
b. According to policies and procedures;
3. Sufficient personnel members are present on a hospital's premises with the qualifications, skills, and knowledge necessary to:
a. Provide the services in the hospital's scope of services,
b. Meet the needs of a patient, and
c. Ensure the health and safety of a patient;
4. Orientation occurs within the first 30 calendar days after a personnel member begins providing hospital services and includes:
a. Informing a personnel member about Department rules for licensing and regulating hospitals and where the rules may be obtained,
b. Reviewing the process by which a personnel member may submit a complaint about patient care to a hospital, and
c. Providing the information required by policies and procedures;
5. Policies and procedures designate the categories of personnel providing medical services or nursing services who are:
a. Required to be qualified in cardiopulmonary resuscitation within 30 calendar days after the individual's starting date, and
b. Required to maintain current qualifications in cardiopulmonary resuscitation;
6. A personnel record for each personnel member is established and maintained and includes:
a. The personnel member's name, date of birth, and contact telephone number;
b. The personnel member's starting date and, if applicable, ending date;
c. Verification of a personnel member's certification, license, or education, if necessary for the position held;
d. Documentation of evidence of freedom from infectious tuberculosis required in R9-10-230(5);
e. Verification of current cardiopulmonary resuscitation qualifications, if necessary for the position held; and
f. Orientation documentation;
7. Personnel receive in-service education according to criteria established in policies and procedures;
8. In-service education documentation for a personnel member includes:
a. The subject matter,
b. The date of the in-service education, and
c. The signature of the personnel member;
9. Personnel records and in-service education documentation are maintained by the hospital for at least 24 months after the last date the personnel member worked; and
10. Personnel records and in-service education documentation, for a personnel member who has not worked in the hospital during the previous 12 months, are provided to the Department within 72 hours after the Department's request.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-207. Medical Staff**

**A.** A governing authority shall ensure that:
1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a hospital;
2. The medical staff bylaws and medical staff regulations are approved according to the medical staff bylaws and governing authority requirements;
3. A medical staff member complies with medical staff bylaws and medical staff regulations;

4. The medical staff of a general hospital or a special hospital includes at least two physicians who have clinical privileges to admit inpatients to the general hospital or special hospital;
5. The medical staff of a rural general hospital includes at least one physician who has clinical privileges to admit inpatients to the rural general hospital and one additional physician who serves on a committee according to subsection (A)(7)(c);
6. A medical staff member is available to direct patient care;
7. Medical staff bylaws or medical staff regulations are established, documented, and implemented for the process of:
   a. Conducting peer review according to A.R.S. Title 36, Chapter 4, Article 5;
   b. Appointing members to the medical staff, subject to approval by the governing authority;
   c. Establishing committees including identifying the purpose and organization of each committee;
   d. Appointing one or more medical staff members to a committee;
   e. Obtaining and documenting permission for an autopsy of a patient, performing an autopsy, and notifying, if applicable, the medical practitioner coordinating the patient's medical services when an autopsy is performed;
   f. Requiring that each inpatient has a medical practitioner who coordinates the inpatient's care;
   g. Defining the responsibilities of a medical staff member to provide medical services to the medical staff member's patient;
   h. Defining a medical staff member's responsibilities for the transport or transfer of a patient;
   i. Specifying requirements for oral, telephone, and electronic orders, including which orders require identification of the time of the order;
   j. Establishing a time-frame for a medical staff member to complete a patient's medical record;
   k. Establishing criteria for granting, denying, revoking, and suspending clinical privileges;
   l. Specifying pre-anesthesia and post-anesthesia responsibilities for medical staff members; and
   m. Approving the use of medication and devices under investigation by the U.S. Department of Health and Human Services, Food and Drug Administration including:
      i. Establishing criteria for patient selection;
      ii. Obtaining informed consent before administering the investigational medication or device; and
      iii. Documenting the administration of and, if applicable, the adverse reaction to an investigational medication or device; and
8. The organized medical staff reviews the medical staff bylaws and the medical staff regulations at least once every three years and updates the bylaws and regulations as needed.

**B.** An administrator shall ensure that:
1. A medical staff member provides evidence of freedom from infectious tuberculosis according to the requirements in R9-10-230(5);
2. A record for each medical staff member is established and maintained that includes:
   a. A completed application for clinical privileges;
   b. The dates and lengths of appointment and reappointment of clinical privileges;
   c. The specific clinical privileges granted to the medical staff member, including revision or revocation dates for each clinical privilege; and
   d. A verification of current Arizona health care professional active license according to A.R.S. Title 32; and
3. Except for documentation of peer review conducted according to A.R.S. § 36-445, a record under subsection (B)(2) is provided to the Department for review:
   a. As soon as possible, but not more than two hours after the time of the Department's request, if the individual is a current medical staff member; and
   b. Within 72 hours after the time of the Department's request if the individual is no longer a current medical staff member.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-208. Admission**

**A.** An administrator shall ensure that:
1. A patient is admitted as an inpatient on the order of a medical staff member;
2. An individual, authorized by policies and procedures, is available to accept a patient for admission;
3. Except in an emergency, informed consent is obtained from a patient or the patient's representative before or at the time of admission;
4. The informed consent obtained in subsection (A)(3) or the lack of consent in an emergency is documented in the patient's medical record;
5. A physician or other medical staff member performs a medical history and physical examination on a patient within 30 calendar days before admission or within 48 hours after admission and documents the medical history and physical examination in the patient's medical record within 48 hours after admission;

6. If a physician or other medical staff member performs a medical history and physical examination on a patient before admission, the physician or the medical staff member enters an interval note into the patient's medical record at the time of admission; and
7. A patient or the patient's representative is given an opportunity to:
   a. Designate an individual who is willing to participate in discharge planning and act as the patient's aftercare provider;
   b. Provide contact information for the patient's aftercare provider; and
   c. Change the patient's designated aftercare provider before discharge.

**B.** If a patient is admitted after a suicide attempt or exhibits suicidal ideation, an administrator shall ensure that the requirements in R9-10-225(B) are met as part of an inpatient assessment.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-208 renumbered to R9-10-214; new Section R9-10-208 renumbered from R9-10-210 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 26 A.A.R. 2797, with an effective date of January 1, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-209. Discharge Planning; Discharge**

**A.** For an inpatient, an administrator shall ensure that discharge planning:
1. Is completed before discharge occurs;
2. Identifies the specific needs of the patient after discharge, if applicable;
3. Includes the participation of the patient or patient's representative and, if applicable, the patient's aftercare provider;
4. If the patient is being discharged to the patient's residence, which is not part of a health care institution:
   a. Includes at least one attempt, which is documented in the patient's medical record, to notify the patient's aftercare provider, if designated, before the patient's discharge; and
   b. Prepares the patient, the patient's representative, or the patient's aftercare provider, as applicable, to carry out the discharge instructions required in subsection (B)(3)(a), including:
      i. Answering questions about the discharge instructions and aftercare; and
      ii. Providing a demonstration of the aftercare tasks to the patient, the patient's representative, or the patient's aftercare provider, as applicable;
5. Provides the patient or the patient's representative with written information identifying classes or subclasses of health care institutions and the level of care that the health care institutions provide that may meet the patient's assessed and anticipated needs after discharge, if applicable; and
6. Is documented in the patient's medical record.

**B.** For an inpatient discharge or a transfer of an inpatient, an administrator shall ensure that:
1. There is a discharge summary that includes:
   a. A description of the patient's medical condition and the medical services provided to the patient, and
   b. The signature of the medical practitioner coordinating the patient's medical services;
2. There is a documented discharge order for the patient by a medical practitioner coordinating the patient's medical services before discharge unless the patient leaves the hospital against a medical staff member's advice;
3. If the patient is not being transferred:
   a. There are documented discharge instructions; and
   b. The patient or patient's representative and the patient's aftercare provider, if designated, is provided with a copy of the discharge instructions; and
4. If the patient is being transferred, the transfer complies with R9-10-211.

**C.** For an inpatient discharge or a transfer of an inpatient who was admitted after a suicide attempt or who exhibits suicidal ideation, an administrator shall ensure that the requirements in R9-10-225(B) are met as part of discharge planning.

**D.** Except as provided in subsection (E), an administrator shall ensure that an outpatient is discharged according to policies and procedures.

**E.** For a discharge of an outpatient receiving emergency services, an administrator shall ensure that:
1. A discharge order is documented by a medical practitioner who provided medical services to the patient before the patient is discharged, unless the patient leaves against a medical staff member's advice; and
2. Discharge instructions are documented and provided to the patient or patient's representative and the patient's aftercare provider, if designated before the patient is discharged, unless the patient leaves the hospital against a medical staff member's advice.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-209 renumbered to R9-10-212; new Section R9-10-209 renumbered from R9-10-211 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

Amended by final rulemaking at 26 A.A.R. 2797, with an effective date of January 1, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-210. Transport**

**A.** For a transport of a patient, the administrator of a sending hospital shall ensure that:
1. Policies and procedures are established, documented, and implemented that:
   a. Specify the process by which the sending hospital personnel members coordinate the transport and the medical services provided to a patient to protect the health and safety of the patient;
   b. Require an assessment of the patient by a registered nurse or a medical staff member before transporting the patient and after the patient's return;
   c. Specify the information in the sending hospital's patient medical record that is required to accompany the patient, which shall include the information related to the medical services to be provided to the patient at the receiving health care institution;
   d. Specify how the sending hospital personnel members communicate patient medical record information that the sending hospital does not provide at the time of transport but is requested by the receiving health care institution; and
   e. Specify how a medical staff member explains the risks and benefits of a transport to the patient or the patient's representative based on the:
      i. Patient's medical condition, and
      ii. Mode of transport; and
2. Documentation in the patient's medical record includes:
   a. Consent for transport by the patient or the patient's representative or why consent could not be obtained;
   b. The acceptance of the patient by and communication with an individual at the receiving health care institution;
   c. The date and the time of the transport to the receiving health care institution;
   d. The date and time of the patient's return to the sending hospital, if applicable;
   e. The mode of transportation; and
   f. The type of personnel member or medical staff member assisting in the transport if an order requires that a patient be assisted during transport.

**B.** For a transport of a patient to a receiving hospital, the administrator of the receiving hospital shall ensure that:
1. Policies and procedures are established, documented, and implemented that:
   a. Specify the process by which the receiving hospital personnel members coordinate the transport and the medical services provided to a patient to protect the health and safety of the patient;
   b. Require an assessment of the patient by a registered nurse or a medical staff member upon arrival of the patient and before the patient is returned to the sending health care institution unless the receiving facility is a satellite facility, as established in A.R.S. § 36-422, and does not have a registered nurse or a medical staff member at the satellite facility;
   c. Specify the information in the receiving hospital's patient medical record required to accompany the patient when the patient is returned to the sending health care institution, if applicable; and
   d. Specify how the receiving hospital personnel members communicate patient medical record information to the sending health care institution that is not provided at the time of the patient's return; and
2. Documentation in the patient's medical record includes:
   a. The date and time the patient arrived at the receiving hospital;
   b. The medical services provided to the patient at the receiving hospital;
   c. Any adverse reaction or negative outcome the patient experienced at the receiving hospital, if applicable;
   d. The date and time the receiving hospital returned the patient to the sending health care institution, if applicable;
   e. The mode of transportation to return the patient to the sending health care institution, if applicable; and
   f. The type of personnel member or medical staff member assisting in the transport if an order requires that a patient be assisted during transport.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-210 renumbered to R9-10-208; new Section R9-10-210 renumbered from R9-10-212 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-211. Transfer**

For a transfer of a patient, the administrator of a sending hospital shall ensure that:
1. Policies and procedures are established, documented, and implemented that:
   a. Specify the process by which the sending hospital personnel members coordinate the transfer and the medical services provided to a patient to protect the health and safety of the patient during the transfer;
   b. Require an assessment of the patient by a registered nurse or a medical staff member of the sending hospital before the patient is transferred;

c. Specify how the sending hospital personnel members communicate medical record information that is not provided at the time of the transfer; and
d. Specify how a medical staff member explains the risks and benefits of a transfer to the patient or the patient's representative based on the:
i. Patient's medical condition, and
ii. Mode of transfer;
2. One of the following accompanies the patient during transfer:
a. A copy of the patient's medical record for the current inpatient admission; or
b. All of the following for the current inpatient admission:
i. A medical staff member's summary of medical services provided to the patient,
ii. A care plan containing up-to-date information,
iii. Consultation reports,
iv. Laboratory and radiology reports,
v. A record of medications administered to the patient for the seven calendar days before the date of transfer,
vi. Medical staff member's orders in effect at the time of transfer, and
vii. Any known allergy; and
3. Documentation in the patient's medical record includes:
a. Consent for transfer by the patient or the patient's representative, except in an emergency;
b. The acceptance of the patient by and communication with an individual at the receiving health care institution;
c. The date and the time of the transfer to the receiving health care institution;
d. The mode of transportation; and
e. The type of personnel member or medical staff member assisting in the transfer if an order requires that a patient be assisted during transfer.

**Historical Note**

Former Section R9-10-211 renumbered as R9-10-311 as an emergency effective February 22, 1979, new Section R9-10-211 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-211 renumbered to R9-10-209; new Section R9-10-211 renumbered from R9-10-213 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-212. Patient Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the hospital's premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
b. Where patient rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
a. Abuse;
b. Neglect;
c. Exploitation;
d. Coercion;
e. Manipulation;
f. Sexual abuse;
g. Sexual assault;
h. Seclusion, except as allowed under R9-10-217 or R9-10-225;
i. Restraint, if not necessary to prevent imminent harm to self or others or as allowed under R9-10-225;
j. Retaliation for submitting a complaint to the Department or another entity; or
k. Misappropriation of personal and private property by a hospital's medical staff, personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
a. Except in an emergency, either consents to or refuses treatment;
b. May refuse examination or withdraw consent for treatment before treatment is initiated;
c. Is informed of:
i. Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of the proposed psychotropic medication or surgical procedure;

ii. How to obtain a schedule of hospital rates and charges required in A.R.S. § 36-436.01(B);
iii. The patient complaint policies and procedures, including the telephone number of hospital personnel to contact about complaints, and the Department's telephone number if the hospital is unable to resolve the patient's complaint; and
iv. Except as authorized by the Health Insurance Portability and Accountability Act of 1996, proposed involvement of the patient in research, experimentation, or education, if applicable;

d. Except in an emergency, is provided a description of the health care directives policies and procedures:
i. If an inpatient, at the time of admission; or
ii. If an outpatient:
(1) Before any invasive procedure, except phlebotomy for obtaining blood for diagnostic purposes; or
(2) If the hospital services include a planned series of treatments, at the start of each series;

e. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospital for identification and administrative purposes; and

f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
i. Medical record, or
ii. Financial records.

**C.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To have access to a telephone;
5. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
6. To receive a referral to another health care institution if the hospital is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
7. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
8. To participate or refuse to participate in research or experimental treatment; and
9. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

Former Section R9-10-212 renumbered as R9-10-312 as an emergency effective February 22, 1979, new Section R9-10-212 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-212 renumbered to R9-10-210; new Section R9-10-212 renumbered from R9-10-209 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-213. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each patient according to A.R.S. § Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
b. Dated, legible, and authenticated; and
c. Not changed to make the initial entry illegible;
3. An order is:
a. Dated when the order is entered in the patient's medical record and includes the time of the order;
b. Authenticated by a medical staff member according to policies and procedures; and
c. If the order is a verbal order, authenticated by a medical staff member or medical practitioner;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to personnel members and medical staff members authorized by policies and procedures to access the medical record;
6. Policies and procedures include the maximum time-frame to retrieve an onsite or off-site patient's medical record at the request of a medical staff member or authorized personnel member; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If a hospital maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a medical record for an inpatient contains:

1. Patient information that includes:
   a. The patient's name;
   b. The patient's address;
   c. The patient's date of birth; and
   d. Any known allergy, including medication allergies or sensitivities;
2. Medication information that includes:
   a. A medication ordered for the patient; and
   b. A medication administered to the patient including:
      i. The date and time of administration;
      ii. The name, strength, dosage, amount, and route of administration;
      iii. The identification and authentication of the individual administering the medication; and
      iv. Any adverse reaction the patient has to the medication;
3. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
4. A medical history and results of a physical examination or an interval note;
5. If the patient provides a health care directive, the health care directive signed by the patient;
6. An admitting diagnosis;
7. The date of admission and, if applicable, the date of discharge;
8. Names of the admitting medical staff member and medical practitioners coordinating the patient's care;
9. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
10. Orders;
11. Care plans;
12. Documentation of hospital services provided to the patient;
13. Progress notes;
14. The disposition of the patient after discharge;
15. Discharge planning, including discharge instructions required in R9-10-209(B)(3);
16. A discharge summary; and
17. If applicable:
    a. A laboratory report,
    b. A pathology report,
    c. An autopsy report,
    d. A radiologic report,
    e. A diagnostic imaging report,
    f. Documentation of restraint or seclusion, and
    g. A consultation report.

**D.** An administrator shall ensure that a hospital's medical record for an outpatient contains:

1. Patient information that includes:
   a. The patient's name;
   b. The patient's address;
   c. The patient's date of birth;
   d. The name and contact information of the patient's representative, if applicable; and
   e. Any known allergy including medication allergies or sensitivities;
2. If necessary for treatment, medication information that includes:
   a. A medication ordered for the patient; and
   b. A medication administered to the patient including:
      i. The date and time of administration;
      ii. The name, strength, dosage, amount, and route of administration;
      iii. The identification and authentication of the individual administering the medication; and
      iv. Any adverse reaction the patient has to the medication;
3. Documentation of general and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
4. An admitting diagnosis or reason for outpatient medical services;

5. Orders;
6. Documentation of hospital services provided to the patient; and
7. If applicable:
   a. A laboratory report,
   b. A pathology report,
   c. An autopsy report,
   d. A radiologic report,
   e. A diagnostic imaging report,
   f. Documentation of restraint or seclusion, and
   g. A consultation report.

**E.** In addition to the requirements in subsection (D), an administrator shall ensure that the hospital's record of emergency services provided to a patient contains:
1. Documentation of treatment the patient received before arrival at the hospital, if available;
2. The patient's medical history;
3. An assessment, including the name of the individual performing the assessment;
4. The patient's chief complaint;
5. The name of the individual who treated the patient in the emergency room, if applicable; and
6. The disposition of the patient after discharge.

**Historical Note**

Former Section R9-10-213 renumbered as R9-10-313 as an emergency effective February 23, 1979, new Section R9-10-213 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-213 renumbered to R9-10-211; new Section R9-10-213 renumbered from R9-10-228 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-214. Nursing Services**

**A.** An administrator shall ensure that:
1. Nursing services are provided 24 hours a day, and
2. A nurse executive is appointed who is qualified according to policies and procedures.

**B.** A nurse executive shall designate a registered nurse who is present on the hospital's premises to be accountable for managing the nursing services when the nurse executive is not present in the hospital.

**C.** A nurse executive shall ensure that:
1. Policies and procedures for nursing services are established, documented, and implemented;
2. An acuity plan is established, documented, and implemented that includes:
   a. A method that establishes the types and numbers of nursing personnel that are required for each unit in the hospital;
   b. An assessment of a patient's need for nursing services made by a registered nurse providing nursing services directly to the patient; and
   c. A policy and procedure stating the steps a hospital will take to:
      i. Obtain the necessary nursing personnel to meet patient acuity, and
      ii. Make assignments for patient care according to the acuity plan;
3. Registered nurses, including registered nurses providing nursing services directly to a patient, are knowledgeable about the acuity plan and implement the acuity plan established under subsection (C)(2);
4. If licensed capacity in an organized service is exceeded or patients are kept in areas without licensed beds, nursing personnel are assigned according to the specific rules for the organized service in this Chapter;
5. There is at least one registered nurse on the hospital's premises whether or not there is a patient;
6. A general hospital has at least two registered nurses on the general hospital's premises when there is more than one patient;
7. A special hospital offering emergency services or obstetrical services has at least two registered nurses on the special hospital's premises when there is more than one patient;
8. A special hospital not offering emergency services or obstetrical services has at least one registered nurse and one other nurse on the special hospital's premises when there is more than one patient;
9. A rural general hospital with more than one patient has at least one registered nurse and at least one other nursing personnel member on the rural general hospital's premises. If there is only one registered nurse on the rural general hospital's premises, an additional registered nurse is on-call who is able to be present on the rural general hospital's premises within 15 minutes after being called;
10. If a hospital has a patient in a unit, there is at least one registered nurse present in the unit;
11. If a hospital has more than one patient in a unit, there is at least one registered nurse and one additional nursing personnel member present in the unit;
12. At least one registered nurse is present and accountable for the nursing services provided to a patient:

a. During the delivery of a neonate,
b. In an operating room, and
c. In a post-anesthesia care unit;

13. Nursing personnel work schedules are planned, reviewed, adjusted, and documented to meet patient needs and emergencies;
14. A registered nurse assesses, plans, directs, and evaluates nursing services provided to a patient;
15. There is a care plan for each inpatient based on the inpatient's need for nursing services; and
16. Nursing personnel document nursing services in a patient's medical record.

**Historical Note**

Former Section R9-10-214 renumbered as R9-10-314 as an emergency effective February 22, 1979, new Section R9-10-214 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-214 renumbered to R9-10-215; new Section R9-10-214 renumbered from R9-10-208 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-215. Surgical Services**

An administrator of a general hospital shall ensure that:

1. There is an organized service that provides surgical services under the direction of a medical staff member;
2. There is a designated area for providing surgical services as an organized service;
3. The area of the hospital designated for surgical services is managed by a registered nurse or a physician;
4. Documentation is available in the surgical services area that specifies each medical staff member's clinical privileges to perform surgical procedures in the surgical services area;
5. Postoperative orders are documented in the patient's medical record;
6. There is a chronological log of surgical procedures performed in the surgical services area that contains:
   a. The date of the surgical procedure,
   b. The patient's name,
   c. The type of surgical procedure,
   d. The time in and time out of the operating room,
   e. The name and title of each individual performing or assisting in the surgical procedure,
   f. The type of anesthesia used,
   g. An identification of the operating room used, and
   h. The disposition of the patient after the surgical procedure;
7. The chronological log required in subsection (6) is maintained in the surgical services area for at least 12 months after the date of the surgical procedure and then maintained by the hospital for an additional 12 months;
8. The medical staff designate in writing the surgical procedures that may be performed in areas other than the surgical services area;
9. The hospital has the medical staff members, personnel members, and equipment to provide the surgical procedures offered in the surgical services area;
10. A patient and the surgical procedure to be performed on the patient are identified before initiating the surgical procedure;
11. Except in an emergency, a medical staff member or a surgeon performs a medical history and physical examination within 30 calendar days before performing a surgical procedure on a patient;
12. Except as provided in subsection (14), a medical staff member or a surgeon enters an interval note in the patient's medical record before performing a surgical procedure;
13. Except as provided in subsection (14), the following are documented in a patient's medical record before a surgical procedure:
    a. A preoperative diagnosis;
    b. Each diagnostic test performed in the hospital;
    c. A medical history and physical examination as required in subsection (11) and an interval note as required in subsection (12);
    d. A consent or refusal for blood or blood products signed by the patient or the patient's representative, if applicable; and
    e. Informed consent according to policies and procedures; and
14. In an emergency, the documentation required in subsections (12) and (13) is completed within 24 hours after a surgical procedure on a patient is completed.

**Historical Note**

Former Section R9-10-215 renumbered as R9-10-315 as an emergency effective February 22, 1979, new Section R9-10-215 adopted effective February 23, 1979 (Supp. 79-1). Amended subsection (D) effective August 31, 1988 (Supp. 88-3). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-215 renumbered to R9-10-216; new Section R9-10-215 renumbered from R9-10-214 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13;

effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-216. Anesthesia Services**

An administrator shall ensure that:

1. Anesthesia services provided in conjunction with surgical services performed in the operating room are provided as an organized service under the direction of a medical staff member;
2. Documentation is available in the surgical services area that specifies the medical staff member's clinical privileges to administer anesthesia;
3. Except in an emergency, an anesthesiologist or a nurse anesthetist performs a pre-anesthesia evaluation within 48 hours before anesthesia is administered in conjunction with surgical services;
4. Anesthesia administration is documented in a patient's medical record and includes:
   a. A pre-anesthesia evaluation, if applicable;
   b. An intra-operative anesthesia record;
   c. The postoperative status of the patient upon leaving the operating room; and
   d. Post-anesthesia documentation by the individual performing the post-anesthesia evaluation that includes the information required by the medical staff bylaws and medical staff regulations; and
5. A registered nurse or a physician documents resuscitative measures in the patient's medical record.

**Historical Note**

Adopted as an emergency effective April 2, 1976 (Supp. 76-2). Adopted effective August 25, 1977 (Supp. 77-4). Former Section R9-10-216 renumbered as R9-10-316 as an emergency effective February 22, 1979, new Section R9-10-216 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-216 renumbered to R9-10-217; new Section R9-10-216 renumbered from R9-10-215 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-217. Emergency Services**

**A.** An administrator of a general hospital or a rural general hospital shall ensure that:
1. Emergency services are provided 24 hours a day in a designated area of the hospital;
2. Emergency services are provided as an organized service under the direction of a medical staff member;
3. The scope and extent of emergency services offered are documented in the hospital's scope of services;
4. Emergency services are provided to an individual, including a woman in active labor, requesting emergency services;
5. If emergency services cannot be provided at the hospital to meet the needs of a patient in an emergency, measures and procedures are implemented to minimize risk to the patient until the patient is transported or transferred to another hospital;
6. A roster of on-call medical staff members is available in the emergency services area;
7. There is a chronological log of emergency services provided to patients that includes:
   a. The patient's name;
   b. The date, time, and mode of arrival; and
   c. The disposition of the patient including discharge, transfer, or admission; and
8. The chronological log required in subsection (A)(7) is maintained:
   a. In the emergency services area for at least 12 months after the date of the emergency services; and
   b. By the hospital for at least an additional four years.

**B.** An administrator of a special hospital that provides emergency services shall comply with subsection (A).

**C.** An administrator of a hospital that provides emergency services, but does not provide perinatal organized services, shall ensure that emergency perinatal services are provided within the hospital's capabilities to meet the needs of a patient and a neonate, including the capability to deliver a neonate and to keep the neonate warm until transfer to a hospital providing perinatal organized services.

**D.** An administrator of a hospital that provides emergency services shall ensure that a room used for seclusion in a designated area of the hospital used for providing emergency services, complies with applicable physical plant health and safety codes and standards for a secure hold room as described in the American Institute of Architects and Facilities Guidelines Institute, Guidelines for Design and Construction of Health Care Facilities, incorporated by reference in R9-10-104.01.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-217 renumbered to R9-10-218; new Section R9-10-217 renumbered from R9-10-216 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-218. Pharmaceutical Services**

An administrator shall ensure that:

1. Pharmaceutical services are provided under the direction of a pharmacist according to A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23;
2. A copy of the pharmacy license is provided to the Department for review upon the Department's request;
3. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
   a. Develop a drug formulary,
   b. Update the drug formulary at least once every 12 months,
   c. Develop medication usage and medication substitution policies and procedures, and
   d. Specify which medications and medication classifications are required to be automatically stopped after a specified time period unless the ordering medical staff member specifically orders otherwise;
4. An expired, mislabeled, or unusable medication is disposed of according to policies and procedures;
5. A medication administration error or an adverse reaction is reported to the ordering medical staff member or the medical staff member's designee;
6. A pharmacy medication dispensing error is reported to the pharmacist;
7. In a pharmacist's absence, personnel members designated by policies and procedures have access to a locked area containing a medication;
8. A medication is maintained at temperatures recommended by the manufacturer;
9. A cart used for an emergency:
   a. Contains medication, supplies, and equipment as specified in policies and procedures;
   b. Is available to a unit; and
   c. Is sealed until opened in an emergency;
10. Emergency cart contents and sealing of the emergency cart are verified and documented according to policies and procedures;
11. Policies and procedures specify individuals who may:
    a. Order medication, and
    b. Administer medication;
12. A medication is administered in compliance with an order;
13. A medication administered to a patient is documented as required in R9-10-213;
14. If pain medication is administered to a patient, documentation in the patient's medical record includes:
    a. An assessment of the patient's pain before administering the medication, and
    b. The effect of the pain medication administered; and
15. Policies and procedures specify a process for review through the quality management program of:
    a. A medication administration error,
    b. An adverse reaction to a medication, and
    c. A pharmacy medication dispensing error.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-218 renumbered to R9-10-219; new Section R9-10-218 renumbered from R9-10-217 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-219. Clinical Laboratory Services and Pathology Services**

An administrator shall ensure that:

1. Clinical laboratory services and pathology services are provided by a hospital through a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation or certificate of compliance in subsection (1) is provided to the Department for review upon the Department's request;
3. A general hospital or a rural general hospital provides clinical laboratory services 24 hours a day on the hospital's premises to meet the needs of a patient in an emergency;
4. A special hospital whose patients require clinical laboratory services:
   a. Is able to provide clinical laboratory services when needed by the patients,
   b. Obtains specimens for clinical laboratory services without transporting the patients from the special hospital's premises, and
   c. Has the examination of the specimens performed by a clinical laboratory on the special hospital's premises or by arrangement with a clinical laboratory not on the special hospital's premises;
5. A hospital that provides clinical laboratory services 24 hours a day has on duty or on-call laboratory personnel authorized by policies and procedures to perform testing;

6. A hospital that offers surgical services provides pathology services on the hospital's premises or by contracted service to meet the needs of a patient;
7. Clinical laboratory and pathology test results are:
   a. Available to the medical staff:
      i. Within 24 hours after the test is completed if the test is performed at a laboratory on the hospital's premises, or
      ii. Within 24 hours after the test result is received if the test is performed at a laboratory not on the hospital's premises; and
   b. Documented in a patient's medical record;
8. If a test result is obtained that indicates a patient may have an emergency medical condition, as established by medical staff, laboratory personnel notify the ordering medical staff member or a registered nurse in the patient's assigned unit;
9. If a clinical laboratory report, a pathology report, or an autopsy report is completed on a patient, a copy of the report is included in the patient's medical record;
10. Policies and procedures are established, documented, and implemented for:
    a. Procuring, storing, transfusing, and disposing of blood and blood products;
    b. Blood typing, antibody detection, and blood compatibility testing; and
    c. Investigating transfusion adverse reactions that specify a process for review through the quality management program;
11. If blood and blood products are provided by contract, the contract includes:
    a. The availability of blood and blood products through the contract, and
    b. The process for delivery of blood and blood products through the contract; and
12. Expired laboratory supplies are discarded according to policies and procedures.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-219 renumbered to R9-10-220; new Section R9-10-219 renumbered from R9-10-218 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-220. Radiology Services and Diagnostic Imaging Services**

**A.** An administrator shall ensure that:
1. Radiology services and diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
2. A copy of a certificate documenting compliance with subsection (A)(1) is provided to the Department for review upon the Department's request;
3. A general hospital or a rural general hospital provides radiology services 24 hours a day on the hospital's premises to meet the emergency needs of a patient;
4. A hospital that provides surgical services has radiology services and diagnostic imaging services on the hospital's premises to meet the needs of patients;
5. A general hospital or a rural general hospital has a radiologic technologist on duty or on-call; and
6. Except as provided in subsection (A)(4), a special hospital whose patients require radiology services and diagnostic imaging services is able to provide the radiology services and diagnostic imaging services when needed by the patients:
   a. On the special hospital's premises, or
   b. By arrangement with a radiology and diagnostic imaging facility that is not on the special hospital's premises.

**B.** An administrator of a hospital that provides radiology services or diagnostic imaging services on the hospital's premises shall ensure that:
1. Radiology services and diagnostic imaging services are provided:
   a. Under the direction of a medical staff member; and
   b. According to an order that includes:
      i. The patient's name,
      ii. The name of the ordering individual,
      iii. The radiological or diagnostic imaging procedure ordered, and
      iv. The reason for the procedure;
2. A medical staff member or radiologist interprets the radiologic or diagnostic image;
3. A radiologic or diagnostic imaging patient report is prepared that includes:
   a. The patient's name;
   b. The date of the procedure;
   c. A medical staff member's or radiologist's interpretation of the image;
   d. The type and amount of radiopharmaceutical used, if applicable; and
   e. The adverse reaction to the radiopharmaceutical, if any; and
4. A radiologic or diagnostic imaging report is included in the patient's medical record.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-220 renumbered to R9-10-221; new Section R9-10-220 renumbered from R9-10-219 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-221. Intensive Care Services**

Except for a special hospital that provides only psychiatric services, an administrator of a hospital that provides intensive care services shall ensure that:

1. Intensive care services are provided as an organized service in a designated area under the direction of a medical staff member;
2. An inpatient admitted for intensive care services is personally visited by a physician at least once every 24 hours;
3. Admission and discharge criteria for intensive care services are established;
4. A personnel member's responsibilities for initiation of medical services in an emergency to a patient in an intensive care unit pending the arrival of a medical staff member are established and documented in policies and procedures;
5. In addition to the requirements in R9-10-214(C), an intensive care unit is staffed:
   a. With at least one registered nurse assigned for every two patients, and
   b. According to an acuity plan as required in R9-10-214;
6. Each intensive care unit has a policy and procedure that provides for meeting the needs of the patients;
7. If the medical services of an intensive care patient are reduced to a lesser level of care in the hospital, but the patient is not physically relocated, the nurse to patient ratio is based on the needs of the patient;
8. Private duty staff do not provide hospital services in an intensive care unit;
9. At least one registered nurse assigned to a patient in an intensive care unit is certified in advanced cardiac life support specific to the age of the patient;
10. Resuscitation, emergency, and other equipment are available to meet the needs of a patient including:
    a. Ventilatory assistance equipment,
    b. Respiratory and cardiac monitoring equipment,
    c. Suction equipment,
    d. Portable radiologic equipment, and
    e. A patient weighing device for patients restricted to a bed; and
11. An intensive care unit has at least one emergency cart that is maintained according to R9-10-218.

**Historical Note**

Former Section R9-10-221 renumbered as R9-10-317 as an emergency effective February 22, 1979, new Section R9-10-221 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-221 renumbered to R9-10-222; new Section R9-10-221 renumbered from R9-10-220 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-222. Respiratory Care Services**

An administrator of a hospital that provides respiratory care services shall ensure that:

1. Respiratory care services are provided under the direction of a medical staff member;
2. Respiratory care services are provided according to an order that includes:
   a. The patient's name;
   b. The name and signature of the ordering individual;
   c. The type, frequency, and, if applicable, duration of treatment;
   d. The type and dosage of medication and diluent; and
   e. The oxygen concentration or oxygen liter flow and method of administration;
3. Respiratory care services provided to a patient are documented in the patient's medical record and include:
   a. The date and time of administration;
   b. The type of respiratory care services;
   c. The effect of respiratory care services;
   d. If applicable, any adverse reaction to respiratory care services; and
   e. The authentication of the individual providing the respiratory care services; and
4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-219.

**Historical Note**

Former Section R9-10-222 renumbered as R9-10-318 as an emergency effective February 22, 1979, new Section R9-10-222 adopted

effective February 23, 1979 (Supp. 79-1). Correction, subsection (D)(3) reference to paragraph (E)(2) should read subsection (D)(2). (Supp. 79-6). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-222 renumbered to R9-10-223; new Section R9-10-222 renumbered from R9-10-221 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-223. Perinatal Services**

**A.** An administrator of a hospital that provides perinatal organized services shall ensure that:
1. Perinatal services are provided in a designated area under the direction of a medical staff member;
2. Only medical and surgical procedures approved by the medical staff are performed in the perinatal services unit;
3. The perinatal services unit has the capability to initiate an emergency cesarean delivery within the time-frame established by the medical staff and documented in policies and procedures;
4. Only a patient in need of perinatal services or gynecological services receives perinatal services or gynecological services in the perinatal services unit;
5. A patient receiving gynecological services does not share a room with a patient receiving perinatal services;
6. A chronological log of perinatal services provided to patients is maintained that includes:
   a. The patient's name;
   b. The date, time, and mode of the patient's arrival;
   c. The disposition of the patient including discharge, transfer, or admission time;
   d. The following information for a delivery of a neonate:
      i. The neonate's name or other identifier;
      ii. The name of the medical staff member who delivered the neonate;
      iii. The delivery time and date; and
      iv. Complications of delivery, if any; and
   e. If an abortion procedure was performed at or after 20 weeks gestational age, whether the fetus was delivered alive;
7. The chronological log required in subsection (A)(6) is maintained by the hospital in the perinatal services unit for at least 12 months after the date the perinatal services are provided and then maintained by the hospital for at least an additional 12 months;
8. The perinatal services unit provides fetal monitoring;
9. The perinatal services unit has ultrasound capability;
10. Except in an emergency, a neonate is identified as required by policies and procedures before moving the neonate from a delivery area;
11. Policies and procedures specify:
    a. Security measures to prevent neonatal abduction, and
    b. How the hospital determines to whom a neonate may be discharged;
12. A neonate is discharged only to an individual who:
    a. Is authorized according to subsection (A)(11), and
    b. Provides identification;
13. A neonate's medical record identifies the individual to whom the neonate is discharged;
14. A patient or the individual to whom the neonate is discharged receives perinatal education, discharge instructions, and a referral for follow-up care for a neonate in addition to the discharge planning requirements in R9-10-209;
15. Intensive care services for neonates comply with the requirements in R9-10-221;
16. At least one registered nurse is on duty in a nursery when there is a neonate in the nursery except as provided in subsection (A)(17);
17. A nursery occupied only by a neonate, who is placed in the nursery for the convenience of the neonate's mother and does not require treatment as established in this Article, is staffed by a nurse;
18. Equipment and supplies are available to a nursery, labor-delivery-recovery room, or labor-delivery-recovery-postpartum room to meet the needs of each neonate; and
19. In a nursery, only a neonate's bed or bassinet is used for changing diapers, bathing, or dressing the neonate.

**B.** An administrator of a hospital that does not provide perinatal organized services shall comply with the requirements in R9-10-217(C).

**C.** In addition to applicable requirements in A.R.S. Title 36, Chapter 20, an administrator of a hospital in which an abortion procedure is performed shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that require:
   a. For an abortion procedure performed at or after 20 weeks gestational age, a personnel member or medical staff member qualified according to policies and procedures to perform neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure is performed before the delivery of the fetus;
   b. Compliance with A.R.S. § 36-2301.01, if applicable;
   c. Neonatal resuscitation of a fetus delivered alive, according to A.R.S. § 36-2301(D)(3); and
   d. A medical record to be established and maintained for a fetus delivered alive;
2. The medical record of a patient receiving an abortion procedure contains:

a. Documentation from the physician providing the abortion procedure and other personnel members present certifying that the fetus was not delivered alive, or
b. A link to the medical record of a fetus delivered alive; and

3. For a fetus delivered alive, a medical record contains:
   a. An identification of the fetus, including:
      i. The name of the patient from whom the fetus was delivered alive, and
      ii. The date the fetus was delivered alive;
   b. Orders issued by a physician, physician assistant, or registered nurse practitioner;
   c. A record of medical services, nursing services, and health-related services provided to the fetus delivered alive;
   d. If applicable, information about medication administered to the fetus delivered alive; and
   e. If the fetus had a lethal fetal condition, the results of the confirmation of the lethal fetal condition.

**Historical Note**

Former Section R9-10-223 renumbered as R9-10-319 as an emergency effective February 22, 1979, new Section R9-10-223 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-223 renumbered to R9-10-224; new Section R9-10-223 renumbered from R9-10-222 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-224. Pediatric Services**

**A.** An administrator of a hospital that provides pediatric services or pediatric organized services according to the requirements in this Section shall ensure that:
1. Consistent with the health and safety of a pediatric patient, arrangements are made for a parent or a guardian of the pediatric patient to stay overnight;
2. Policies and procedures are established, documented, and implemented for:
   a. Infection control for shared toys, books, stuffed animals, and other items in a community playroom; and
   b. Visitation of a pediatric patient, including age limits if applicable;
3. A pediatric inpatient is only admitted if the hospital has the staff, equipment, and supplies available to meet the needs of the pediatric patient based on the pediatric patient's medical condition and the hospital's scope of services; and
4. If the hospital provides pediatric intensive care services, the pediatric intensive care services comply with intensive care services requirements in R9-10-221.

**B.** An administrator of a hospital that provides pediatric organized services shall ensure that pediatric services are provided in a designated area under the direction of a medical staff member.

**C.** An administrator shall ensure that in a multi-organized service unit or a patient care unit that is providing medical and nursing services to an adult patient and a pediatric patient according to this Section:
1. A pediatric patient is not placed in a patient room with an adult patient, and
2. A medication for a pediatric patient that is stored in the patient care unit is stored separately from a medication for an adult patient.

**D.** A hospital may use a bed in a pediatric organized services patient care unit for an adult patient if an administrator establishes, documents, and implements policies and procedures that:
1. Delineate the specific conditions under which an adult patient is placed in a bed in the pediatric organized services unit, and
2. Except as provided in subsections (H) and (I), ensure that an adult patient is:
   a. Not placed in a pediatric organized services patient care unit if a pediatric patient is admitted to and present in the pediatric organized services patient care unit, and
   b. Transferred out of the pediatric organized services patient care unit to an appropriate level of care when a pediatric patient is admitted to the pediatric organized services patient care unit.

**E.** Except as provided in subsections (F) and (G), an administrator of a hospital that does not provide pediatric organized services may admit a pediatric inpatient only in an emergency.

**F.** Subsection (G) only applies to a general hospital or rural general hospital that:
1. Does not provide pediatric organized services;
2. Has designated in the general hospital's or rural general hospital's scope of services, inpatient services that are available to a pediatric patient;
3. Has a licensed capacity of less than 100; and
4. Is located in a county with a population of less than 500,000.

**G.** An administrator of a general hospital or rural general hospital that meets the criteria in subsection (F) shall ensure that:
1. There are pediatric-appropriate equipment and supplies available, based on the hospital services designated for pediatric patients in the general hospital or rural general hospital's scope of services; and

2. Personnel members that are or may be assigned to provide hospital services to a pediatric patient have the appropriate skills and knowledge for providing hospital services to a pediatric patient, based on the general hospital's or rural general hospital's scope of services.

**H.** Subsection (I) only applies to a general hospital or a rural general hospital that:
1. Provides pediatric organized services in a patient care unit;
2. Has designated in the general hospital's or rural general hospital's scope of services, inpatient services that are available to an adult patient in a pediatric organized services patient care unit;
3. Has a licensed capacity of less than 100; and
4. Is located in a county with a population of less than 500,000.

**I.** An administrator of a general hospital or rural general hospital that meets the criteria in subsection (H) shall comply with the requirements in subsection (D)(1).

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 18 A.A.R. 1719, effective June 30, 2012 (Supp. 12-2). Section R9-10-224 renumbered to R9-10-225; new Section R9-10-224 renumbered from R9-10-223 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-225. Psychiatric Services**

**A.** An administrator of a hospital that contains an organized psychiatric services unit or a special hospital licensed to provide psychiatric services shall ensure that in the organized psychiatric unit or special hospital:
1. Psychiatric services are provided under the direction of a medical staff member;
2. An inpatient admitted to the organized psychiatric services unit or special hospital has a principal diagnosis of a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor;
3. Except in an emergency, a patient receives a nursing assessment before treatment for the patient is initiated;
4. An individual whose medical needs cannot be met while the individual is an inpatient in an organized psychiatric services unit or a special hospital is not admitted to or is transferred out of the organized psychiatric services unit or special hospital;
5. Policies and procedures for the organized psychiatric services unit or special hospital are established, documented, and implemented that:
   a. Establish qualifications for medical staff members and personnel members who provide clinical oversight to behavioral health technicians;
   b. Establish the process for patient assessment, including identification of a patient's medical conditions and criteria for the on-going monitoring of any identified medical condition;
   c. Establish the process for developing and implementing a patient's care plan including:
      i. Obtaining the patient's or the patient's representative's participation in the development of the patient's care plan;
      ii. Ensuring that the patient is informed of the modality, frequency, and duration of any treatments that are included in the patient's care plan;
      iii. Informing the patient that the patient has the right to refuse any treatment;
      iv. Updating the patient's care plan and informing the patient of any changes to the patient's care plan; and
      v. Documenting the actions in subsection (A)(5)(c)(i) through (iv) in the patient's medical record;
   d. Establish the process for warning an identified or identifiable individual, as described in A.R.S. § 36-517.02 (B) through (C), if a patient communicates to a medical staff member or personnel member a threat of imminent serious physical harm or death to the individual and the patient has the apparent intent and ability to carry out the threat;
   e. Establish the criteria for determining when an inpatient's absence is unauthorized, including whether the inpatient:
      i. Was admitted under A.R.S. Title 36, Chapter 5, Articles 1, 2, or 3;
      ii. Is absent against medical advice; or
      iii. Is under 18 years of age;
   f. Identify each type of restraint and seclusion used in the organized psychiatric services unit or special hospital and include for each type of restraint and seclusion used:
      i. The qualifications of a medical staff member or personnel member who can:
         (1) Order the restraint or seclusion,
         (2) Place a patient in the restraint or seclusion,
         (3) Monitor a patient in the restraint or seclusion,
         (4) Evaluate a patient's physical and psychological well-being after being placed in the restraint or seclusion and when released from the restraint or seclusion, or
         (5) Renew the order for restraint or seclusion;
      ii. On-going training requirements for a medical staff member or personnel member who has direct patient contact while the patient is in a restraint or in seclusion; and

iii. Criteria for monitoring and assessing a patient including:
(1) Frequencies of monitoring and assessment based on a patient's condition, cognitive status, situational factors, and risks associated with the specific restraint or seclusion;
(2) For the renewal of an order for restraint or seclusion, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
(3) Assessment content, which may include, depending on a patient's condition, the patient's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
(4) If a mechanical restraint is used, how often the mechanical restraint is monitored or loosened; and
(5) A process for meeting a patient's nutritional needs and elimination needs;
g. Establish the criteria and procedures for renewing an order for restraint or seclusion;
h. Establish procedures for internal review of the use of restraint or seclusion;
i. Establish requirements for notifying the parent or guardian of a patient who is under 18 years of age and who is restrained or secluded; and
j. Establish medical record and personnel record documentation requirements for restraint and seclusion, if applicable;

6. If time-out is used in the organized psychiatric services unit or special hospital, a time-out:
a. Takes place in an area that is unlocked, lighted, quiet, and private;
b. Does not take place in the room approved for seclusion by the Department under R9-10-104;
c. Is time-limited and does not exceed two hours per incident or four hours per day;
d. Does not result in a patient's missing a meal if the patient is in time-out at mealtime;
e. Includes monitoring of the patient by a medical staff member or personnel member at least once every 15 minutes to ensure the patient's health, safety, and welfare and to determine if the patient is ready to leave time-out; and
f. Is documented in the patient's medical record, to include:
i. The date of the time-out,
ii. The reason for the time-out,
iii. The duration of the time-out, and
iv. The action planned and taken to address the reason for the time-out;

7. Restraint or seclusion is:
a. Not used as a means of coercion, discipline, convenience, or retaliation;
b. Only used when all of the following conditions are met:
i. Except as provided in subsection (A)(8), after obtaining an order for the restraint or seclusion;
ii. For the management of a patient's aggressive, violent, or self-destructive behavior;
iii. When less restrictive interventions have been determined to be ineffective; and
iv. To ensure the immediate physical safety of the patient, to prevent imminent harm to the patient or another individual, or to stop physical harm to another individual; and
c. Discontinued at the earliest possible time;

8. If as a result of a patient's aggressive, violent, or self-destructive behavior, harm to the patient or another individual is imminent or the patient or another individual is being physically harmed, a personnel member:
a. May initiate an emergency application of restraint or seclusion for the patient before obtaining an order for the restraint or seclusion, and
b. Obtains an order for the restraint or seclusion of the patient during the emergency application of the restraint or seclusion;

9. Restraint or seclusion is:
a. Only ordered by a physician or a registered nurse practitioner, and
b. Not written as a standing order or on an as-needed basis;

10. An order for restraint or seclusion includes:
a. The name of the individual ordering the restraint or seclusion;
b. The date and time that the restraint or seclusion was ordered;
c. The specific restraint or seclusion ordered;
d. If a drug is ordered as a chemical restraint, the drug's name, strength, dosage, and route of administration;
e. The specific criteria for release from restraint or seclusion without an additional order; and
f. The maximum duration authorized for the restraint or seclusion;

11. An order for restraint or seclusion is limited to the duration of the emergency situation and does not exceed:
a. Four continuous hours for a patient who is 18 years of age or older,
b. Two continuous hours for a patient who is between the ages of nine and 17 years of age, or
c. One continuous hour for a patient who is younger than nine years of age;

12. If restraint and seclusion are used on a patient simultaneously, the patient receives continuous:
a. Face-to-face monitoring by a medical staff member or personnel member, or
b. Video and audio monitoring by a medical staff member or personnel member who is in close proximity to the patient;

13. If an order for restraint or seclusion of a patient is not provided by a medical practitioner coordinating the patient's medical services, the medical practitioner is notified as soon as possible;
14. A medical staff member or personnel member does not participate in restraint or seclusion, monitor a patient during restraint or seclusion, or evaluate a patient after restraint or seclusion until the medical staff member or personnel member completes education and training that:
    a. Includes:
        i. Techniques to identify medical staff member, personnel member, and patient behaviors; events; and environmental factors that may trigger circumstances that require restraint or seclusion;
        ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods;
        iii. Techniques for identifying the least restrictive intervention based on an assessment of the patient's medical or behavioral health condition;
        iv. The safe use of restraint and the safe use of seclusion, including training in how to recognize and respond to signs of physical and psychological distress in a patient who is restrained or secluded;
        v. Clinical identification of specific behavioral changes that indicate that the restraint or seclusion is no longer necessary;
        vi. Monitoring and assessing a patient while the patient is in restraint or seclusion according to policies and procedures; and
        vii. Training exercises in which medical staff members and personnel members successfully demonstrate the techniques that the medical staff members and personnel members have learned for managing emergency situations; and
    b. Is provided by individuals qualified according to policies and procedures;
15. When a patient is placed in restraint or seclusion:
    a. The restraint or seclusion is conducted according to policies and procedures;
    b. The restraint or seclusion is proportionate and appropriate to the severity of the patient's behavior and the patient's:
        i. Chronological and developmental age;
        ii. Size;
        iii. Gender;
        iv. Physical condition;
        v. Medical condition;
        vi. Psychiatric condition; and
        vii. Personal history, including any history of physical or sexual abuse;
    c. The physician or registered nurse practitioner who ordered the restraint or seclusion is available for consultation throughout the duration of the restraint or seclusion;
    d. A patient is monitored and assessed according to policies and procedures;
    e. A physician or other health professional authorized by policies and procedures assesses the patient within one hour after the patient is placed in the restraint or seclusion and determines:
        i. The patient's current behavior,
        ii. The patient's reaction to the restraint or seclusion used,
        iii. The patient's medical and behavioral condition, and
        iv. Whether to continue or terminate the restraint or seclusion;
    f. The patient is given the opportunity:
        i. To eat during mealtime, and
        ii. To use the toilet; and
    g. The restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order;
16. If a patient is placed in seclusion, the room used for seclusion:
    a. Is approved for use as a seclusion room by the Department under R9-10-104;
    b. Is not used as a patient's bedroom or a sleeping area;
    c. Allows full view of the patient in all areas of the room;
    d. Is free of hazards, such as unprotected light fixtures or electrical outlets;
    e. Contains at least 60 square feet of floor space; and
    f. Except as provided in subsection (A)(17), contains a non-adjustable bed that:
        i. Consists of a mattress on a solid platform that is:
            (1) Constructed of a durable, non-hazardous material; and
            (2) Raised off of the floor;
        ii. Does not have wire springs or a storage drawer; and
        iii. Is securely anchored in place;
17. If a room used for seclusion does not contain a non-adjustable bed required in subsection (A)(16)(f):
    a. A piece of equipment is available for use in the room used for seclusion that:
        i. Is commercially manufactured to safely and humanely restrain a patient's body;
        ii. Provides support to the trunk and head of a patient's body;
        iii. Provides restraint to the trunk of a patient's body;

iv. Is able to restrict movement of a patient's arms, legs, trunk, and head;
v. Allows a patient's body to recline; and
vi. Does not inflict harm on a patient's body; and
b. Documentation of the manufacturer's specifications for the piece of equipment in subsection (A)(17)(a) is maintained;
18. A seclusion room may be used for services or activities other than seclusion if:
a. A sign stating the service or activity scheduled or being provided in the room is conspicuously posted outside the room;
b. No permanent equipment other than the bed required in subsection (A)(16)(f) is in the room;
c. Policies and procedures are established, documented, and implemented that:
i. Delineate which services or activities other than seclusion may be provided in the room,
ii. List what types of equipment or supplies may be placed in the room for the delineated services, and
iii. Provide for the prompt removal of equipment and supplies from the room before the room is used for seclusion; and
d. The sign required in subsection (A)(18)(a) and equipment and supplies in the room, other than the bed required in subsection (A)(16)(f), are removed before a patient is placed in seclusion in the room;
19. A medical staff member or personnel member documents the following information in a patient's medical record before the end of the shift in which the patient is placed in restraint or seclusion or, if the patient's restraint or seclusion does not end during the shift in which it began, during the shift in which the patient's restraint or seclusion ends:
a. The emergency situation that required the patient to be restrained or put in seclusion;
b. The times the patient's restraint or seclusion actually began and ended;
c. The time of the face-to-face assessment required in subsection (A)(12)(a);
d. The monitoring required in subsection (A)(12)(b) or (15)(d), as applicable;
e. The times the patient was given the opportunity to eat or use the toilet according to subsection (A)(15)(f); and
f. The names of the medical staff members and personnel members with direct patient contact while the patient was in the restraint or seclusion; and
20. If an emergency situation continues beyond the time limit of an order for restraint or seclusion, the order is renewed according to policies and procedures.

**B.** For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, in addition to the admission requirements in R9-10-208 and discharge planning requirements in R9-10-209, an administrator shall ensure that:
1. The patient receives a suicide assessment; and
2. The patient or the patient's representative receives:
a. The results of the suicide assessment in subsection (B)(1);
b. Information about the availability of age-appropriate, suicide crisis services, including contact information;
c. Specific information about or a referral to one of the following for ongoing or follow-up treatment related to suicide, including scheduling an appointment for the patient when practicable:
i. Another health care institution;
ii. A medical practitioner or, for a patient going to another state after discharge, a similarly licensed individual in the other state; or
iii. A behavioral health professional certified or licensed under A.R.S. Title 32 to provide treatment related to suicide or, for a patient going to another state after discharge, a similarly certified or licensed individual in the other state; and
d. Information about and instructions on how to access the Department of Insurance and Financial Institution's website, available through difi.az.gov, developed in compliance with A.R.S. § 20-3503(B), including how to file an appeal of an insurance determination.

**C.** An administrator of a hospital that provides opioid treatment services to an outpatient shall comply with the requirements in R9-10-1020.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-225 renumbered to R9-10-227; new Section R9-10-225 renumbered from R9-10-224 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-226. Behavioral Health Observation/Stabilization Services**

An administrator of a hospital that is authorized to provide behavioral health observation/stabilization services shall ensure that:
1. Behavioral health observation/stabilization services are provided according to the requirements in R9-10-1012, and
2. Restraint and seclusion are provided according to the requirements for restraint and seclusion in R9-10-225.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effec-

tive October 1, 2002 (Supp. 02-2). Section R9-10-226 renumbered to R9-10-229; new Section R9-10-226 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-227. Rehabilitation Services**

An administrator shall ensure that:

1. If rehabilitation services are provided as an organized service, the rehabilitation services are provided under the direction of an individual qualified according to policies and procedures;
2. Rehabilitation services are provided according to an order; and
3. The medical record of a patient receiving rehabilitation services includes:
   a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis,
   b. A documented care plan that is developed in coordination with the ordering individual and the individual providing the rehabilitation services,
   c. The rehabilitation services provided,
   d. The patient's response to the rehabilitation services, and
   e. The authentication of the individual providing the rehabilitation services.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-227 renumbered to R9-10-231; new Section R9-10-227 renumbered from R9-10-225 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-228. Multi-organized Service Unit**

**A.** A governing authority may designate the following as a multi-organized service unit:

1. An adult unit that provides both intensive care services and medical and nursing services other than intensive care services,
2. A pediatric unit that provides both intensive care services and medical and nursing services other than intensive care services,
3. A unit that provides both perinatal services and intensive care services for obstetrical patients,
4. A unit that provides both intensive care services for neonates and a continuing care nursery, or
5. A unit that provides medical and nursing services to adult and pediatric patients.

**B.** An administrator shall ensure that:

1. For a patient in a multi-organized service unit, a medical staff member designates in the patient's medical record which organized service is to be provided to the patient;
2. A multi-organized service unit is in compliance with the requirements in this Article that would apply if each organized service were offered as a single organized service unit; and
3. A multi-organized service unit and each bed in the unit are in compliance with physical plant health and safety codes and standards incorporated by reference in R9-10-104.01 for all organized services provided in the multi-organized service unit.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-228 renumbered to R9-10-213; new Section R9-10-228 renumbered from R9-10-234 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-229. Social Services**

An administrator of a hospital that provides social services shall ensure that:

1. A registered nurse or another personnel member designated according to policies and procedures coordinates social services;
2. If a personnel member provides social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, the personnel member is licensed under A.R.S. Title 32, Chapter 33, Article 5;
3. A medical staff member, nurse, patient, patient's representative, or member of the patient's family may request social services;
4. A personnel member providing social services participates in discharge planning as necessary to meet the needs of a patient;
5. The patient has privacy when communicating with a personnel member providing social services; and
6. Social services provided to a patient are documented in the patient's medical record and the entries are authenticated by the individual providing the social services.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-229 renumbered to R9-10-230; new Section R9-10-229 renumbered from R9-10-226 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-230. Infection Control**

An administrator shall ensure that:

1. An infection control program that meets the requirements of this Section is established under the direction of an individual qualified according to policies and procedures;
2. An infection control program has a procedure for documenting:
   a. The collection and analysis of infection control data,
   b. The actions taken relating to infections and communicable diseases, and
   c. Reports of communicable diseases to the governing authority and state and county health departments;
3. Infection control documents are maintained for at least 12 months after the date of the document;
4. Policies and procedures are established, documented, and implemented:
   a. To prevent or minimize, identify, report, and investigate infections and communicable diseases that include:
      i. Isolating a patient;
      ii. Sterilizing equipment and supplies;
      iii. Maintaining and storing sterile equipment and supplies;
      iv. Using personal protective equipment such as gowns, masks, or face protection;
      v. Disposing of biohazardous medical waste; and
      vi. Moving and processing soiled linens and clothing;
   b. That specify communicable diseases, medical conditions, or criteria that prevent an individual, a personnel member, or a medical staff member from:
      i. Working in the hospital,
      ii. Providing patient care, or
      iii. Providing environmental services;
   c. That establish criteria for determining whether a medical staff member is at an increased risk of exposure to infectious tuberculosis based on:
      i. The level of risk in the area of the hospital premises where the medical staff member practices, and
      ii. The work that the medical staff member performs; and
   d. That establish the frequency of tuberculosis screening for an individual determined to be at an increased risk of exposure;
5. Tuberculosis screening is performed for a personnel member or medical staff member:
   a. On or before the date the personnel member or medical staff member begins providing services at or on behalf of the hospital, and
   b. As part of a tuberculosis infection control program according to R9-10-113;
6. Soiled linen and clothing are:
   a. Collected in a manner to minimize or prevent contamination,
   b. Bagged at the site of use, and
   c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
7. A personnel member washes hands or uses a hand disinfection product after each patient contact and after handling soiled linen, soiled clothing, or potentially infectious material;
8. An infection control committee is established according to policies and procedures and consists of:
   a. At least one medical staff member,
   b. The individual directing the infection control program, and
   c. Other personnel identified in policies and procedures; and
9. The infection control committee:
   a. Develops a plan for preventing, tracking, and controlling infections;
   b. Reviews the type and frequency of infections and develops recommendations for improvement;
   c. Meets and provides a quarterly written report for inclusion by the quality management program; and
   d. Maintains a record of actions taken and minutes of meetings.

**Historical Note**

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-230 renumbered to R9-10-233; new Section R9-10-230 renumbered from R9-10-229 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-10-231. Dietary Services**

An administrator shall ensure that:

1. Dietary services are provided according to 9 A.A.C. 8, Article 1;
2. A copy of the hospital's food establishment license or permit under 9 A.A.C. 8, Article 1, is maintained;

3. For a hospital that contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the hospital, a copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1, is maintained;
4. If a hospital contracts with a food establishment to prepare and deliver food to the hospital, the hospital is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;
5. Dietary services are provided under the direction of an individual qualified to direct the provision of dietary services according to policies and procedures;
6. There are personnel members on duty to meet the dietary needs of patients;
7. Personnel members providing dietary services are qualified to provide dietary services according to policies and procedures;
8. A nutrition assessment of a patient is:
   a. Performed according to policies and procedures, and
   b. Communicated to the medical practitioner coordinating the patient's medical services if the nutrition assessment reveals a specific dietary need;
9. A medical staff member documents an order for a diet for each patient in the patient's medical record;
10. A current diet manual approved by a registered dietitian is available to personnel members and medical staff members; and
11. A patient's dietary needs are met 24 hours a day.

**Historical Note**

Former Section R9-10-231 renumbered as R9-10-320 as an emergency effective February 22, 1979, new Section R9-10-231 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-231 renumbered to R9-10-232; new Section R9-10-231 renumbered from R9-10-227 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-232. Disaster Management**

An administrator shall ensure that:

1. A disaster plan is developed and documented that includes:
   a. Procedures for protecting the health and safety of patients and other individuals;
   b. Assigned personnel responsibilities; and
   c. Instructions for the evacuation, transport, or transfer of patients, maintenance of medical records, and arrangements to provide any other hospital services to meet the patients' needs;
2. A plan exists for back-up power and water supply;
3. A fire drill is performed on each shift at least once every three months;
4. A disaster drill is performed on each shift at least once every 12 months;
5. Documentation of a fire drill required in subsection (3) and a disaster drill required in subsection (4) includes:
   a. The date and time of the drill;
   b. A critique of the drill; and
   c. Recommendations for improvement, if applicable; and
6. Documentation of a fire drill or a disaster drill is maintained by the hospital for at least 12 months after the date of the drill.

**Historical Note**

Former Section R9-10-232 renumbered as R9-10-321 as an emergency effective February 22, 1979, new Section R9-10-232 adopted effective February 23, 1979 (Supp. 79-1). Section amended by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-232 renumbered to R9-10-234; new Section R9-10-232 renumbered from R9-10-231 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-233. Environmental Standards**

An administrator shall ensure that:

1. An individual providing environmental services who has the potential to transmit infectious tuberculosis to patients, as determined by the infection control risk assessment criteria in R9-10-230(4)(c), provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing environmental services at or on behalf of the hospital, and
   b. According to R9-10-113;
2. The hospital premises and equipment are:
   a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control infection or illness; and
   b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. The hospital maintains a tobacco smoke-free environment;
5. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14, and policies and procedures;

6. Equipment used to provide hospital services is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations; and
7. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair.

**Historical Note**

Former Section R9-10-233 renumbered as R9-10-322 as an emergency effective February 22, 1979, new Section R9-10-233 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section expired under A.R.S. § 41-1056(E) at 14 A.A.R. 2374, effective February 29, 2008 (Supp. 08-2). New Section R9-10-233 renumbered from R9-10-230 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-10-234. Physical Plant Standards**

**A.** An administrator shall ensure that:
1. A hospital complies with the applicable physical plant health and safety codes and standards incorporated by reference in A hospital complies with the applicable physical plant health and safety codes and standards incorporated by reference in R9-10-104.01 in effect on the date the hospital submitted, according to R9-10-104, an application for an approval of architectural plans and specifications to the Department;
2. A hospital's premises or any part of the hospital premises is not leased to or used by another person;
3. A unit with inpatient beds is not used as a passageway to another health care institution; and
4. A hospital's premises are not licensed as more than one health care institution.

**B.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the inspection report, and
3. Maintain documentation of a current fire inspection report.

**Historical Note**

New Section made by final rulemaking 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Section R9-10-234 renumbered to R9-10-228; new Section R9-10-234 renumbered from R9-10-232 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Duplicate language in subsection (A)(1) corrected (Supp. 22-2).

**R9-10-235. Administrative Separation**

**A.** In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-201, the following definition applies in this Section: "Administrative separation" means the temporary isolation of a patient for the purpose of preserving the integrity of evidence during the course of a criminal investigation or for a situation where not isolating the patient presents a risk of serious harm to other individuals or a serious risk to the safety or security of a hospital.

**B.** Only a hospital established according to A.R.S. § 36-202 may use administrative separation.

**C.** An administrator appointed according to A.R.S. § 36-205 shall ensure that:
1. Administrative separation:
   a. Is only used for a patient admitted to the hospital pursuant to a criminal court order; and
   b. Is not used:
      i. In conjunction with a restraint,
      ii. As a method to manage behaviors, or
      iii. If prohibited by law; and
2. Policies and procedures are established, documented, and implemented for administrative separation that:
   a. Include the process and criteria for requesting an administrative separation;
   b. Include the process and deadlines for approving a request for an administrative separation;
   c. Cover patient notification of the right to appeal the administrative separation and to file a complaint;
   d. Include the process for providing a patient access to:
      i. Incoming mail, and
      ii. An advocate or legal representative;

e. Include the process for providing treatment to a patient while in administrative separation;
f. Include the process for establishing investigative goals; and
g. Include the process for determining when administrative separation will no longer be used for a patient.

**Historical Note**

New Section R9-10-235 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

## ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES

*Article 3, consisting of Sections R9-10-311 through R9-10-333, repealed at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).*

### R9-10-301. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

"Child and adolescent residential treatment services" means behavioral health services and physical health services provided in or by a behavioral health inpatient facility to a patient who is:

Under 18 years of age, or

Under 21 years of age and meets the criteria in R9-10-318(B).

**Historical Note**

New Section R9-10-301 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

### R9-10-302. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a behavioral health inpatient facility shall include in a Department-provided format whether the applicant is requesting authorization to provide:

1. Inpatient services to individuals 18 years of age and older, including the licensed capacity requested;
2. Pre-petition screening;
3. Court-ordered evaluation;
4. Court-ordered treatment;
5. Behavioral health observation/stabilization services, including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals:
   a. Under 18 years of age, and
   b. 18 years of age and older;
6. Child and adolescent residential treatment services, including the licensed capacity requested;
7. Detoxification services;
8. Seclusion;
9. Clinical laboratory services;
10. Radiology services; or
11. Diagnostic imaging services.

**Historical Note**

New Section R9-10-302 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

### R9-10-303. Administration

**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a behavioral health in-patient facility;
2. Establish, in writing:
   a. A behavioral health inpatient facility's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-304;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
   a. Expected not to be present on the behavioral health inpatient facility's premises for more than 30 calendar days, or
   b. Not present on the behavioral health inpatient facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:
1. Is directly accountable to the governing authority of a behavioral health inpatient facility for the daily operation of the behavioral health inpatient facility and for all services provided by or at the behavioral health inpatient facility;
2. Has the authority and responsibility to manage the behavioral health inpatient facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the behavioral health inpatient facility's premises and accountable for the behavioral health inpatient facility when the administrator is not present on the behavioral health inpatient facility's premises.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a patient;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Cover cardiopulmonary resuscitation training including:
      i. The method and content of cardiopulmonary resuscitation training,
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
      iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
      iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
   f. Cover first aid training;
   g. Cover the requirements in subsection (J), if applicable;
   h. Include a method to identify a patient to ensure the patient receives physical health and behavioral health services as ordered;
   i. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
   j. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. The behavioral health inpatient facility to respond to a patient's complaint;
   k. Cover health care directives;
   l. Cover medical records, including electronic medical records;
   m. Cover quality management, including incident reports and supporting documentation;
   n. Cover contracted services; and
   o. Cover when an individual may visit a patient in the behavioral health inpatient facility;
2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, assessment, treatment plan, transport, and transfer;
   b. Cover discharge planning and discharge, including the requirements in R9-10-309(B) for a patient who was admitted after a suicide attempt or who exhibits suicidal ideation;
   c. Cover the provision of behavioral health services and physical health services;
   d. Include when general consent and informed consent are required;
   e. Cover restraint and, if applicable, seclusion;
   f. Cover dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
   g. Cover prescribing a controlled substance to minimize substance abuse by a patient;
   h. Cover infection control;
   i. Cover telemedicine, if applicable;
   j. Cover environmental services that affect patient care;
   k. Cover patient outings;
   l. Cover whether pets and animals are allowed on the premises, including procedures to ensure that any pets or animals allowed on the premises do not endanger the health or safety of patients or the public;
   m. If the behavioral health inpatient facility is involved in research, cover the establishment or use of a Human Subject Review Committee;
   n. Cover the process for receiving a fee from a patient and refunding a fee to a patient;
   o. Cover the process for obtaining patient preferences for social, recreational, or rehabilitative activities and meals and snacks;
   p. Cover the security of a patient's possessions that are allowed on the premises; and
   q. Cover smoking and the use of tobacco products on the premises;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers and students; and

5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health inpatient facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health inpatient facility.

**D.** An administrator shall designate a:
1. Medical director who:
   a. Provides direction for physical health services provided by or at the behavioral health inpatient facility;
   b. Is a physician or registered nurse practitioner; and
   c. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(2)(b) and (D)(1)(a) and (b);
2. Clinical director who:
   a. Provides direction for the behavioral health services provided by or at the behavioral health inpatient facility;
   b. Is a behavioral health professional; and
   c. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(2)(b) and (D)(2)(a) and (b); and
3. Registered nurse to provide direction for nursing services provided by or at the behavioral health inpatient facility.

**E.** An administrator shall provide written notification to the Department of a patient's:
1. Death, if the patient's death is required to be reported according to A.R.S. § 11-593, within one working day after the patient's death; and
2. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical services provider.

**F.** Except as specified in R9-10-318(A)(1), if abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from a behavioral health inpatient facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 46-454.

**G.** If an administrator has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from a behavioral health inpatient facility's employee or personnel member, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 46-454;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (G)(1); and
   c. The report in subsection (G)(2);
4. Maintain the documentation in subsection (G)(3) for at least 12 months after the date of the report in subsection (G)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (G)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (G)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**H.** An administrator shall establish and document the criteria for determining when a patient's absence is unauthorized, including the criteria for a patient who:
1. Was admitted under A.R.S. Title 36, Chapter 5, Articles 1, 2, or 3;
2. Is absent against medical advice; or
3. Is under the age of 18.

**I.** An administrator shall:
1. For a patient who is under a court's jurisdiction, within an hour after determining that the patient's absence is unauthorized according to the criteria in subsection (H), notify the appropriate court or a person designated by the appropriate court;
2. Document the notification in subsection (I)(1) and the written log required in subsection (I)(3);
3. Maintain a written log of unauthorized absences for at least 12 months after the date of a patient's absence that includes the:
   a. Name of a patient absent without authorization;
   b. If applicable, name of the person notified as required in subsection (I)(1); and
   c. Date of the notification; and
4. Evaluate and take action related to unauthorized absences under the quality management program in R9-10-304.

**J.** If a behavioral health inpatient facility has a physician or registered nurse practitioner on-call to comply with R9-10-306(J)(1), an administrator shall ensure that:
1. The on-call schedule is documented;
2. Personnel members are aware of:
   a. The location at which the on-call schedule is available to personnel members of the behavioral health inpatient facility,
   b. The process through which the on-call physician or registered nurse practitioner is contacted,
   c. The circumstances that would require the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility, and
   d. The process through which a request is made for the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility;
3. A request for the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility is documented, including:
   a. The time that a request for the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility is made,
   b. The name of the individual making the request,
   c. The reason for the request,
   d. The name of the physician or registered nurse practitioner contacted and requested to come to the behavioral health in-patient facility, and
   e. The time the on-call physician or registered nurse practitioner arrives at the behavioral health inpatient facility in response to a request;
4. The documentation in subsections (J)(1) and (3) is maintained for at least 12 months after the last date on the documentation; and
5. Documentation related to the request is included in the medical record of the applicable patient.

**Historical Note**

New Section R9-10-303 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-304. Quality Management**

An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any changes made or actions taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

New Section R9-10-304 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-305. Contracted Services**

An administrator shall ensure that:
1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section R9-10-305 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-306. Personnel**

**A.** An administrator shall ensure that:

1. A personnel member, an employee, or a student is at least 18 years old; and
2. A volunteer is at least 21 years old.

**B.** An administrator shall ensure that:
1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures;

**C.** An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.

**D.** An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as a baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision, as defined in A.A.C. R4-6-101.

**E.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have direct interaction with a participant for more than eight hours in a week, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the behavioral health inpatient facility, and
2. As specified in R9-10-113.

**F.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the employee's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. The individual's qualifications and on-going training for each type of restraint or seclusion used, as required in R9-10-316;
   f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   g. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-303(C)(1)(e);
   h. First aid training, if required for the individual according to this Article or policies and procedures; and
   i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (D).

**G.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout an individual's period of providing services in or for the behavioral health inpatient facility, and
   b. For at least 24 months after the last date the individual provided services in or for the behavioral health inpatient facility; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the behavioral health inpatient facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**H.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and

c. The subject or topics covered in the orientation;

4. A clinical director develops, documents, and implements a plan to provide in-service education specific to the duties of a personnel member; and
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training.

**I.** An administrator shall ensure that a behavioral health inpatient facility has a daily staffing schedule that:
1. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;
2. Includes documentation of the employees who work each calendar day and the hours worked by each employee; and
3. Is maintained for at least 12 months after the last date on the daily staffing schedule.

**J.** An administrator shall ensure that:
1. A physician or registered nurse practitioner is present on the behavioral health inpatient facility's premises or on-call,
2. A registered nurse is present on the behavioral health inpatient facility's premises, and
3. A registered nurse who provides direction for the nursing services provided at the behavioral health inpatient facility is present at the behavioral health inpatient facility at least 40 hours every week.

**Historical Note**

New Section R9-10-306 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-307. Admission; Assessment**

**A.** Except as provided in R9-10-315(E) or (F), an administrator shall ensure that:
1. A patient is admitted based upon the patient's presenting behavioral health issue and treatment needs and the behavioral health inpatient facility's ability and authority to provide physical health services, behavioral health services, and ancillary services consistent with the patient's treatment needs;
2. A patient is admitted on the order of a medical practitioner or clinical director;
3. A medical practitioner or clinical director, authorized by policies and procedures to accept a patient for admission, is available;
4. Except in an emergency or as provided in subsections (A)(6) and (7), general consent is obtained from a patient or, if applicable, the patient's representative before or at the time of admission;
5. The general consent obtained in subsection (A)(4) or the lack of consent in an emergency is documented in the patient's medical record;
6. General consent is not required from a patient receiving a court-ordered evaluation or court-ordered treatment;
7. General consent is not required from a patient receiving treatment according to A.R.S. § 36-512;
8. A medical practitioner performs a medical history and physical examination on a patient within 30 calendar days before admission or within 24 hours after admission and documents the medical history and physical examination in the patient's medical record within 24 hours after admission;
9. If a medical practitioner performs a medical history and physical examination on a patient before admission, the medical practitioner enters an interval note into the patient's medical record within seven calendar days after admission;
10. Except when a patient needs crisis services, a behavioral health assessment of a patient is completed to determine the acuity of the patient's behavioral health issue and to identify the behavioral health services needed by the patient before treatment for the patient is initiated and whenever the patient has a significant change in condition or experiences an event that affects treatment;
11. If the patient was admitted after a suicide attempt or exhibits suicidal ideation, the behavioral health assessment in subsection (A)(10) includes a suicide assessment;
12. If a behavioral health assessment in subsection (A)(10), including a suicide assessment in subsection (A)(11) if applicable, is conducted by a:
    a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed under A.R.S. Title 32 to provide the behavioral health services needed by the patient, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by and the acuity of the patient; or
    b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed under A.R.S. Title 32 to provide the behavioral health services needed by the patient, supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by and the acuity of the patient;
13. When a patient is admitted, a registered nurse:
    a. Conducts a nursing assessment of a patient's medical condition and history;
    b. Determines whether the:

i. Patient requires immediate physical health services, and
ii. Patient's behavioral health issue may be related to the patient's medical condition and history;
c. Determines the acuity of the patient's medical condition;
d. Documents the patient's nursing assessment and the determinations required in subsection (A)(13)(b) and (c) in the patient's medical record; and
e. Signs the patient's medical record;
14. A behavioral health assessment:
a. Documents the patient's:
i. Presenting issue, including the acuity of the patient's presenting issue;
ii. Substance abuse history;
iii. Co-occurring disorder;
iv. Legal history, including:
(1) Custody,
(2) Guardianship, and
(3) Pending litigation;
v. Court-ordered evaluation;
vi. Court-ordered treatment;
vii. Criminal justice record;
viii. Family history;
ix. Behavioral health treatment history;
x. Symptoms reported by the patient; and
xi. Referrals needed by the patient, if any; and
b. Includes:
i. Recommendations for further assessment or examination of the patient's needs;
ii. Recommendations for staffing levels or personnel member qualifications related to the patient's treatment to ensure patient health and safety;
iii. For a patient who:
(1) Is admitted to receive crisis services, the behavioral health services and physical health services that will be provided to the patient; or
(2) Does not need crisis services, the behavioral health services or physical health services that will be provided to the patient until the patient's treatment plan is completed; and
iv. The signature and date signed of the personnel member conducting the behavioral health assessment;
15. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
16. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
17. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;
18. The request in subsection (A)(16) and the opportunity in subsection (A)(17) are documented in the patient's medical record;
19. For a patient who is admitted to receive crisis services, the patient's behavioral health assessment is documented in the patient's medical record within eight hours after admission;
20. Except as provided in subsection (A)(19), a patient's behavioral health assessment is documented in the patient's medical record within 24 hours after completing the assessment; and
21. If the information listed in subsection (A)(14) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained.

**B.** If the results of a suicide assessment required in subsection (A)(11) indicate that the patient could be a danger to self upon discharge, an administrator shall ensure that the information in R9-10-309(B)(2) is made available to the patient or the patient's representative as part of the opportunity for participation in the patient's behavioral health assessment required in subsection (A)(17).

**Historical Note**

New Section R9-10-307 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-308. Treatment Plan**

**A.** Except for a patient admitted to receive crisis services or as provided in R9-10-315(E) or (F), an administrator shall ensure that a treatment plan is developed and implemented for a patient that:
1. Is based on the behavioral health assessment and on-going changes to the behavioral health assessment of the patient;
2. Is completed:

a. By a behavioral health professional or by a behavioral health technician under the clinical oversight of a behavioral health professional, and
b. Before the patient receives treatment;
3. Is documented in the patient's medical record within 24 hours after the patient first receives treatment;
4. Includes:
a. The patient's presenting issue, including the acuity of the patient's presenting issue;
b. The behavioral health services and physical health services to be provided to the patient;
c. If the patient was admitted after a suicide attempt or who exhibits suicidal ideation:
i. The results of the suicide assessment required in R9-10-307(11), and
ii. Information specific to helping prevent a recurrence;
d. The signature of the patient or the patient's representative and date signed, or documentation of the refusal to sign;
e. The date when the patient's treatment plan will be reviewed;
f. If a discharge date has been determined, the treatment needed after discharge; and
g. The signature of the personnel member who developed the treatment plan and the date signed;
5. If the treatment plan was completed by a behavioral health technician, is reviewed and signed by a behavioral health professional within 24 hours after the completion of the treatment plan to ensure that the treatment plan identifies the acuity of the patient and meets the patient's treatment needs; and
6. Is reviewed and updated on an on-going basis:
a. According to the review date specified in the treatment plan,
b. When a treatment goal is accomplished or changes,
c. When additional information that affects the patient's behavioral health assessment is identified, and
d. When a patient has a significant change in condition or experiences an event that affects treatment.

**B.** An administrator shall ensure that:
1. A request for participation in developing a patient's treatment plan is made to the patient or the patient's representative;
2. An opportunity for participation in developing the patient's treatment plan is provided to the patient or the patient's representative; and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the patient's medical record.

**C.** If a patient who is admitted to receive crisis services remains admitted as a patient after the patient no longer needs crisis services, an administrator shall ensure that a treatment plan for the patient is:
1. Except for subsection (A)(3), completed according to the requirements in subsection (A); and
2. Documented in the patient's medical record within 24 hours after the patient no longer needs crisis services.

**Historical Note**

New Section R9-10-308 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-309. Discharge**

**A.** Except as provided in R9-10-315(E) or (F), an administrator shall ensure that a discharge plan for a patient is:
1. Developed that:
a. Identifies any specific needs of the patient after discharge;
b. If the discharge date has been determined, includes the discharge date;
c. Is completed before discharge occurs; and
d. Includes a description of the level of care that may meet the patient's assessed and anticipated needs after discharge;
2. Documented in the patient's medical record within 48 hours after the discharge plan is completed; and
3. Provided to the patient or the patient's representative before the discharge occurs.

**B.** For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, in addition to the discharge planning requirements in subsection (A), an administrator shall ensure that:
1. The patient receives a suicide assessment; and
2. The patient or the patient's representative receives:
a. The results of the suicide assessment;
b. Information about the availability of age-appropriate, suicide crisis services, including contact information; and
c. Information about and instructions on how to access the Department of Insurance and Financial Institution's website, available through difi.az.gov, developed in compliance with A.R.S. § 20-3503(B), including how to file an appeal of an insurance determination.

**C.** An administrator shall ensure that:
1. A request for participation in developing a patient's discharge plan is made to the patient or the patient's representative,

2. An opportunity for participation in developing the patient's discharge plan is provided to the patient or the patient's representative, and
3. The request in subsection (C)(1) and the opportunity in subsection (C)(2) are documented in the patient's medical record.

**D.** An administrator shall ensure that a patient is discharged from a behavioral health inpatient facility when the patient's treatment needs are not consistent with the services that the behavioral health inpatient facility is authorized and able to provide.

**E.** An administrator shall ensure that there is a documented discharge order by a medical practitioner or behavioral health professional before a patient is discharged unless the patient leaves the behavioral health inpatient facility against a medical practitioner's or behavioral health professional's advice.

**F.** An administrator shall ensure that, at the time of discharge, a patient receives:
1. A referral for treatment or ancillary services that the patient may need after discharge, if applicable; and
2. For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, specific information about or a referral to one of the following for ongoing or follow-up treatment related to suicide, including scheduling an appointment for the patient when practicable:
   a. Another health care institution;
   b. A medical practitioner or, for a patient going to another state after discharge, a similarly licensed individual in the other state; or
   c. A behavioral health professional certified or licensed under A.R.S. Title 32 to provide treatment related to suicide or, for a patient going to another state after discharge, a similarly certified or licensed individual in the other state.

**G.** If a patient is discharged to any location other than a health care institution, an administrator shall ensure that:
1. Discharge instructions are documented, and
2. The patient or the patient's representative is provided with a copy of the discharge instructions.

**H.** An administrator shall ensure that a discharge summary:
1. Is entered into the patient's medical record within 10 working days after a patient's discharge; and
2. Includes:
   a. The following information authenticated by a medical practitioner or behavioral health professional:
      i. The patient's presenting issue and other physical health and behavioral health issues identified in the patient's nursing assessment, behavioral health assessment, or treatment plan;
      ii. A summary of the treatment provided to the patient;
      iii. The patient's progress in meeting treatment goals, including treatment goals that were and were not achieved; and
      iv. The name, dosage, and frequency of each medication ordered for the patient by a medical practitioner at the behavioral health inpatient facility at the time of the patient's discharge;
   b. For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, the following information:
      i. A description of the specific information about ongoing or follow-up treatment related to suicide provided to the patient or the patient's representative;
      ii. Whether a referral was made for the patient according to subsection (F)(2) for ongoing or follow-up treatment related to suicide and, if so, information about the referral; and
      iii. Whether an appointment was scheduled for the patient according to subsection (F)(2) for ongoing or follow-up treatment related to suicide and, if so, the date and time of the appointment; and
   c. A description of the disposition of the patient's possessions, funds, or medications brought to the behavioral health inpatient facility by the patient.

**I.** An administrator shall ensure that a patient who is dependent upon a prescribed medication is offered detoxification services, opioid treatment, or a written referral to detoxification services or opioid treatment before the patient is discharged from the behavioral health inpatient facility if a medical practitioner for the behavioral health inpatient facility will not be prescribing the medication for the patient at or after discharge.

**Historical Note**

New Section R9-10-309 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-310. Transport; Transfer**

**A.** Except as provided in subsection (B), an administrator shall ensure that:
1. A personnel member coordinates the transport and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before and after the transport,
   b. Information from the patient's medical record is provided to a receiving health care institution,
   c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative, and
   d. A personnel member communicates or documents why the personnel member did not communicate with an individual at a receiving health care institution; and
3. The patient's medical record includes documentation of:

a. Communication or lack of communication with an individual at a receiving health care institution;
b. The date and time of the transport;
c. The mode of transportation; and
d. If applicable, the name of the personnel member accompanying the patient during a transport.

**B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a patient by the patient or the patient's representative,
3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative, or
4. A transport to another licensed health care institution in an emergency.

**C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before the transfer;
   b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the patient during a transfer.

**Historical Note**

Adopted as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 4, 1979 (Supp. 79-3). Amended effective January 28, 1980 (Supp. 80-1). Repealed effective February 4, 1981 (Supp. 81-1). New Section R9-10-310 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-311. Patient Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (D) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (D); and
3. Policies and procedures include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsection (D), and
   b. Where patient rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed under R9-10-316, restraint or seclusion;
   i. Retaliation for submitting a complaint to the Department or another entity;
   j. Misappropriation of personal and private property by the behavioral health inpatient facility's personnel members, employees, volunteers, or students;
   k. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the patient's treatment needs, except as established in a fee agreement signed by the patient or the patient's representative; or
   l. Treatment that involves the denial of:
      i. Food,
      ii. The opportunity to sleep, or
      iii. The opportunity to use the toilet;
3. Except as provided in subsection (C), a patient is allowed to:
   a. Associate with individuals of the patient's choice, receive visitors, and make telephone calls during the hours established by the behavioral health inpatient facility;

b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
c. Unless restricted by a court order, send and receive uncensored and unopened mail; and

4. Except as provided in R9-10-318, a patient or, if applicable, the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5; is necessary to save the patient's life or physical health; or is provided according to A.R.S. § 36-512;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication and the associated risks and possible complications of the proposed psychotropic medication;
   d. Is informed of the following:
      i. The policy on health care directives, and
      ii. The patient complaint process; and
   e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records.

**C.** If a medical director or clinical director determines that a patient's treatment requires the behavioral health inpatient facility to restrict the patient's ability to participate in an activity in subsection (B)(3), the medical director or clinical director shall:
1. Document a specific treatment purpose in the patient's medical record that justifies restricting the patient from the activity,
2. Inform the patient of the reason why the activity is being restricted, and
3. Inform the patient of the patient's right to file a complaint and the procedure for filing a complaint.

**D.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that:
   a. Supports and respects the patient's individuality, choices, strengths, and abilities;
   b. Supports the patient's personal liberty and only restricts the patient's personal liberty according to a court order, by the patient's or the patient's representative's general consent, or as permitted in this Chapter; and
   c. Is provided in the least restrictive environment that meets the patient's treatment needs;
3. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
   a. A patient may be photographed when admitted to a behavioral health inpatient facility for identification and administrative purposes;
   b. For a patient receiving treatment according to A.R.S. Title 36, Chapter 37; or
   c. For video recordings used for security purposes that are maintained only on a temporary basis;
4. Not to be prevented or impeded from exercising the patient's civil rights unless the patient has been adjudicated incompetent or a court of competent jurisdiction has found that the patient is not able to exercise a specific right or category of rights;
5. To review, upon written request, the patient's own medical record according to A.R.S. §§12-2293, 12-2294, and 12-2294.01;
6. To receive a referral to another health care institution if the behavioral health inpatient facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
7. To participate or have the patient's representative participate in the development of a treatment plan or decisions concerning treatment;
8. To participate or refuse to participate in research or experimental treatment; and
9. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

Section R9-10-311, formerly numbered as R9-10-211, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-311 repealed, new Section R9-10-311 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-311 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-312. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;

3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative, or
   c. As permitted by law; and
6. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If a behavioral health inpatient facility maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
   a. The patient's name;
   b. The patient's address;
   c. The patient's date of birth; and
   d. Any known allergy, including medication allergies;
2. Medication information that includes:
   a. Documentation of medication ordered for the patient; and
   b. Documentation of medication administered to the patient that includes:
      i. The date and time of administration;
      ii. The name, strength, dosage, amount, and route of administration;
      iii. For a medication administered for pain on a PRN basis:
         (1) An assessment of the patient's pain before administering the medication, and
         (2) The effect of the medication administered;
      iv. For a psychotropic medication administered on a PRN basis:
         (1) An assessment of the patient's behavior before administering the psychotropic medication, and
         (2) The effect of the psychotropic medication administered;
      v. The identification and authentication of the individual administering the medication or providing assistance in the self-administration of the medication; and
      vi. Any adverse reaction the patient has to the medication;
3. If applicable, documented general consent and informed consent by the patient or the patient's representative;
4. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
5. The patient's medical history and results of a physical examination or an interval note;
6. If the patient provides a health care directive, the health care directive signed by the patient or the patient's representative;
7. An admitting diagnosis or presenting symptoms;
8. The date of admission and, if applicable, the date of discharge;
9. The name of the admitting medical practitioner or behavioral health professional;
10. Orders;
11. The patient's nursing assessment and behavioral health assessment and any interval notes;
12. Treatment plans;
13. Documentation of behavioral health services and physical health services provided to the patient;
14. Progress notes;
15. If applicable, documentation of restraint or seclusion;
16. If applicable, documentation that evacuation from the behavioral health inpatient facility would cause harm to the patient;
17. The disposition of the patient after discharge;
18. The discharge plan;

19. The discharge summary; and
20. If applicable:
    a. A laboratory report,
    b. A radiologic report,
    c. A diagnostic report, and
    d. A consultation report.

**Historical Note**

Section R9-10-312, formerly numbered as R9-10-212, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-312 repealed, new Section R9-10-312 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-312 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-313. Transportation; Patient Outings**

**A.** An administrator of a behavioral health inpatient facility that uses a vehicle owned or leased by the behavioral health inpatient facility to provide transportation to a patient shall ensure that:
1. The vehicle:
    a. Is safe and in good repair,
    b. Contains a first aid kit,
    c. Contains drinking water sufficient to meet the needs of each patient present in the vehicle, and
    d. Contains a working heating and air conditioning system;
2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
3. A driver of the vehicle:
    a. Is 21 years of age or older;
    b. Has a valid driver license;
    c. Operates the vehicle in a manner that does not endanger a patient in the vehicle;
    d. Does not leave in the vehicle an unattended:
        i. Child;
        ii. Patient who may be a threat to the health, safety, or welfare of the patient or another individual; or
        iii. Patient who is incapable of independent exit from the vehicle; and
    e. Ensures the safe and hazard-free loading and unloading of patients; and
4. Transportation safety is maintained as follows:
    a. An individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
    b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a patient's body.

**B.** An administrator shall ensure that an outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each patient participating in the outing.

**C.** An administrator shall ensure that:
1. At least two personnel members are present on an outing;
2. In addition to the personnel members required in subsection (C)(1), a sufficient number of personnel members are present on an outing to ensure the health and safety of a patient on the outing;
3. Each personnel member on the outing has documentation of current training in cardiopulmonary resuscitation according to R9-10-303(C)(1)(e) and first aid training;
4. Documentation is developed before an outing that includes:
    a. The name of each patient participating in the outing;
    b. A description of the outing;
    c. The date of the outing;
    d. The anticipated departure and return times;
    e. The name, address, and, if available, telephone number of the outing destination; and
    f. If applicable, the license plate number of a vehicle used to provide transportation for the outing;
5. The documentation described in subsection (C)(4) is updated to include the actual departure and return times and is maintained for at least 12 months after the date of the outing; and
6. Emergency information for a patient participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
    a. The patient's name;
    b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the patient during the anticipated duration of the outing;
    c. The patient's allergies; and

d. The name and telephone number of a designated individual, to notify in case of an emergency, who is present on the behavioral health inpatient facility's premises.

**Historical Note**

Section R9-10-313, formerly numbered as R9-10-213, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-313 repealed, new Section R9-10-313 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-313 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-314. Physical Health Services**

**A.** An administrator shall ensure that:
1. Medical services are provided under the direction of a physician or registered nurse practitioner;
2. Nursing services are provided:
   a. Under the direction of a registered nurse,
   b. According to an acuity plan developed for the behavioral health inpatient facility, and
   c. To meet the needs of a patient based on the patient's acuity; and
3. If a behavioral health inpatient facility is authorized to provide:
   a. Clinical laboratory services, as defined in R9-10-101, the behavioral health inpatient facility complies with the requirements for clinical laboratory services in R9-10-219; or
   b. Radiology services or diagnostic imaging services, the behavioral health inpatient facility complies with the requirements in R9-10-220.

**B.** An administrator shall ensure that, if a patient requires immediate medical services to ensure the patient's health and safety that the behavioral health inpatient facility is not authorized or not able to provide, a personnel member arranges for the patient to be transported to a hospital, another health care institution, or a health care provider where the medical services can be provided.

**Historical Note**

Section R9-10-314, formerly numbered as R9-10-214, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-314 repealed, new Section R9-10-314 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-314 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-315. Behavioral Health Services**

**A.** An administrator shall ensure that:
1. Behavioral health services listed in the behavioral health inpatient facility's scope of services are provided to meet the needs of a patient;
2. When behavioral health services are:
   a. Listed in the behavioral health inpatient facility's scope of services, the behavioral health services are provided on the behavioral health inpatient facility's premises; and
   b. Provided in a setting or activity with more than one patient participating, before a patient participates, the diagnoses, treatment needs, developmental levels, social skills, verbal skills, and personal histories, including any history of physical abuse or sexual abuse, of the patients participating are reviewed to ensure that the:
      i. Health and safety of each patient is protected, and
      ii. Treatment needs of each patient participating in the setting or activity are being met;
3. An acuity plan is developed, documented, and implemented for each unit in the behavioral health inpatient facility that:
   a. Includes:
      i. A method that establishes the types and numbers of personnel members that are required for each unit in the behavioral health inpatient facility to ensure patient health and safety, and
      ii. A policy and procedure stating the steps the behavioral health inpatient facility will take to obtain or assign the necessary personnel members to address patient acuity;
   b. Is used when making assignments for patient treatment; and
   c. Is reviewed and updated, as necessary, at least once every 12 months;
4. A patient is assigned to a unit in the behavioral health inpatient facility based, as applicable, on the patient's:
   a. Presenting issue,
   b. Substance abuse history,
   c. Behavioral health treatment history,

d. Acuity, and
e. Treatment needs; and

5. A patient does not share any space, participate in any activity or treatment, or verbally or physically interact with any other patient that, based on the other patient's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history, may present a threat to the patient's health and safety.

**B.** An administrator shall ensure that counseling is:
1. Offered as described in the behavioral health inpatient facility's scope of services,
2. Provided according to the frequency and number of hours identified in the patient's treatment plan, and
3. Provided by a behavioral health professional or a behavioral health technician.

**C.** An administrator shall ensure that each counseling session is documented in a patient's medical record to include:
1. The date of the counseling session;
2. The amount of time spent in the counseling session;
3. Whether the counseling was individual counseling, family counseling, or group counseling;
4. The treatment goals addressed in the counseling session; and
5. The signature of the personnel member who provided the counseling and the date signed.

**D.** An administrator of a behavioral health inpatient facility authorized to provide pre-petition screening shall ensure pre-petition screening is provided according to the pre-petition screening requirements in A.R.S. Title 36, Chapter 5.

**E.** An administrator of a behavioral health inpatient facility authorized to provide court-ordered evaluation shall ensure that court-ordered evaluation is provided according to the court-evaluation requirements in A.R.S. Title 36, Chapter 5.

**F.** Except as specified in subsection (G), an administrator is not required to comply with the following provisions in this Chapter for a patient receiving court-ordered evaluation:
1. Admission requirements in R9-10-307,
2. Patient assessment requirements in R9-10-307,
3. Treatment plan requirements in R9-10-308, and
4. Discharge requirements in R9-10-309.

**G.** For a patient receiving court-ordered evaluation who attempts suicide or exhibits suicidal ideation, an administrator shall ensure that the following requirements are met:
1. Patient assessment requirements in R9-10-307(10), (11), and (12);
2. Treatment plan requirements in R9-10-308(A)(4)(c); and
3. Discharge requirements in R9-10-309(B), (F)(2), and (H)(2)(b).

**H.** An administrator of a behavioral health inpatient facility authorized to provide court-ordered treatment shall ensure that court-ordered treatment is provided according to the court-ordered treatment requirements in A.R.S. Title 36, Chapter 5.

**Historical Note**

Section R9-10-315, formerly numbered as R9-10-215, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-315 repealed, new Section R9-10-315 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-315 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

**R9-10-316. Seclusion; Restraint**

**A.** An administrator shall ensure that restraint is provided according to the requirements in subsection (C).

**B.** An administrator of a behavioral health inpatient facility authorized to provide seclusion shall ensure that:
1. Seclusion is provided according to the requirements in subsection (C);
2. If a patient is placed in seclusion, the room used for seclusion:
   a. Is approved for use as a seclusion room by the Department;
   b. Is not used as a patient's bedroom or a sleeping area;
   c. Allows full view of the patient in all areas of the room;
   d. Is free of hazards, such as unprotected light fixtures or electrical outlets;
   e. Contains at least 60 square feet of floor space; and
   f. Except as provided in subsection (B)(3), contains a non-adjustable bed that:
      i. Consists of a mattress on a solid platform that is:
         (1) Constructed of a durable, non-hazardous material; and
         (2) Raised off of the floor;
      ii. Does not have wire springs or a storage drawer; and
      iii. Is securely anchored in place;
3. If a room used for seclusion does not contain a non-adjustable bed required in subsection (B)(2)(f):
   a. A piece of equipment is available that:

i. Is commercially manufactured to safely and humanely restrain a patient's body;
ii. Provides support to the trunk and head of a patient's body;
iii. Provides restraint to the trunk of a patient's body;
iv. Is able to restrict movement of a patient's arms, legs, body, and head;
v. Allows a patient's body to recline; and
vi. Does not inflict harm on a patient's body; and

b. Documentation of the manufacturer's specifications for the piece of equipment in subsection (B)(3)(a) is maintained; and

4. A seclusion room may be used for services or activities other than seclusion if:
   a. A sign stating the service or activity scheduled or being provided in the room is conspicuously posted outside the room;
   b. No permanent equipment other than the bed required in subsection (B)(2)(f) is in the room;
   c. Policies and procedures:
      i. Delineate which services or activities other than seclusion may be provided in the room,
      ii. List what types of equipment or supplies may be placed in the room for the delineated services, and
      iii. Provide for the prompt removal of equipment and supplies from the room before the room is used for seclusion; and
   d. The sign required in subsection (B)(4)(a) and equipment and supplies in the room, other than the bed required in subsection (B)(2)(f), are removed before being used for seclusion.

**C.** An administrator shall ensure that:

1. Policies and procedures for providing restraint or seclusion are established, documented, and implemented to protect the health and safety of a patient that:
   a. Establish the process for patient assessment, including identification of a patient's medical conditions and criteria for the on-going monitoring of any identified medical condition;
   b. Identify each type of restraint or seclusion used and include for each type of restraint or seclusion used:
      i. The qualifications of a personnel member who can:
         (1) Order the restraint or seclusion,
         (2) Place a patient in the restraint or seclusion,
         (3) Monitor a patient in the restraint or seclusion,
         (4) Evaluate a patient's physical and psychological well-being after being placed in the restraint or seclusion and when released from the restraint or seclusion, or
         (5) Renew the order for restraint or seclusion;
      ii. On-going training requirements for a personnel member who has direct patient contact while the patient is in a restraint or seclusion; and
      iii. Criteria for monitoring and assessing a patient including:
         (1) Frequencies of monitoring and assessment based on a patient's medical condition and risks associated with the specific restraint or seclusion;
         (2) For the renewal of an order for restraint or seclusion, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
         (3) Assessment content, which may include, depending on a patient's condition, the patient's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
         (4) If a mechanical restraint is used, how often the mechanical restraint is loosened; and
         (5) A process for meeting a patient's nutritional needs and elimination needs;
   c. Establish the criteria and procedures for renewing an order for restraint or seclusion;
   d. Establish procedures for internal review of the use of restraint or seclusion; and
   e. Establish medical record and personnel record documentation requirements for restraint and seclusion, if applicable;
2. An order for restraint or seclusion is:
   a. Obtained from a physician or registered nurse practitioner, and
   b. Not written as a standing order or on an as-needed basis;
3. Restraint or seclusion is:
   a. Not used as a means of coercion, discipline, convenience, or retaliation;
   b. Only used when all of the following conditions are met:
      i. Except as provided in subsection (C)(4), after obtaining an order for the restraint or seclusion;
      ii. For the management of a patient's aggressive, violent, or self-destructive behavior;
      iii. When less restrictive interventions have been determined to be ineffective; and
      iv. To ensure the immediate physical safety of the patient, to prevent imminent harm to the patient or another individual, or to stop physical harm to another individual; and
   c. Discontinued at the earliest possible time;

4. If as a result of a patient's aggressive, violent, or self-destructive behavior, harm to the patient or another individual is imminent or the patient or another individual is being physically harmed, a personnel member:
   a. May initiate an emergency application of restraint or seclusion for the patient before obtaining an order for the restraint or seclusion, and
   b. Obtains an order for the restraint or seclusion of the patient during the emergency application of the restraint or seclusion;
5. An order for restraint or seclusion includes:
   a. The name of the physician or registered nurse practitioner ordering the restraint or seclusion;
   b. The date and time that the restraint or seclusion was ordered;
   c. The specific restraint or seclusion ordered;
   d. If a drug is ordered as a chemical restraint, the drug's name, strength, dosage, and route of administration;
   e. The specific criteria for release from restraint or seclusion without an additional order; and
   f. The maximum duration authorized for the restraint or seclusion;
6. An order for restraint or seclusion is limited to the duration of the emergency situation and does not exceed three continuous hours;
7. If an order for restraint or seclusion of a patient is not provided by the patient's attending physician, the patient's attending physician is notified as soon as possible;
8. A medical practitioner or personnel member does not participate in restraint or seclusion, assess or monitor a patient during restraint or seclusion, or evaluate a patient after restraint or seclusion, and a physician or registered nurse practitioner does not order restraint or seclusion, until the medical practitioner or personnel member, completes education and training that:
   a. Includes:
      i. Techniques to identify medical practitioner, personnel member, and patient behaviors, events, and environmental factors that may trigger circumstances that require restraint or seclusion;
      ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods;
      iii. Techniques for identifying the least restrictive intervention based on an assessment of the patient's medical or behavioral health condition;
      iv. The safe use of restraint and the safe use of seclusion, including training in how to recognize and respond to signs of physical and psychological distress in a patient who is restrained or secluded;
      v. Clinical identification of specific behavioral changes that indicate that the restraint or seclusion is no longer necessary;
      vi. Monitoring and assessing a patient while the patient is in restraint or seclusion according to policies and procedures; and
      vii. Except for the medical practitioner, training exercises in which the personnel member successfully demonstrates the techniques that the medical practitioner or personnel member has learned for managing emergency situations; and
   b. Is provided by individuals qualified according to policies and procedures;
9. When a patient is placed in restraint or seclusion:
   a. The restraint or seclusion is conducted according to policies and procedures;
   b. The restraint or seclusion is proportionate and appropriate to the severity of the patient's behavior and the patient's:
      i. Chronological and developmental age;
      ii. Size;
      iii. Gender;
      iv. Physical condition;
      v. Medical condition;
      vi. Psychiatric condition; and
      vii. Personal history, including any history of physical or sexual abuse;
   c. The physician or registered nurse practitioner who ordered the restraint or seclusion is available for consultation throughout the duration of the restraint or seclusion;
   d. The patient is monitored and assessed according to policies and procedures;
   e. A physician or registered nurse assesses the patient within one hour after the patient is placed in the restraint or seclusion and determines:
      i. The patient's current behavior,
      ii. The patient's reaction to the restraint or seclusion used,
      iii. The patient's medical and behavioral condition, and
      iv. Whether to continue or terminate the restraint or seclusion;
   f. The patient is given the opportunity:
      i. To eat during mealtime, and
      ii. To use the toilet; and
   g. The restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order;
10. A medical practitioner or personnel member documents the following information in a patient's medical record before the end of the shift in which the patient is placed in restraint or seclusion or, if the patient's restraint or seclusion does not end during the shift in which it began, during the shift in which the patient's restraint or seclusion ends:

a. The emergency situation that required the patient to be restrained or put in seclusion;
b. The times the patient's restraint or seclusion actually began and ended;
c. The time of the assessment required in subsection (C)(9)(e);
d. The monitoring required in subsection (C)(9)(d);
e. The names of the medical practitioners and personnel members with direct patient contact while the patient was in the restraint or seclusion;
f. The times the patient was given the opportunity to eat or use the toilet according to subsection (C)(9)(f); and
g. The patient evaluation required in subsection (C)(12);

11. If an emergency situation continues beyond the time limit of an order for restraint or seclusion, the order is renewed according to policies and procedures that include:
a. The specific criteria for release from restraint or seclusion without an additional order, and
b. The maximum duration authorized for the restraint or seclusion; and
12. A patient is evaluated after restraint or seclusion is no longer being used for the patient.

**Historical Note**

Section R9-10-316, formerly numbered as R9-10-216, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-316 repealed, new Section R9-10-316 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-316 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-317. Behavioral Health Observation/Stabilization Services**

**A.** An administrator of a behavioral health inpatient facility authorized to provide behavioral health observation/stabilization services shall comply with the requirements for behavioral health observation/stabilization services in R9-10-1012.

**B.** If a behavioral health inpatient facility is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age, an administrator shall ensure that, in addition to complying with the requirements in R9-10-1012, the behavioral health inpatient facility complies with the requirements for a patient under 18 years of age, personnel records, and physical plant in R9-10-318.

**Historical Note**

Section R9-10-317, formerly numbered as R9-10-221, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-317 repealed, new Section R9-10-317 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-317 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-318. Child and Adolescent Residential Treatment Services**

**A.** An administrator of a behavioral health inpatient facility authorized to provide child and adolescent residential treatment services shall:

1. If abuse, neglect, or exploitation of a patient under 18 years of age is alleged or suspected to have occurred before the patient was accepted or while the patient is not on the premises and not receiving services from an employee or personnel member of the behavioral health inpatient facility, report the alleged or suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 13-3620;
2. If the administrator has a reasonable basis, according to A.R.S. § 13-3620, to believe that abuse, neglect, or exploitation of a patient under 18 years of age has occurred on the premises or while the patient is receiving services from an employee or a personnel member:
a. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
b. Report the suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 13-3620;
c. Document:
i. The suspected abuse, neglect, or exploitation;
ii. Any action taken according to subsection (A)(2)(a); and
iii. The report in subsection (A)(2)(b);
d. Maintain the documentation in subsection (A)(2)(c) for at least 12 months after the date of the report in subsection (A)(2)(b);
e. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (A)(2)(b):
i. The dates, times, and description of the suspected abuse, neglect, or exploitation;

ii. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
iii. The names of witnesses to the suspected abuse, neglect, or exploitation; and
iv. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and

f. Maintain a copy of the documented information required in subsection (A)(2)(e) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated;

3. If a patient who is under 18 years of age is absent and the absence is unauthorized as determined according to the criteria in R9-10-303(H), within an hour after determining that the patient's absence is unauthorized, notify:
   a. Except as provided in subsection (A)(3)(b), the patient's parent or legal guardian; and
   b. For a patient who is under a court's jurisdiction, the appropriate court or a person designated by the appropriate court;
4. Document the notification in subsection (A)(3) in the patient's medical record and the written log required in R9-10-303(I)(3);
5. In addition to the personnel records requirements in R9-10-306(F), ensure that a personnel record for each employee, volunteer, and student contains documentation of the individual's compliance with the finger-printing requirements in A.R.S. § 36-425.03;
6. Ensure that the patient's representative for a patient who is under 18 years of age:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent to treatment before treatment is initiated, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01; is necessary to save the patient's life or physical health; or is provided according to A.R.S. § 36-512;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication and the associated risks and possible complications of the proposed psychotropic medication;
   d. Is informed of the following:
      i. The policy on health care directives, and
      ii. The patient complaint process; and
   e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records;
7. In addition to the restrictions provided in R9-10-311(C), ensure that a parent of a patient under 18 years of age is allowed to restrict the patient from:
   a. Associating with individuals of the patient's choice, receiving visitors, and making telephone calls during the hours established by the behavioral health inpatient facility;
   b. Having privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
   c. Sending and receiving uncensored and unopened mail;
8. Establish, document, and implement policies and procedures to ensure that a patient is protected from the following from other patients at the behavioral health inpatient facility:
   a. Threats,
   b. Ridicule,
   c. Verbal harassment,
   d. Punishment, or
   e. Abuse;
9. Ensure that:
   a. The interior of the behavioral health inpatient facility has furnishings and decorations appropriate to the ages of the patients receiving services at the behavioral health inpatient facility;
   b. A patient older than three years of age does not sleep in a crib;
   c. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to patients in a quantity sufficient to meet each patient's needs and are appropriate to each patient's age, developmental level, and treatment needs; and
   d. A patient's educational needs are addressed according to A.R.S. Title 15, Chapter 7, Article 4;
10. In addition to the requirements for seclusion or restraint in R9-10-316, ensure that:
    a. An order for restraint or seclusion is limited to the duration of the emergency situation and does not exceed:
       i. Two continuous hours for a patient who is between the ages of nine and 17, or
       ii. One continuous hour for a patient who is younger than nine; and
    b. Requirements are established for notifying the parent or guardian of a patient who is under 18 years of age and who is restrained or secluded; and
11. Prohibit a patient under 18 years of age from possessing or using tobacco products on the premises.

**B.** An administrator of a behavioral health inpatient facility authorized to provide child and adolescent residential treatment services may continue to provide behavioral health services to a patient who is 18 years of age or older:
1. If the patient:
   a. Was admitted to the behavioral health inpatient facility before the patient's 18th birthday,
   b. Is not 21 years of age or older, and

c. Is completing high school or a high school equivalency diploma or participating in a job training pro-gram; or
2. Through the last calendar day of the month of the patient's 18th birthday.

**Historical Note**

Section R9-10-318, formerly numbered as R9-10-222, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-318 repealed, new Section R9-10-318 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-318 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-318 renumbered to R9-10-319; new Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

**R9-10-319. Detoxification Services**

An administrator of a behavioral health inpatient facility authorized to provide detoxification services shall ensure that:
1. Detoxification services are available;
2. Policies and procedures state:
   a. Whether the behavioral health inpatient facility is authorized to provide involuntary, court-ordered alcohol treatment;
   b. Whether the behavioral health inpatient facility includes a local alcoholism reception center, as defined in A.R.S. § 36-2021;
   c. The types of substances for which the behavioral health inpatient facility provides detoxification services;
   d. The detoxification process or processes used by the behavioral health inpatient facility; and
   e. When an adjustable bed can be used by a patient and what actions are necessary, including supervision, to protect the patient's health and safety when the patient is in an adjustable bed; and
3. A physician or registered nurse practitioner with skills and knowledge in providing detoxification services is present at the behavioral health inpatient facility or on-call.

**Historical Note**

Section R9-10-319, formerly numbered as R9-10-223, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-319 repealed, new Section R9-10-319 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-319 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-319 renumbered to R9-10-320; new Section R9-10-319 renumbered from R9-10-318 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-320. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:
1. Include:
   a. A process for providing information to a patient about medication prescribed for the patient including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse reaction to a medication, or
      iii. A medication overdose;
   c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs;
   d. Procedures for documenting medication administration and assistance in the self-administration of medication;
   e. Procedures for assisting a patient in obtaining medication; and
   f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**B.** If a behavioral health inpatient facility provides medication administration, an administrator shall ensure that:
1. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner;
   b. Specify the individuals who may:
      i. Order medication, and

ii. Administer medication;
c. Ensure that medication is administered to a patient only as prescribed; and
d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a patient is:
a. Administered in compliance with an order, and
b. Documented in the patient's medical record.

**C.** If a behavioral health inpatient facility provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A patient's medication is stored by the behavioral health inpatient facility;
2. The following assistance is provided to a patient:
a. A reminder when it is time to take the medication;
b. Opening the medication container for the patient;
c. Observing the patient while the patient removes the medication from the container;
d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
i. The patient taking the medication is the individual stated on the medication container label,
ii. The patient is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
iii. The patient is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
e. Observing the patient while the patient takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
b. Includes:
i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a patient:
a. Is in compliance with an order, and
b. Is documented in the patient's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members; and
3. If pharmaceutical services are provided on the premises:
a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
i. Develop a drug formulary,
ii. Update the drug formulary at least once every 12 months,
iii. Develop medication usage and medication substitution policies and procedures, and
iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
b. The pharmaceutical services are provided under the direction of a pharmacist;
c. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
d. A copy of the pharmacy license is provided to the Department upon request.

**E.** When medication is stored at a behavioral health inpatient facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
c. A medication recall and notification of patients who received recalled medication; and
d. Storing, inventorying, and dispensing controlled substances.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the behavioral health inpatient facility's clinical director.

**Historical Note**

Section R9-10-320, formerly numbered as R9-10-231, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-320 repealed, new Section R9-10-320 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-320 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-320 renumbered to R9-10-321; new Section R9-10-320 renumbered from R9-10-319 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-321. Food Services**

**A.** An administrator shall ensure that:
1. The behavioral health inpatient facility obtains a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
2. A copy of the behavioral health inpatient facility's food establishment license or permit is maintained;
3. If a behavioral health inpatient facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health inpatient facility:
   a. A copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health inpatient facility; and
   b. The behavioral health inpatient facility is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;
4. A registered dietitian is employed full-time, part-time, or as a consultant; and
5. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to meet the nutritional needs of the patients.

**B.** A registered dietitian or director of food services shall ensure that:
1. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the behavioral health inpatient facility are served according to posted menus;
3. Meals and snacks for each day are planned using:
   a. The applicable guidelines in http://www.health.gov/dietaryguidelines/2015, and
   b. Preferences for meals and snacks obtained from patients;
4. A patient is provided:
   a. A diet that meets the patient's nutritional needs as specified in the patient's assessment or treatment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(4)(d);
   c. The option to have a daily evening snack identified in subsection (B)(4)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. A patient group agrees; and
      ii. The patient is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
5. A patient requiring assistance to eat is provided with assistance that recognizes the patient's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
6. Water is available and accessible to patients.

**C.** An administrator shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a patient such as cut, chopped, ground, pureed, or thickened;
4. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below; and
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
      i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;

ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
vi. Leftovers are reheated to a temperature of at least 165° F;

5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
6. Frozen foods are stored at a temperature of 0° F or below; and
7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**Historical Note**

Section R9-10-321, formerly numbered as R9-10-232, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-321 repealed, new Section R9-10-321 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-321 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-321 renumbered to R9-10-322; new Section R9-10-321 renumbered from R9-10-320 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-322. Emergency and Safety Standards**

**A.** An administrator shall ensure that a behavioral health inpatient facility has:
1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and a sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that are in working order; or
2. An alternative method to ensure a patient's safety, documented and approved by the local jurisdiction.

**B.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
   a. When, how, and where patients will be relocated;
   b. How a patient's medical record will be available to individuals providing services to the patient during a disaster;
   c. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
   d. A plan for obtaining food and water for individuals present in the behavioral health inpatient facility or the behavioral health inpatient facility's relocation site during a disaster;
2. The disaster plan required in subsection (B)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (B)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, volunteer, or student participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and patients:
   a. Is conducted at least once every six months; and
   b. Includes all individuals on the premises except for:
      i. A patient whose medical record contains documentation that evacuation from the behavioral health inpatient facility would cause harm to the patient, and
      ii. Sufficient personnel members to ensure the health and safety of patients not evacuated according to subsection (B)(5)(b)(i);
6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for employees and patients to evacuate to a designated area;
   c. If applicable:
      i. An identification of patients needing assistance for evacuation, and
      ii. An identification of patients who were not evacuated;
   d. Any problems encountered in conducting the evacuation drill; and
   e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health inpatient facility.

**C.** An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Section R9-10-322, formerly numbered as R9-10-233, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-322 repealed, new Section R9-10-322 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-322 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-322 renumbered to R9-10-323; new Section R9-10-322 renumbered from R9-10-321 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-323. Environmental Standards**

**A.** An administrator shall ensure that:

1. The premises and equipment are:
   a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
   b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
4. Equipment used at the behavioral health inpatient facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
6. Garbage and refuse are:
   a. In areas used for food storage, food preparation, or food service, stored in covered containers lined with plastic bags;
   b. In areas not used for food storage, food preparation, or food service, stored:
      i. According to the requirements in subsection (6)(a), or
      ii. In a paper-lined container that is cleaned and sanitized as often as necessary to ensure that the container is clean; and
   c. Removed from the premises at least once a week;
7. Heating and cooling systems maintain the behavioral health inpatient facility at a temperature between 70° F and 84° F;
8. Common areas:
   a. Are lighted to assure the safety of patients, and
   b. Have lighting sufficient to allow personnel members to monitor patient activity;
9. Hot water temperatures are maintained between 95° F and 120° F in the areas of a behavioral health inpatient facility used by patients;
10. The supply of hot and cold water is sufficient to meet the personal hygiene needs of patients and the cleaning and sanitation requirements in this Article;
11. Soiled linen and soiled clothing stored by the behavioral health inpatient facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
12. Oxygen containers are secured in an upright position;
13. Poisonous or toxic materials stored by the behavioral health inpatient facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
14. Combustible or flammable liquids and hazardous materials stored by a behavioral health inpatient facility are stored in the original labeled containers or safety containers in a locked area inaccessible to patients;
15. If pets or animals are allowed in the behavioral health inpatient facility, pets or animals are:
   a. Controlled to prevent endangering the patients and to maintain sanitation;
   b. Licensed consistent with local ordinances; and
   c. For a dog or cat, vaccinated against rabies;
16. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
   a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
   b. If necessary, corrective action is taken to ensure the water is safe to drink; and
   c. Documentation of testing is maintained for at least 12 months after the date of the test; and

17. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to applicable state laws and rules.

**B.** An administrator shall ensure that:
1. Smoking tobacco products is not permitted within a behavioral health inpatient facility; and
2. Except as provided in R9-10-318(A)(11), smoking tobacco products may be permitted on the premises outside a behavioral health inpatient facility if:
   a. Signs designating smoking areas are conspicuously posted, and
   b. Smoking is prohibited in areas where combustible materials are stored or in use.

**C.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. At least one personnel member with cardiopulmonary resuscitation training that meets the requirements in R9-10-303(C)(1)(e) is present in the pool area when a patient is in the pool area, and
2. At least two personnel members are present in the pool area when two or more patients are in the pool area.

**Historical Note**

Section R9-10-323, formerly numbered as R9-10-234, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-323 repealed, new Section R9-10-323 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-323 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-323 renumbered to R9-10-324; new Section R9-10-323 renumbered from R9-10-322 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-324. Physical Plant Standards**

**A.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the behavioral health inpatient facility's scope of services, and
2. An individual accepted as a patient by the behavioral health inpatient facility.

**B.** An administrator shall ensure that:
1. A behavioral health inpatient facility has a:
   a. Waiting area with seating for patients and visitors;
   b. Room that provides privacy for a patient to receive treatment or visitors; and
   c. Common area and a dining area that:
      i. Are not converted, partitioned, or otherwise used as a sleeping area; and
      ii. Contain furniture and materials to accommodate the recreational and socialization needs of the patients and other individuals in the behavioral health inpatient facility;
2. A bathroom is available for use by visitors during the behavioral health inpatient facility's hours of operation and:
   a. Provides privacy; and
   b. Contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue,
      iv. Soap for hand washing,
      v. Paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A window that opens or another means of ventilation;
3. For every six patients, there is at least one working toilet that flushes and has a seat and one sink with running water;
4. For every eight patients, there is at least one working bathtub or shower with a slip-resistant surface;
5. A patient bathroom complies with the following:
   a. Provides privacy when in use;
   b. Contains:
      i. A shatterproof mirror, unless the patient's treatment plan requires otherwise;
      ii. A window that opens or another means of ventilation; and
      iii. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
   c. Has plumbing, piping, ductwork, or other potentially hazardous elements concealed above a ceiling;
   d. If the bathroom or shower area has a door, the door swings outward to allow for staff emergency access;
   e. If grab bars for the toilet and tub or shower or other assistive devices are identified in the patient's treatment plan, has grab bars or other assistive devices to provide for patient safety;
   f. If a grab bar is provided, has the space between the grab bar and the wall filled to prevent a cord being tied around the grab bar;
   g. Does not contain a towel bar, a shower curtain rod, or a lever handle that is not a specifically designed anti-ligature lever handle;

h. Has tamper-resistant lighting fixtures, sprinkler heads, and electrical outlets; and
i. For a bathroom with a sprinkler head where a patient is not supervised while the patient is in the bathroom, has a sprinkler head that is recessed or designed to minimize patient access;

6. If a patient bathroom door locks from the inside, an employee has a key and access to the bathroom;
7. Each patient is provided a bedroom for sleeping;
8. A patient bedroom complies with the following:
   a. Is not used as a common area;
   b. Is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of a patient occupying the bedroom;
   c. Contains a door that opens into a hallway, common area, or outdoors and, except as provided in subsection (E), another means of egress;
   d. Is constructed and furnished to provide unimpeded access to the door;
   e. Has window or door covers that provide patient privacy;
   f. Has floor to ceiling walls:
   g. Is a:
      i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
      ii. Shared bedroom that:
         (1) Is shared by no more than four patients;
         (2) Contains, except as provided in subsection (B)(9), at least 60 square feet of floor space, not including a closet, for each patient occupying the bedroom; and
         (3) Provides sufficient space between beds to ensure that a patient has unobstructed access to the bedroom door;
   h. Contains for each patient occupying the bedroom:
      i. A bed that is: at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and linens that is not a threat to health and safety; and
      ii. Individual storage space for personnel effects and clothing such as shelves, a dresser, or chest of drawers;
   i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each patient;
   j. Has sufficient lighting for a patient occupying the bedroom to read; and
   k. If applicable, has a drawer pull that is recessed to eliminate the possibility of use as a tie-off point;
9. If a behavioral health inpatient facility licensed before November 1, 2003 was approved for 50 square feet of floor space for each patient in a bedroom, ensure that the bedroom contains at least 50 square feet for each patient not including the closet;
10. In a patient bathroom or a patient bedroom:
    a. The ceiling is secured from access or at least 9 feet in height; and
    b. A ventilation grille is:
       i. Secured and has perforations that are too small to use as a tie-off point, or
       ii. Of sufficient height to prevent patient access;
11. For a door located in an area of the behavioral health inpatient facility that is accessible to patients:
    a. A door closing device, if used on a patient bedroom door, is mounted on the public side of the door;
    b. A door's hinges are designed to minimize points for hanging;
    c. Except for a door lever handle that contains specifically designed anti-ligature hardware, a door lever handle points downward when in the latched or unlatched position; and
    d. Hardware has tamper-resistant fasteners; and
12. A window located in an area of the behavioral health inpatient facility that is accessible to patients is fabricated with laminated safety glass or protected by polycarbonate, laminate, or safety screens.

**C.** An administrator of a licensed behavioral health inpatient facility may submit a request, in a Department-provided format, for additional time to comply with a physical plant requirement in subsection (B)(5)(c) through (B)(5)(i), (B)(10), (B)(11), or (B)(12) that includes:
1. The rule citation for the specific plant requirement,
2. The current physical plant condition that does not comply with the physical plant requirement,
3. How the current physical plant condition will be changed to comply with the physical plant requirement,
4. Estimated completion date of the identified physical plant change, and
5. Specific actions taken to ensure the health and safety of a patient until the physical plant requirement is met.

**D.** When the Department receives a request for additional time to comply with a physical plant requirement in subsection (B)(5)(c) through (B)(5)(i), (B)(10), (B)(11), or (B)(12) submitted according to subsection (C), the Department may approve the request for up to 24 months after the effective date of these rules based on:
1. The behavioral health inpatient facility's scope of services,
2. The expected patient acuity based on the behavioral health inpatient facility's scope of services,
3. The specific physical plant requirement in the request, and

4. The threat to patients' health and safety.

**E.** A bedroom in a behavioral health inpatient facility is not required to have a second means of egress if:
1. An administrator ensures that policies and procedures are established, documented, and implemented that provide for the safe evacuation of a patient in the bedroom based on the patient's physical and mental limitations and the location of the bedroom; or
2. The building where the bedroom is located has a fire alarm system and a sprinkler system required in R9-10-322(A)(1).

**F.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. The swimming pool is enclosed by a wall or fence that:
   a. Is at least five feet in height as measured on the exterior of the wall or fence;
   b. Has no vertical openings greater that four inches across;
   c. Has no horizontal openings, except as described in subsection (F)(1)(e);
   d. Is not chain-link;
   e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
   f. Has a self-closing, self-latching gate that:
      i. Opens away from the swimming pool,
      ii. Has a latch located at least 54 inches from the ground, and
      iii. Is locked when the swimming pool is not in use; and
2. A life preserver or shepherd's crook is available and accessible in the pool area.

**G.** An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (F)(1) is covered and locked when not in use.

**Historical Note**

Section R9-10-324, formerly numbered as R9-10-235, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-324 repealed, new Section R9-10-324 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-324 renumbered from R9-10-323 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-325. Repealed**

**Historical Note**

Section R9-10-325, formerly numbered as R9-10-236, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-325 repealed, new Section R9-10-325 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-326. Repealed**

**Historical Note**

Section R9-10-326, formerly numbered as R9-10-237, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-326 repealed, new Section R9-10-326 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-327. Repealed**

**Historical Note**

Section R9-10-327, formerly numbered as R9-10-241, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-327 repealed, new Section R9-10-327 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-328. Repealed**

**Historical Note**

Section R9-10-328, formerly numbered as R9-10-242, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-328 repealed, new Section R9-10-328 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-329. Repealed**

**Historical Note**

Section R9-10-329, formerly numbered as R9-10-243, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-329 repealed, new Section R9-10-329 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-330. Repealed**

**Historical Note**

Section R9-10-330, formerly numbered as R9-10-244, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-330 repealed, new Section R9-10-330 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-331. Repealed**

**Historical Note**

Section R9-10-331, formerly numbered as R9-10-245, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-331 repealed, new Section R9-10-331 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-332. Repealed**

**Historical Note**

Section R9-10-332, formerly numbered as R9-10-246, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-332 repealed, new Section R9-10-332 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-333. Repealed**

**Historical Note**

Section R9-10-333, formerly numbered as R9-10-247, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-333 repealed, new Section R9-10-333 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-334. Repealed**

**Historical Note**

Section R9-10-334, formerly numbered as R9-10-249, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Repealed effective February 4, 1981 (Supp. 81-1).

**R9-10-335. Repealed**

**Historical Note**

Section R9-10-335, formerly numbered as R9-10-250, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Repealed effective February 4, 1981 (Supp. 81-1).

## ARTICLE 4. NURSING CARE INSTITUTIONS

*Article 4, consisting of Sections R9-10-411 through R9-10-438, repealed at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).*

**R9-10-401. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article unless otherwise specified:

1. "Administrator" has the same meaning as in A.R.S. § 36-446.

2. "Care plan" means a documented description of physical health services and behavioral health services expected to be provided to a resident, based on the resident's comprehensive assessment, that includes measurable objectives and the methods for meeting the objectives.
3. "Direct care" means medical services, nursing services, or social services provided to a resident.
4. "Director of nursing" means an individual who is responsible for the nursing services provided in a nursing care institution.
5. "Highest practicable" means a resident's optimal level of functioning and well-being based on the resident's current functional status and potential for improvement as determined by the resident's comprehensive assessment.
6. "Intermittent" means not on a regular basis.
7. "Nursing care institution services" means medical services, nursing services, behavioral care, health-related services, ancillary services, social services, and environmental services provided to a resident.
8. "Resident group" means residents or residents' family members who:
   a. Plan and participate in resident activities, or
   b. Meet to discuss nursing care institution issues and policies.
9. "Secured" means the use of a method, device, or structure that:
   a. Prevents a resident from leaving an area of the nursing care institution's premises, or
   b. Alerts a personnel member of a resident's departure from the nursing care institution.
10. "Social services" means assistance provided to or activities provided for a resident to maintain or improve the resident's physical, mental, and psychosocial capabilities.
11. "Total health condition" means a resident's overall physical and psychosocial well-being as determined by the resident's comprehensive assessment.
12. "Unnecessary drug" means a medication that is not required because:
   a. There is no documented indication for a resident's use of the medication;
   b. The medication is duplicative;
   c. The medication is administered before determining whether the resident requires the medication; or
   d. The resident has experienced an adverse reaction from the medication, indicating that the medication should be reduced or discontinued.
13. "Ventilator" means a device designed to provide, to a resident who is physically unable to breathe or who is breathing insufficiently, the mechanism of breathing by mechanically moving breathable air into and out of the resident's lungs.

**Historical Note**

New Section R9-10-401 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-402. Supplemental Application Requirements**

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a nursing care institution shall include:

1. In a Department-provided format whether the applicant:
   a. Has:
      i. A secured area for a resident with Alzheimer's disease or other dementia, or
      ii. An area for a resident on a ventilator;
   b. Is requesting authorization to provide to a resident:
      i. Behavioral health services,
      ii. Clinical laboratory services,
      iii. Dialysis services, or
      iv. Radiology services and diagnostic imaging services; and
   c. Is requesting authorization to operate a nutrition and feeding assistant training program; and
2. If the governing authority is requesting authorization to operate a nutrition and feeding assistant training program, the information in R9-10-116(B)(1)(a), (B)(1)(c), and (B)(2).

**Historical Note**

New Section R9-10-402 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-403. Administration**

**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a nursing care institution;
2. Establish, in writing, the nursing care institution's scope of services;

3. Designate, in writing, a nursing care institution administrator licensed according to A.R.S. Title 36, Chapter 4, Article 6;
4. Adopt a quality management program according to R9-10-404;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator licensed according to A.R.S. § Title 36, Chapter 4, Article 6, if the administrator is:
   a. Expected not to be present on the nursing care institution's premises for more than 30 calendar days, or
   b. Not present on the nursing care institution's premises for more than 30 calendar days; and
7. Except as permitted in subsection (A)(6), when there is a change of administrator, notify the Department according to A.R.S. § 36-425(I) and submit a copy of the new administrator's license under A.R.S. Title 36, Chapter 4, Article 6 to the Department.

**B.** An administrator:
1. Is directly accountable to the governing authority of a nursing care institution for the daily operation of the nursing care institution and all services provided by or at the nursing care institution;
2. Has the authority and responsibility to manage the nursing care institution;
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the nursing care institution's premises and accountable for the nursing care institution when the administrator is not present on the nursing care institution's premises;
4. Ensures the nursing care institution's compliance with A.R.S. § 36-411; and
5. If the nursing care institution provides feeding and nutrition assistant training, ensures the nursing care institution complies with the requirements for the operation of a feeding and nutrition assistant training program in R9-10-116.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to resident care;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Cover cardiopulmonary resuscitation training including:
      i. Which personnel members are required to obtain cardiopulmonary resuscitation training,
      ii. The method and content of cardiopulmonary resuscitation training,
      iii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
      iv. The time-frame for renewal of cardiopulmonary resuscitation training, and
      v. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
   f. Cover first aid training;
   g. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
   h. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;
   i. Cover specific steps for:
      i. A resident to file a complaint, and
      ii. The nursing care institution to respond to a resident's complaint;
   j. Cover health care directives;
   k. Cover medical records, including electronic medical records;
   l. Cover a quality management program, including incident reports and supporting documentation;
   m. Cover contracted services;
   n. Cover resident's personal accounts;
   o. Cover petty cash funds;
   p. Cover fees and refund policies;
   q. Cover misappropriation of resident property; and
   r. Cover when an individual may visit a resident in a nursing care institution; and
2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;
   b. Cover the provision of physical health services and behavioral health services;
   c. Include when general consent and informed consent are required;
   d. Cover storing, dispensing, administering, and disposing of medication;
   e. Cover infection control;
   f. Cover how personnel members will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
   g. Cover telemedicine, if applicable; and

h. Cover environmental services that affect resident care;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a nursing care institution, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the nursing care institution.

**D.** Except for health screening services, an administrator shall ensure that medical services, nursing services, health-related services, behavioral health services, or ancillary services provided by a nursing care institution are only provided to a resident.

**E.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a nursing care institution's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
2. For a resident under 18 years of age, according to A.R.S. § 13-3620.

**F.** If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a nursing care institution's employee or personnel member, an administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the resident as follows:
   a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
   b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (F)(1); and
   c. The report in subsection (F)(2);
4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**G.** An administrator shall:
1. Allow a resident advocate to assist a resident, the resident's representative, or a resident group with a request or recommendation, and document in writing any complaint submitted to the nursing care institution;
2. Ensure that a monthly schedule of recreational activities for residents is developed, documented, and implemented; and
3. Ensure that the following are conspicuously posted on the premises:
   a. The current nursing care institution license and quality rating issued by the Department;
   b. The name, address, and telephone number of:
      i. The Department's Office of Long Term Care,
      ii. The State Long-Term Care Ombudsman Program, and
      iii. Adult Protective Services of the Department of Economic Security;
   c. A notice that a resident may file a complaint with the Department concerning the nursing care institution;
   d. The monthly schedule of recreational activities; and
   e. One of the following:
      i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect; or
      ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.

**H.** An administrator shall provide written notification to the Department of a resident's:
1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency medical services provider.

**I.** If an administrator administers a resident's personal account at the request of the resident or the resident's representative, the administrator shall:
1. Comply with policies and procedures established according to subsection (C)(1)(n);
2. Designate a personnel member who is responsible for the personal accounts;
3. Maintain a complete and separate accounting of each personal account;
4. Obtain written authorization from the resident or the resident's representative for a personal account transaction;
5. Document an account transaction and provide a copy of the documentation to the resident or the resident's representative upon request and at least every three months;
6. Transfer all money from the resident's personal account in excess of $50.00 to an interest-bearing account and credit the interest to the resident's personal account; and
7. Within 30 calendar days after the resident's death, transfer, or discharge, return all money in the resident's personal account and a final accounting to the resident, the resident's representative, or the probate jurisdiction administering the resident's estate.

**J.** If a petty cash fund is established for use by residents, the administrator shall ensure that:
1. The policies and procedures established according to subsection (C)(1)(o) include:
   a. A prescribed cash limit of the petty cash fund, and
   b. The hours of the day a resident may access the petty cash fund; and
2. A resident's written acknowledgment is obtained for a petty cash transaction.

**Historical Note**

New Section R9-10-403 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-404. Quality Management**

An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to residents;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to resident care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to resident care; and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

New Section R9-10-404 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-405. Contracted Services**

An administrator shall ensure that:
1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section R9-10-405 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-406. Personnel**

**A.** An administrator shall ensure that a behavioral health technician or behavioral health paraprofessional is at least 18 years old.

**B.** An administrator shall ensure that:
1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and

ii. The acuity of the residents receiving physical health services or behavioral health services from the personnel member according to the established job description; and

b. Include:

i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,

ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and

iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are present on a nursing care institution's premises with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the nursing care institution's scope of services,
   b. Meet the needs of a resident, and
   c. Ensure the health and safety of a resident.

**C.** Except as provided in R9-10-415, an administrator shall ensure that, if a personnel member provides social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, the personnel member is licensed under A.R.S. Title 32, Chapter 33, Article 5.

**D.** An administrator shall ensure that an individual who is a licensed baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision as defined in 4 A.A.C. 6, Article 1.

**E.** An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the nursing care institution, and
2. As specified in R9-10-113.

**F.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's compliance with the requirements in A.R.S. § 36-411;
   d. Orientation and in-service education as required by policies and procedures;
   e. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   g. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-303(C)(1)(e);
   h. First aid training, if required for the individual according to this Article or policies and procedures; and
   i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (E); and
   j. If the individual is a nutrition and feeding assistant:
      i. Completion of the nutrition and feeding assistant training course required in R9-10-116, and
      ii. A nurse's observations required in R9-10- 423(C)(6).

**G.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout the individual's period of providing services in or for the nursing care institution, and
   b. For at least 24 months after the last date the individual provided services in or for the nursing care institution; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the nursing care institution during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**H.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;

4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training.
5. A work schedule of each personnel member is developed and maintained at the nursing care institution for at least 12 months after the date of the work schedule.

**I.** An administrator shall designate a qualified individual to provide:
1. Social services, and
2. Recreational activities.

**Historical Note**

New Section R9-10-406 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-407. Admission**

An administrator shall ensure that:
1. A resident is admitted only on a physician's order;
2. The physician's admitting order includes the nursing care institution services required to meet the immediate needs of a resident, such as medication and food services;
3. At the time of a resident's admission, a registered nurse conducts or coordinates an initial assessment on a resident to ensure the resident's immediate needs for nursing care institution services are met;
4. A resident's needs do not exceed the medical services and nursing services available at the nursing care institution as established in the nursing care institution's scope of services;
5. Before or at the time of admission, a resident or the resident's representative:
   a. Receives a documented agreement with the nursing care institution that includes rates and charges,
   b. Is informed of third-party coverage for rates and charges,
   c. Is informed of the nursing care institution's refund policy, and
   d. Receives written information concerning the nursing care institution's policies and procedures related to a resident's health care directives;
6. Within 30 calendar days before admission or 10 working days after admission, a medical history and physical examination is completed on a resident by:
   a. A physician, or
   b. A physician assistant or a registered nurse practitioner designated by the attending physician;
7. Except as specified in subsection (8), a resident provides evidence of freedom from infectious tuberculosis:
   a. Before or within seven calendar days after the resident's admission, and
   b. As specified in R9-10-113;
8. A resident who transfers from a nursing care institution to another nursing care institution is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
   a. Fewer than 12 months have passed since the resident was screened for tuberculosis, and
   b. The documentation of freedom from infectious tuberculosis required in subsection (7) accompanies the resident at the time of transfer; and
9. Compliance with the requirements in subsection (6) is documented in the resident's medical record.

**Historical Note**

New Section R9-10-407 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-10-408. Transfer; Discharge**

**A.** An administrator shall ensure that:
1. A resident is transferred or discharged if:
   a. The nursing care institution is not authorized or not able to meet the needs of the resident, or
   b. The resident's behavior is a threat to the health or safety of the resident or other individuals at the nursing care institution; and
2. Documentation of a resident's transfer or discharge includes:

a. The date of the transfer or discharge;
b. The reason for the transfer or discharge;
c. A 30-day written notice except:
i. In an emergency, or
ii. If the resident no longer requires nursing care institution services as determined by a physician or the physician's designee;
d. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1); and
e. If applicable, actions taken by a personnel member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the nursing care institution.

**B.** An administrator may transfer or discharge a resident for failure to pay for residency if:
1. The resident or resident's representative receives a 30-day written notice of transfer or discharge, and
2. The 30-day written notice includes an explanation of the resident's right to appeal the transfer or discharge.

**C.** Except for a transfer of a resident due to an emergency, an administrator shall ensure that:
1. A personnel member coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
a. An evaluation of the resident is conducted before the transfer;
b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
a. Communication with an individual at a receiving health care institution;
b. The date and time of the transfer;
c. The mode of transportation; and
d. If applicable, the name of the personnel member accompanying the resident during a transfer.

**D.** Except in an emergency, a director of nursing shall ensure that before a resident is discharged:
1. Written follow-up instructions are developed with the resident or the resident's representative that includes:
a. Information necessary to meet the resident's need for medical services and nursing services; and
b. The state long-term care ombudsman's name, address, and telephone number;
2. A copy of the written follow-up instructions is provided to the resident or the resident's representative; and
3. A discharge summary is developed by a personnel member and authenticated by the resident's attending physician or designee and includes:
a. The resident's medical condition at the time of transfer or discharge,
b. The resident's medical and psychosocial history,
c. The date of the transfer or discharge, and
d. The location of the resident after discharge.

**Historical Note**

New Section R9-10-408 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-409. Transport**

**A.** Except as provided in subsection (B), an administrator shall ensure that:
1. A personnel member coordinates the transport and the services provided to the resident;
2. According to policies and procedures:
a. An evaluation of the resident is conducted before and after the transport,
b. Information from the resident's medical record is provided to a receiving health care institution, and
c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
a. Communication with an individual at a receiving health care institution;
b. The date and time of the transport;
c. The mode of transportation; and
d. If applicable, the name of the personnel member accompanying the resident during a transport.

**B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a resident by the resident or the resident's representative,
3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
4. A transport to another licensed health care institution in an emergency.

**Historical Note**

New Section R9-10-409 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-410. Resident Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the resident rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C); and
3. Policies and procedures include:
   a. How and when a resident or the resident's representative is informed of resident rights in subsection (C), and
   b. Where resident rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A resident has privacy in:
   a. Treatment,
   b. Bathing and toileting,
   c. Room accommodations, and
   d. A visit or meeting with another resident or an individual;
2. A resident is treated with dignity, respect, and consideration;
3. A resident is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by a nursing care institution's personnel members, employees, volunteers, or students; and
4. A resident or the resident's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of proposed alternatives to psychotropic medication or a surgical procedure and the associated risks and possible complications of the psychotropic medication or surgical procedure;
   d. Is informed of the following:
      i. The health care institution's policy on health care directives, and
      ii. The resident complaint process;
   e. Consents to photographs of the resident before the resident is photographed, except that the resident may be photographed when admitted to a nursing care institution for identification and administrative purposes;
   f. May manage the resident's financial affairs;
   g. May review the nursing care institution's current license survey report and, if applicable, plan of correction in effect;
   h. Has access to and may communicate with any individual, organization, or agency;
   i. May participate in a resident group;
   j. May review the resident's financial records within two working days and medical record within one working day after the resident's or the resident's representative's request;
   k. May obtain a copy of the resident's financial records and medical record within two working days after the resident's request and in compliance with A.R.S. § 12-2295;
   l. Except as otherwise permitted by law, consents, in writing, to the release of information in the resident's:
      i. Medical record, and
      ii. Financial records;
   m. May select a pharmacy of choice if the pharmacy complies with policies and procedures and does not pose a risk to the resident;
   n. Is informed of the method for contacting the resident's attending physician;
   o. Is informed of the resident's total health condition;

p. Is provided with a copy of those sections of the resident's medical record that are required for continuity of care free of charge, according to A.R.S. § 12-2295, if the resident is transferred or discharged;
q. Is informed in writing of a change in rates and charges at least 60 calendar days before the effective date of the change; and
r. Except in the event of an emergency, is informed orally or in writing before the nursing care institution makes a change in a resident's room or roommate assignment and notification is documented in the resident's medical record.

**C.** A resident has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;
3. To choose activities and schedules consistent with the resident's interests that do not interfere with other residents;
4. To participate in social, religious, political, and community activities that do not interfere with other residents;
5. To retain personal possessions including furnishings and clothing as space permits unless use of the personal possession infringes on the rights or health and safety of other residents;
6. To share a room with the resident's spouse if space is available and the spouse consents;
7. To receive a referral to another health care institution if the nursing care institution is not authorized or not able to provide physical health services or behavioral health services needed by the resident;
8. To participate or have the resident's representative participate in the development of, or decisions concerning, treatment;
9. To participate or refuse to participate in research or experimental treatment; and
10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

**Historical Note**

New Section R9-10-410 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-411. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
   a. Recorded only by an individual authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the resident's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A resident's medical record is available to an individual:
   a. Authorized to access the resident's medial record according to policies and procedures;
   b. If the individual is not authorized to access the resident's medical record according to policies and procedures, with the written consent of the resident or the resident's representative; or
   c. As permitted by law; and
6. A resident's medical record is protected from loss, damage, or unauthorized use.

**B.** If a nursing care institution maintains residents' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a resident's medical record contains:
1. Resident information that includes:
   a. The resident's name;
   b. The resident's date of birth; and
   c. Any known allergies, including medication allergies;
2. The admission date and, if applicable, the date of discharge;
3. The admitting diagnosis or presenting symptoms;
4. Documentation of general consent and, if applicable, informed consent;
5. If applicable, the name and contact information of the resident's representative and:
   a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
   b. If the resident's representative:

i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
ii. Is a legal guardian, a copy of the court order establishing guardianship;

6. The medical history and physical examination required in R9-10-407(6);
7. A copy of the resident's living will or other health care directive, if applicable;
8. The name and telephone number of the resident's attending physician;
9. Orders;
10. Care plans;
11. Behavioral care plans, if the resident is receiving behavioral care;
12. Documentation of nursing care institution services provided to the resident;
13. Progress notes;
14. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
15. If applicable, documentation that evacuation from the nursing care institution would cause harm to the resident;
16. The disposition of the resident after discharge;
17. The discharge plan;
18. The discharge summary;
19. Transfer documentation;
20. If applicable:
    a. A laboratory report,
    b. A radiologic report,
    c. A diagnostic report, and
    d. A consultation report;
21. Documentation of freedom from infectious tuberculosis required in R9-10-407(7);
22. Documentation of a medication administered to the resident that includes:
    a. The date and time of administration;
    b. The name, strength, dosage, and route of administration;
    c. The type of vaccine, if applicable;
    d. For a medication administered for pain on a PRN basis:
        i. An evaluation of the resident's pain before administering the medication, and
        ii. The effect of the medication administered;
    e. For a psychotropic medication administered on a PRN basis:
        i. An evaluation of the resident's symptoms before administering the psychotropic medication, and
        ii. The effect of the psychotropic medication administered;
    f. The identification, signature, and professional designation of the individual administering the medication; and
    g. Any adverse reaction a resident has to the medication;
23. If the resident has been assessed for receiving nutrition and feeding assistance from a nutrition and feeding assistant, documentation of the assessment and the determination of eligibility; and
24. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-411 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-412. Nursing Services**

**A.** An administrator shall ensure that:
1. Nursing services are provided 24 hours a day in a nursing care institution;
2. A director of nursing is appointed who:
    a. Is a registered nurse,
    b. Works full-time at the nursing care institution, and
    c. Is responsible for the direction of nursing services;
3. The director of nursing or an individual designated by the administrator participates in the quality management program; and
4. If the daily census of the nursing care institution is 60 or more, the director of nursing does not provide direct care to residents on a regular basis.

**B.** A director of nursing shall ensure that:

1. A method is established and documented that identifies the types and numbers of nursing personnel that are necessary to provide nursing services to residents based on the residents' comprehensive assessments, orders for physical health services and behavioral health services, and care plans and the nursing care institution's scope of services;
2. Sufficient nursing personnel, as determined by the method in subsection (B)(1), are on the nursing care institution premises to meet the needs of a resident for nursing services;
3. At least one nurse is present on the nursing care institution's premises and responsible for providing direct care to not more than 64 residents;
4. Documentation of nursing personnel present on the nursing care institution's premises each day is maintained and includes:
   a. The date,
   b. The number of residents,
   c. The name and license or certification title of each nursing personnel member who worked that day, and
   d. The actual number of hours each nursing personnel member worked that day;
5. The documentation of nursing personnel required in subsection (B)(4) is maintained for at least 12 months after the date of the documentation;
6. As soon as possible but not more than 24 hours after one of the following events occur, a nurse notifies a resident's attending physician and, if applicable, the resident's representative, if the resident:
   a. Is injured,
   b. Is involved in an incident that may require medical services, or
   c. Has a significant change in condition; and
7. An unnecessary drug is not administered to a resident.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-412 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-413. Medical Services**

**A.** An administrator shall appoint a medical director.

**B.** A medical director shall ensure that:
1. A resident has an attending physician;
2. An attending physician is available 24 hours a day;
3. An attending physician designates a physician who is available when the attending physician is not available;
4. A physical examination is performed on a resident at least once every 12 months after the date of admission by an individual listed in R9-10-407(6);
5. As required in A.R.S. § 36-406, vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:
   a. The attending physician provides documentation that the vaccination is medically contraindicated;
   b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical record that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or
   c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the last five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention; and
6. If the any of the following services are not provided by the nursing care institution and needed by a resident, the resident is assisted in obtaining, at the resident's expense:
   a. Vision services;
   b. Hearing services;
   c. Dental services;
   d. Clinical laboratory services from a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
   e. Psychosocial services;
   f. Physical therapy;
   g. Speech therapy;
   h. Occupational therapy;
   i. Behavioral health services; and
   j. Services for an individual who has a developmental disability, as defined in A.R.S. Title 36, Chapter 5.1, Article 1.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-413 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-414. Comprehensive Assessment; Care Plan**

**A.** A director of nursing shall ensure that:

1. A comprehensive assessment of a resident:
   a. Is conducted or coordinated by a registered nurse in collaboration with an interdisciplinary team;
   b. Is completed for the resident within 14 calendar days after the resident's admission to a nursing care institution;
   c. Is updated:
      i. No later than 12 months after the date of the resident's last comprehensive assessment, and
      ii. When the resident experiences a significant change;
   d. Includes the following information for the resident:
      i. Identifying information;
      ii. An evaluation of the resident's hearing, speech, and vision;
      iii. An evaluation of the resident's ability to understand and recall information;
      iv. An evaluation of the resident's mental status;
      v. Whether the resident's mental status or behaviors:
         (1) Put the resident at risk for physical illness or injury,
         (2) Significantly interfere with the resident's care,
         (3) Significantly interfere with the resident's ability to participate in activities or social interactions,
         (4) Put other residents or personnel members at significant risk for physical injury,
         (5) Significantly intrude on another resident's privacy, or
         (6) Significantly disrupt care for another resident;
      vi. Preferences for customary routine and activities;
      vii. An evaluation of the resident's ability to perform activities of daily living;
      viii. Need for a mobility device;
      ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
      x. Any diagnosis that impacts nursing care institution services that the resident may require;
      xi. Any medical conditions that impact the resident's functional status, quality of life, or need for nursing care institution services;
      xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;
      xiii. An evaluation of the resident's oral and dental status;
      xiv. An evaluation of the condition of the resident's skin;
      xv. Identification of any medication or treatment administered to the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
      xvi. Identification of any treatment or medication ordered for the resident;
      xvii. A description of the resident or resident's representative's participation in the comprehensive assessment;
      xviii. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;
      xix. Potential for rehabilitation; and
      xx. Potential for discharge; and
   e. Is signed and dated by:
      i. The registered nurse who conducts or coordinates the comprehensive assessment or review; and
      ii. If a behavioral health professional is required to review according to subsection (A)(2), the behavioral health professional who reviewed the comprehensive assessment or review;
2. If any of the conditions in (A)(1)(d)(v) are answered in the affirmative during the comprehensive assessment or review, a behavioral health professional reviews a resident's comprehensive assessment or review and care plan to ensure that the resident's needs for behavioral health services are being met;
3. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing care institution unless a physician, an individual designated by the physician, or a registered nurse determines the resident has a significant change in condition; and
4. A resident's comprehensive assessment is reviewed by a registered nurse at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition.

**B.** An administrator shall ensure that a care plan for a resident:

1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1);

2. Is reviewed and revised based on any change to the resident's comprehensive assessment; and
3. Ensures that a resident is provided nursing care institution services that:
   a. Address any medical condition or behavioral health issue identified in the resident's comprehensive assessment, and
   b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-414 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-415. Behavioral Health Services**

Except for behavioral care, if a nursing care institution is authorized to provide behavioral health services, an administrator shall ensure that:

1. The behavioral health services are provided:
   a. Under the direction of a behavioral health professional licensed or certified to provide the type of behavioral health services in the nursing care institution's scope of services; and
   b. In compliance with the requirements:
      i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
      ii. For an assessment, in R9-10-1011(B); and
2. Except for a psychotropic drug ordered by a medical practitioner for a resident's out-of-control behavior or administered according to an order from a court of competent jurisdiction, informed consent is obtained from a resident or the resident's representative for a psychotropic drug and documented in the resident's medical record before the psychotropic drug is administered to the resident.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-415 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-416. Clinical Laboratory Services**

If clinical laboratory services are authorized to be provided on a nursing care institution's premises, an administrator shall ensure that:

1. Clinical laboratory services and pathology services are provided through a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation, certificate of compliance, or certificate of waiver in subsection (1) is provided to the Department for review upon the Department's request;
3. The nursing care institution:
   a. Is able to provide the clinical laboratory services delineated in the nursing care institution's scope of services when needed by the residents,
   b. Obtains specimens for the clinical laboratory services delineated in the nursing care institution's scope of services without transporting the residents from the nursing care institution's premises, and
   c. Has the examination of the specimens performed by a clinical laboratory;
4. Clinical laboratory and pathology test results are:
   a. Available to the ordering physician:
      i. Within 24 hours after the test is complete with results if the test is performed at a laboratory on the nursing care institution's premises, or
      ii. Within 24 hours after the test result is received if the test is performed at a laboratory outside of the nursing care institution's premises; and
   b. Documented in a resident's medical record;
5. If a test result is obtained that indicates a resident may have an emergency medical condition, as established in policies and procedures, personnel notify:
   a. The ordering physician,
   b. A registered nurse in the resident's assigned unit,
   c. The nursing care institution's administrator, or
   d. The director of nursing;
6. If a clinical laboratory report is completed on a resident, a copy of the report is included in the resident's medical record;

7. If the nursing care institution provides blood or blood products, policies and procedures are established, documented, and implemented for:
   a. Procuring, storing, transfusing, and disposing of blood or blood products;
   b. Blood typing, antibody detection, and blood compatibility testing; and
   c. Investigating transfusion adverse reactions that specify a process for review through the quality management program; and
8. Expired laboratory supplies are discarded according to policies and procedures.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-416 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-417. Dialysis Services**

If dialysis services are authorized to be provided on a nursing care institution's premises, an administrator shall ensure that the dialysis services are provided in compliance with the requirements in R9-10-1018.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-417 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-418. Radiology Services and Diagnostic Imaging Services**

If radiology services or diagnostic imaging services are authorized to be provided on a nursing care institution's premises, an administrator shall ensure that:

1. Radiology services and diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
2. A copy of a certificate documenting compliance with subsection (1) is maintained by the nursing care institution;
3. When needed by a resident, radiology services and diagnostic imaging services delineated in the nursing care institution's scope of services are provided on the nursing care institution's premises;
4. Radiology services and diagnostic imaging services are provided:
   a. Under the direction of a physician; and
   b. According to an order that includes:
      i. The resident's name,
      ii. The name of the ordering individual,
      iii. The radiological or diagnostic imaging procedure ordered, and
      iv. The reason for the procedure;
5. A medical director, attending physician, or radiologist interprets the radiologic or diagnostic image;
6. A radiologic or diagnostic imaging report is prepared that includes:
   a. The resident's name;
   b. The date of the procedure;
   c. A medical director, attending physician, or radiologist's interpretation of the image;
   d. The type and amount of radiopharmaceutical used, if applicable; and
   e. The resident's adverse reaction to the radiopharmaceutical, if any; and
7. A radiologic or diagnostic imaging report is included in the resident's medical record.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-418 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-419. Respiratory Care Services**

If respiratory care services are provided on a nursing care institution's premises, an administrator shall ensure that:

1. Respiratory care services are provided under the direction of a medical director or attending physician;
2. Respiratory care services are provided according to an order that includes:
   a. The resident's name;
   b. The name and signature of the ordering individual;
   c. The type, frequency, and, if applicable, duration of treatment;
   d. The type and dosage of medication and diluent; and

e. The oxygen concentration or oxygen liter flow and method of administration;

3. Respiratory care services provided to a resident are documented in the resident's medical record and include:
   a. The date and time of administration;
   b. The type of respiratory care services provided;
   c. The effect of the respiratory care services;
   d. The resident's adverse reaction to the respiratory care services, if any; and
   e. The authentication of the individual providing the respiratory care services; and
4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-416.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-419 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-420. Rehabilitation Services**

If rehabilitation services are provided on a nursing care institution's premises, an administrator shall ensure that:

1. Rehabilitation services are provided:
   a. Under the direction of an individual qualified according to policies and procedures,
   b. By an individual licensed to provide the rehabilitation services, and
   c. According to an order; and
2. The medical record of a resident receiving rehabilitation services includes:
   a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis,
   b. A documented care plan that is developed in coordination with the ordering individual and the individual providing the rehabilitation services,
   c. The rehabilitation services provided,
   d. The resident's response to the rehabilitation services, and
   e. The authentication of the individual providing the rehabilitation services.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-420 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-421. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:

1. Include:
   a. A process for providing information to a resident about medication prescribed for the resident including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse response to a medication, or
      iii. A medication overdose;
   c. Procedures to ensure that a pharmacist reviews a resident's medications at least once every three months and provides documentation to the resident's attending physician and the director of nursing indicating potential medication problems such as incompatible or duplicative medications;
   d. Procedures for documenting medication services; and
   e. Procedures for assisting a resident in obtaining medication; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**B.** An administrator shall ensure that:

1. Policies and procedures for medication administration:
   a. Are reviewed and approved by the director of nursing;
   b. Specify the individuals who may:
      i. Order medication, and
      ii. Administer medication;
   c. Ensure that medication is administered to a resident only as prescribed; and

d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
3. A medication administered to a resident:
   a. Is administered in compliance with an order, and
   b. Is documented in the resident's medical record; and
4. If a psychotropic medication is administered to a resident, the psychotropic medication:
   a. Is only administered to a resident for a diagnosed medical condition; and
   b. Unless clinically contraindicated or otherwise ordered by an attending physician or the attending physician's designee, is gradually reduced in dosage while the resident is simultaneously provided with interventions such as behavior and environment modification in an effort to discontinue the psychotropic medication, unless a dose reduction is attempted and the resident displays behavior justifying the need for the psychotropic medication, and the attending physician documents the necessity for the continued use and dosage.

**C.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members; and
2. If pharmaceutical services are provided:
   a. The pharmaceutical services are provided under the direction of a pharmacist;
   b. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
   c. A copy of the pharmacy license is provided to the Department upon request.

**D.** When medication is stored at a nursing care institution, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.

**E.** An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the medical practitioner who ordered the medication and the nursing care institution's director of nursing.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-421 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-422. Infection Control**

An administrator shall ensure that:
1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
   a. A method to identify and document infections occurring at the nursing care institution;
   b. Analysis of the types, causes, and spread of infections and communicable diseases at the nursing care institution;
   c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the nursing care institution; and
   d. Documentation of infection control activities including:
      i. The collection and analysis of infection control data,
      ii. The actions taken related to infections and communicable diseases, and
      iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:
   a. Handling and disposal of biohazardous medical waste;
   b. Sterilization, disinfection, and storage of medical equipment and supplies;
   c. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
   d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a resident;
   e. Training of personnel members, employees, and volunteers in infection control practices; and
   f. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;

5. Soiled linen and clothing are:
   a. Collected in a manner to minimize or prevent contamination;
   b. Bagged at the site of use; and
   c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas; and
6. A personnel member, an employee, or a volunteer washes hands or uses a hand disinfection product after a resident contact and after handling soiled linen, soiled clothing, or potentially infectious material.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-422 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-423. Food Services**

**A.** An administrator shall ensure that:
1. The nursing care institution has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
2. A copy of the nursing care institution's food establishment license or permit is maintained;
3. If a nursing care institution contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the nursing care institution:
   a. A copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the nursing care institution; and
   b. The nursing care institution is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
4. A registered dietitian:
   a. Reviews a food menu before the food menu is used to ensure that a resident's nutritional needs are being met,
   b. Documents the review of a food menu, and
   c. Is available for consultation regarding a resident's nutritional needs; and
5. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to ensure that the nutritional needs of a resident are met.

**B.** A registered dietitian or director of food services shall ensure that:
1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a resident such as cut, chopped, ground, pureed, or thickened;
2. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served on each day,
   c Is conspicuously posted at least one day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
3. Meals and snacks for each day are planned and served using the applicable guidelines in http://www.health.gov/dietaryguidelines/2010.asp;
4. A resident is provided:
   a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and care plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(4)(d);
   c. The option to have a daily evening snack identified in subsection (B)(4)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. A resident group agrees; and
      ii. The resident is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
5. A resident is provided with food substitutions of similar nutritional value if:
   a. The resident refuses to eat the food served, or
   b. The resident requests a substitution;
6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning;
7. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils;
8. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair;
9. A resident eats meals in a dining area unless the resident chooses to eat in the resident's room or is confined to the resident's room for medical reasons documented in the resident's medical record; and
10. Water is available and accessible to residents.

**C.** If a nursing care institution has nutrition and feeding assistants, an administrator shall ensure that:
1. A nutrition and feeding assistant:

a. Is at least 16 years of age;
b. If applicable, complies with the fingerprint clearance card requirements in A.R.S. § 36-411;
c. Completes a nutrition and feeding assistant training course within 12 months before initially providing nutrition and feeding assistance;
d. Provides nutrition and feeding assistance where nursing personnel are present;
e. Immediately reports an emergency to a nurse or, if a nurse is not present in the common area, to nursing personnel; and
f. If the nutrition and feeding assistant observes a change in a resident's physical condition or behavior, reports the change to a nurse or, if a nurse is not present in the common area, to nursing personnel;

2. A resident is not eligible to receive nutrition and feeding assistance from a nutrition and feeding assistant if the resident:
a. Has difficulty swallowing,
b. Has had recurrent lung aspirations,
c. Requires enteral feedings,
d. Requires parenteral feedings, or
e. Has any other eating or drinking difficulty that may cause the resident's health or safety to be compromised if the resident receives nutrition and feeding assistance from a nutrition and feeding assistant;
3. Only an eligible resident receives nutrition and feeding assistance from a nutrition and feeding assistant;
4. A nurse determines if a resident is eligible to receive nutrition and feeding assistance from a nutrition and feeding assistant, based on:
a. The resident's comprehensive assessment,
b. The resident's care plan, and
c. An assessment conducted by the nurse when making the determination;
5. A method is implemented that identifies eligible residents that ensures only eligible residents receive nutrition and feeding assistance from a nutrition and feeding assistant;
6. When a nutrition and feeding assistant initially provides nutrition and feeding assistance and at least once every three months, a nurse observes the nutrition and feeding assistant while the nutrition and feeding assistant is providing nutrition and feeding assistance to ensure that the nutrition and feeding assistant is providing nutrition and feeding assistance appropriately;
7. A nurse documents the nurse's observations required in subsection (C)(6); and
8. A nutrition and feeding assistant is provided additional training:
a. According to policies and procedures, and
b. If a nurse identifies a need for additional training based on the nurse's observation in subsection (C)(6).

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-423 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-424. Emergency and Safety Standards**

**A.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
a. When, how, and where residents will be relocated, including:
i. Instructions for the evacuation or transfer of residents,
ii. Assigned responsibilities for each employee and personnel member, and
iii. A plan for continuing to provide services to meet a resident's needs;
b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
c. A plan for back-up power and water supply;
d. A plan to ensure a resident's medications will be available to administer to the resident during a disaster;
e. A plan to ensure a resident is provided nursing services and other services required by the resident during a disaster; and
f. A plan for obtaining food and water for individuals present in the nursing care institution or the nursing care institution's relocation site during a disaster;
2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
a. The date and time of the disaster plan review;
b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
c. A critique of the disaster plan review; and
d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;

5. An evacuation drill for employees and residents:
   a. Is conducted at least once every six months; and
   b. Includes all individuals on the premises except for:
      i. A resident whose medical record contains documentation that evacuation from the nursing care institution would cause harm to the resident, and
      ii. Sufficient personnel members to ensure the health and safety of residents not evacuated according to subsection (A)(5)(b)(i);
6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for employees and residents to evacuate to a designated area;
   c. If applicable:
      i. An identification of residents needing assistance for evacuation, and
      ii. An identification of residents who were not evacuated;
   d. Any problems encountered in conducting the evacuation drill; and
   e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the nursing care institution.

**B.** An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.

**C.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-424 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-425. Environmental Standards**

**A.** An administrator shall ensure that:
1. A nursing care institution's premises and equipment are:
   a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness and infection; and
   b. Free from a condition or situation that may cause a resident or an individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Equipment used to provide direct care is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
5. Garbage and refuse are:
   a. In areas used for food storage, food preparation, or food service, stored in a covered container lined with a plastic bag;
   b. In areas not used for food storage, food preparation, or food service, stored:
      i. According to the requirements in subsection (A)(5)(a), or
      ii. In a paper-lined or plastic-lined container that is cleaned and sanitized as often as necessary to ensure that the container is clean; and
   c. Removed from the premises at least once a week;
6. Heating and cooling systems maintain the nursing care institution at a temperature between 70° F and 84° F;
7. Common areas:
   a. Are lighted to assure the safety of residents, and
   b. Have lighting sufficient to allow personnel members to monitor resident activity;
8. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
9. Linens are clean before use, without holes and stains, and not in need of repair;
10. Oxygen containers are secured in an upright position;
11. Poisonous or toxic materials stored by the nursing care institution are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;

12. Combustible or flammable liquids stored by the nursing care institution are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
13. If pets or animals are allowed in the nursing care institution, pets or animals are:
    a. Controlled to prevent endangering the residents and to maintain sanitation;
    b. Licensed consistent with local ordinances; and
    c. For a dog or cat, vaccinated against rabies;
14. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
    a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
    b. If necessary, corrective action is taken to ensure the water is safe to drink; and
    c. Documentation of testing is retained for at least 12 months after the date of the test; and
15. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

**B.** An administrator shall ensure that:
1. Smoking tobacco products is not permitted within a nursing care institution, and
2. Smoking tobacco products may be permitted outside a nursing care institution if:
    a. Signs designating smoking areas are conspicuously posted, and
    b. Smoking is prohibited in areas where combustible materials are stored or in use.

**C.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. At least one personnel member with cardiopulmonary resuscitation training that meets the requirements in R9-10-403(C)(1)(e) is present in the pool area when a resident is in the pool area, and
2. At least two personnel members are present in the pool area when two or more residents are in the pool area.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-425 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-426. Physical Plant Standards**

**A.** An administrator shall ensure that:
1. A nursing care institution complies with:
    a. The applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the date the nursing care institution submitted architectural plans and specifications to the Department for approval according to R9-10-104; and
    b. The requirements for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01;
2. The premises and equipment are sufficient to accommodate:
    a. The services stated in the nursing care institution's scope of services, and
    b. An individual accepted as a resident by the nursing care institution;
3. A nursing care institution is ventilated by windows or mechanical ventilation, or a combination of both;
4. The corridors are equipped with handrails on each side that are firmly attached to the walls and are not in need of repair;
5. No more than two individuals reside in a resident room unless:
    a. The nursing care institution was operating before October 31, 1982; and
    b. The resident room has not undergone a modification as defined in A.R.S. § 36-401;
6. A resident has a separate bed, a nurse call system, and furniture to meet the resident's needs in a resident room or suite of rooms;
7. A resident room has:
    a. A window to the outside with window coverings for controlling light and visual privacy, and the location of the window permits a resident to see outside from a sitting position;
    b. A closet with clothing racks and shelves accessible to the resident; and
    c. If the resident room contains more than one bed, a curtain or similar type of separation between the beds for privacy; and
8. A resident room or a suite of rooms:
    a. Is accessible without passing through another resident's room; and
    b. Does not open into any area where food is prepared, served, or stored.

**B.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. The swimming pool is enclosed by a wall or fence that:
    a. Is at least five feet in height as measured on the exterior of the wall or fence;
    b. Has no vertical openings greater that four inches across;
    c. Has no horizontal openings, except as described in subsection (B)(1)(e);

d. Is not chain-link;
e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
f. Has a self-closing, self-latching gate that:
i. Opens away from the swimming pool,
ii. Has a latch located at least 54 inches from the ground, and
iii. Is locked when the swimming pool is not in use; and

2. A life preserver or shepherd's crook is available and accessible in the pool area.

**C.** An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (B)(1) is covered and locked when not in use.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-426 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-427. Quality Rating**

**A.** As required in A.R.S. § 36-425.02(A), the Department shall issue a quality rating to each licensed nursing care institution based on the results of a compliance inspection.

**B.** The following quality ratings are established:
1. A quality rating of "A" for excellent is issued if the nursing care institution achieves a score of 90 to 100 points,
2. A quality rating of "B" is issued if the nursing care institution achieves a score of 80 to 89 points,
3. A quality rating of "C" is issued if the nursing care institution achieves a score of 70 to 79 points, and
4. A quality rating of "D" is issued if the nursing care institution achieves a score of 69 or fewer points.

**C.** The quality rating is determined by the total number of points awarded based on the following criteria:
1. Nursing Services:
a. 15 points: The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.
b. 5 points: The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.
c. 5 points: The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.
2. Resident Rights:
a. 10 points: The nursing care institution is implementing a system that ensures a resident's privacy needs are met.
b. 10 points: The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.
c. 5 points: The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.
3. Administration:
a. 10 points: The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last compliance inspection or a complaint investigation conducted between the last compliance inspection and the current compliance inspection.
b. 5 points: The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Department and as required by A.R.S. § 46-454.
c. 5 points: The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.
d. 1 point: The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.
e. 1 point: The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.
f. 2 points: The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.
g. 1 point: The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.
4. Environment and Infection Control:

a. 5 points: The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.
b. 1 point: The nursing care institution establishes and maintains a pest control program that complies with A.A.C. R3-8-201(C)(4).
c. 1 point: The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.
d. 1 point: The nursing care institution ensures orientation to the disaster plan for each personnel member is completed within the first scheduled week of employment.
e. 1 point: The nursing care institution maintains a clean and sanitary environment.
f. 5 points: The nursing care institution is implementing a system to prevent and control infection.
g. 1 point: An employee cleans the employee's hands after each direct resident contact or when hand cleaning is indicated to prevent the spread of infection.

5. Food Services:
a. 1 point: The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license.
b. 3 points: The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan.
c. 2 points: The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs.
d. 2 points: The nursing care institution provides assistance to a resident who needs help in eating so that the resident's nutritional, physical, and social needs are met.
e. 1 point: The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.
f. 1 point: The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.

**D.** A nursing care institution's quality rating remains in effect until a subsequent compliance inspection or complaint investigation is conducted by the Department except as provided in subsection (E).

**E.** If the Department issues a provisional license, the current quality rating is terminated. A provisional licensee may submit an application for a substantial compliance inspection. If the Department determines that, as a result of a substantial compliance inspection, the nursing care institution is in substantial compliance, the Department shall issue a new quality rating according to subsection (C).

**F.** The issuance of a quality rating does not preclude the Department from seeking a civil penalty as provided in A.R.S. § 36-431.01, or suspension or revocation of a license as provided in A.R.S. § 36-427.

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-427 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-428. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-429. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-430. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-431. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-432. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-433. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-434. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-435. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-436. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-437. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

**R9-10-438. Repealed**

**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

## ARTICLE 6. HOSPICES

**R9-10-601. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following apply in this Article unless otherwise specified:

1. "Medical social services" means assistance, other than medical services or nursing services, provided by a personnel member to a patient to assist the patient to cope with concerns about the patient's illness, finances, or personal issues and may include problem-solving, interventions, and identification of resources to address the patient's or the patient's family's concerns.
2. "Palliative care" means medical services or nursing services provided to a patient that is not curative and is designed for pain control or symptom management.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-602. Supplemental Application Requirements**

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a hospice service agency or hospice inpatient facility shall include on the application:

1. For an application as a hospice service agency:
   a. The hours of operation for the hospice's administrative office, and
   b. The geographic region to be served by the hospice service agency; and
2. For an application as a hospice inpatient facility, the requested licensed capacity.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-603. Administration**

**A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of the hospice;
2. Establish, in writing:
   a. A hospice's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management plan according to R9-10-604;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
   a. Expected not to be present:
      i. At a hospice service agency's administrative office for more than 30 calendar days, or
      ii. On a hospice inpatient facility's premises for more than 30 calendar days; or
   b. Not present:
      i. At a hospice service agency's administrative office for more than 30 calendar days, or
      ii. On a hospice inpatient facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:
1. Is directly accountable to the governing authority of a hospice for the daily operation of the hospice and all services provided by or through the hospice;
2. Has the authority and responsibility to manage the hospice;
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the hospice's premises and accountable for the:
   a. Hospice service agency when the administrator is not present at the hospice service agency's administrative office, or
   b. Inpatient hospice facility when the administrator is not on hospice inpatient facility's premises; and
4. Designates a personnel member to provide direction for volunteers.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to patient care;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Include a method to identify a patient to ensure the patient receives hospice services as ordered;
   f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
   g. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. The hospice service agency or hospice inpatient facility to respond to a patient's complaint;
   h. Cover health care directives;
   i. Cover medical records, including electronic medical records;
   j. Cover a quality management program, including incident reports and supporting documentation; and
   k. Cover contracted services;

2. Policies and procedures for hospice services are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, transfer, discharge planning, and discharge;
   b. Cover the provision of hospice services;
   c. Include when general consent and informed consent are required;
   d. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
   e. Cover dispensing, administering, and disposing of medication;
   f. Cover infection control; and
   g. Cover telemedicine, if applicable;
3. For a hospice inpatient facility, policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover visitation of a patient, including:
      i. Allowing visitation by individuals 24 hours a day, and
      ii. Allowing a visitor to bring a pet to visit the patient;
   b. Cover the use and display of a patient's personal belongings; and
   c. Cover environmental services that affect patient care;
4. Policies and procedures are reviewed at least once every three years and updated as needed;
5. Policies and procedures are available to personnel members, employees, volunteers, and students; and
6. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a hospice, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the hospice.

**D.** An administrator shall designate, in writing, a:
1. Physician as the medical director who has the authority and responsibility for providing direction for the medical services provided by the hospice, and
2. Registered nurse as the director of nursing who has the authority and responsibility for managing nursing services provided by the hospice.

**E.** An administrator shall ensure that the following are conspicuously posted:
1. The current Department-issued license;
2. The current telephone number of the Department; and
3. The location at which the following are available for review:
   a. A copy of the most recent Department inspection report;
   b. A list of the services provided by the hospice; and
   c. A written copy of rates and charges, as required in A.R.S. § 36-436.03 .

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-604. Quality Management**

An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-605. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-606. Personnel**

**A.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the patients receiving physical health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are available and, for a hospice inpatient facility, present on the hospice inpatient facility's premises, with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the hospice's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient;
4. Orientation occurs within the first week of providing hospice services and includes:
   a. Informing personnel about Department rules for licensing and regulating hospices and where the rules may be obtained,
   b. Reviewing the process by which a personnel member may submit a complaint about patient care to a hospice, and
   c. Providing the information required by hospice policies and procedures;
5. Personnel receive in-service education according to criteria established in hospice policies and procedures;
6. In-service education documentation for a personnel member includes:
   a. The subject matter,
   b. The date of the in-service education, and
   c. The signature of each individual who participated in the in-service education; and
7. A personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the hospice service facility or hospice inpatient facility, and
   b. As specified in R9-10-113.

**B.** An administrator shall ensure that record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures; and
   e. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(7).

**C.** An administrator shall ensure that personnel records are:

1. Maintained:
   a. Throughout the individual's period of providing services in or for the hospice, and
   b. For at least 24 months after the last date the individual provided services in or for the hospice; and
2. For a personnel member who has not provided physical health services at or for the hospice during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-607. Admission**

**A.** Before admitting an individual as a patient, an administrator shall obtain:
1. The name of the individual's physician;
2. Documentation that the individual has a diagnosis by a physician that indicates that the individual has a specific, progressive, normally irreversible disease that is likely to cause the individual's death in six months or less; and
3. Documentation from the individual or the individual's representative acknowledging that:
   a. Hospice services include palliative care and supportive services and are not curative, and
   b. The individual or individual's representative has received a list of services to be provided by the hospice.

**B.** At the time of admission, a physician or registered nurse shall:
1. Assess a patient's medical, social, nutritional, and psychological needs; and
2. As applicable, obtain informed consent or general consent.

**C.** Before or at the time of admission, a personnel member qualified according to policies and procedures shall assess the social and psychological needs of a patient's family, if applicable.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-608. Care Plan**

**A.** An administrator shall ensure that a care plan is developed for each patient:
1. Based on the:
   a. Assessment of the:
      i. Patient; and
      ii. Patient's family, if applicable;
   b. Hospice service agency's or inpatient hospice facility's scope of service;
2. With participation from a:
   a. Physician,
   b. Registered nurse, and
   c. Another personnel member as designated in R9-10-612(A)(4); and
3. That includes:
   a. The patient's diagnosis;
   b. The patient's health care directives;
   c. The patient's cognitive awareness of self, location, and time;
   d. The patient's functional abilities and limitations;
   e. Goals for pain control and symptom management;
   f. The type, duration, and frequency of services to be provided to the patient and, if applicable, the patient's family;
   g. Treatments the patient is receiving from a health care institution or health care professional other than the hospice, if applicable;
   h. Medications ordered for the patient;
   i. Any known allergies;
   j. Nutritional requirements and preferences; and
   k. Specific measures to improve the patient's safety and protect the patient against injury.

**B.** An administrator shall ensure that:
1. A request for participation in a patient's care plan is made to the patient or patient's representative;
2. An opportunity for participation in the patient's care plan is provided to the patient, patient's representative, or patient's family; and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the patient's medical record.

**C.** An administrator shall ensure that:
1. Hospice services are provided to a patient and, if applicable, the patient's family according to the patient's care plan;
2. A patient's care plan is reviewed and updated:

a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of the services being provided;
b. If the patient's physician orders a change in the care plan; and
c. At least every 30 calendar days; and

3. A patient's physician authenticates the care plan with a signature within 14 calendar days after the care plan is initially developed and whenever the care plan is reviewed or updated.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-608 renumbered to R9-10-609; new Section R9-10-608 renumbered from R9-10-611 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-609. Transfer**

Except for a transfer of a patient due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before the transfer;
   b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the patient during a transfer.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-609 renumbered to R9-10-610; new Section R9-10-609 renumbered from R9-10-608 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-610. Patient Rights**

**A.** An administrator shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
   b. Where patient rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by the hospice's personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;

d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospice for identification and administrative purposes;
e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
   i. Medical record, or
   ii. Financial records;
f. Is informed of:
   i. The components of hospice services provided by the hospice;
   ii. The rates and charges for the components of hospice services before the components are initiated and before a change in rates, charges, or services;
   iii. The hospice's policy on health care directives; and
   iv. The patient complaint process; and
g. Is informed that a written copy of rates and charges, as required in A.R.S. § 36-436.03, may be requested.

**C.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the hospice inpatient facility is not authorized or not able to provide physical health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-610 renumbered to R9-10-611; new Section R9-10-610 renumbered from R9-10-609 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-611. Medical Records**

**A.** An administrator shall ensure that:
1. A patient's medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of a patient or the patient's representative; or
   c. As permitted by law; and
6. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If a hospice maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
   a. The patient's name,
   b. The patient's address,
   c. The patient's telephone number,
   d. The patient's date of birth, and
   e. Any known allergy;

2. The admission date and, if applicable, the date that the patient stopped receiving services from the hospice;
3. The name and telephone number of the patient's physician;
4. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative;
      i. Is a legal guardian, a copy of the court order establishing guardianship; or
      ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
5. The admitting diagnosis;
6. If applicable, documented general consent and informed consent, by the patient or the patient's representative;
7. Documentation of medical history;
8. A copy of the patient's living will, health care power of attorney, or other health care directive, if applicable;
9. Orders;
10. The assessment required in R9-10-607(B)(1);
11. Care plans;
12. Progress notes for each patient contact, including:
   a. The date of the patient contact,
   b. The services provided,
   c. A description of the patient's condition, and
   d. Instructions given to the patient or patient's representative;
13. Documentation of hospice services provided to the patient;
14. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
15. Documentation of coordination of patient care;
16. Documentation of contacts with the patient's physician by a personnel member;
17. The discharge summary, if applicable;
18. If applicable, transfer documentation from a sending health care institution; and
19. Documentation of a medication administered to the patient that includes:
   a. The date and time of administration;
   b. The name, strength, dosage, and route of administration;
   c. For a medication administered for pain, when initially administered or when administered on a PRN basis:
      i. An assessment of the patient's pain before administering the medication, and
      ii. The effect of the medication administered;
   d. For a psychotropic medication, when initially administered or when administered on a PRN basis:
      i. An assessment of the patient's behavior before administering the psychotropic medication, and
      ii. The effect of the psychotropic medication administered;
   e. The identification, signature, and professional designation of the individual administering the medication; and
   f. Any adverse reaction a patient has to the medication.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-611 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-611 renumbered to R9-10-608; new Section R9-10-611 renumbered from R9-10-610 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-612. Hospice Services**

**A.** An administrator shall ensure that the following are included in the hospice services provided by the hospice:
1. Medical services;
2. Nursing services;
3. Nutritional services, including menu planning and the designation of the kind and amount of food appropriate for a patient;
4. Medical social services, provided as follows:
   a. By a personnel member qualified according to policies and procedures to coordinate medical social services; and
   b. If a personnel member provides medical social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, by a personnel member who is licensed under A.R.S. Title 32, Chapter 33, Article 5;
5. Bereavement counseling for a patient's family for at least one year after the death of the patient; and
6. Spiritual counseling services, consistent with a patient's customs, religious preferences, cultural background, and ethnicity.

**B.** In addition to the services specified in subsection (A), an administrator of a hospice service agency shall ensure that the following are included in the hospice services provided by the hospice:
1. Home health aide services;
2. Respite care services; and
3. Supportive services, as defined in A.R.S. § 36-151.

**C.** An administrator shall ensure that the medical director provides direction for medical services provided by or through the hospice.

**D.** A medical director shall ensure that:
1. A patient's need for medical services is met, according to the patient's care plan and the hospice's scope of services; and
2. If a patient is receiving medical services not provided by or through the hospice, hospice services are coordinated with the physician providing medical services to the patient.

**E.** A director of nursing shall ensure that:
1. A registered nurse or practical nurse provides nursing services according to the hospice's policies and procedures;
2. A sufficient number of nurses are available to provide the nursing services identified in each patient's care plan;
3. The care plan for a patient is implemented;
4. A personnel member is only assigned to provide services the personnel member can competently perform;
5. A registered nurse:
   a. Assigns tasks in writing to a home health aide who is providing home health aide service to a patient,
   b. Provides direction for the home health aide services provided to a patient, and
   c. Verifies the competency of the home health aide in performing assigned tasks;
6. A registered dietitian or a personnel member under the direction of a registered dietitian plans menus for a patient;
7. A patient's condition and the services provided to the patient are documented in the patient's medical record after each patient contact;
8. A patient's physician is immediately informed of a change in the patient's condition that requires medical services; and
9. The implementation of a patient's care plan is coordinated among the personnel members providing hospice services to the patient.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-612 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-613. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:
1. Include:
   a. A process for providing information to a patient about medication prescribed for the patient including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse reaction to a medication, or
      iii. A medication overdose;
   c. Procedures to ensure that a patient's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs;
   d. Procedures for:
      i. Documenting medication administration; and
      ii. Monitoring a patient who self-administers medication;
   e. Procedures for assisting a patient in obtaining medication; and
   f. If applicable, procedures for providing medication administration off the premises; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**B.** If a hospice provides medication administration, an administrator shall ensure that:
1. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner;
   b. Specify the individuals who may:
      i. Order medication, and

ii. Administer medication;
c. Ensure that medication is administered to a patient only as prescribed; and
d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a patient:
a. Is administered in compliance with an order, and
b. Is documented in the patient's medical record.

**C.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members;
3. If pharmaceutical services are provided on the premises:
a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by the hospice's policies and procedures is established to:
i. Develop a drug formulary,
ii. Update the drug formulary at least every 12 months,
iii. Develop medication usage and medication substitution policies and procedures, and
iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
b. The pharmaceutical services are provided under the direction of a pharmacist;
c. The pharmaceutical services comply with ARS Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
d. A copy of the pharmacy license is provided to the Department upon request.

**D.** When medication is stored at a hospice inpatient facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
c. A medication recall and notification of patients who received recalled medication; and
d. Storing, inventorying, and dispensing controlled substances.

**E.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the hospice's director of nursing.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-613 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-614. Infection Control**

An administrator shall ensure that:
1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
a. A method to identify and document infections;
b. Analysis of the types, causes, and spread of infections and communicable diseases;
c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases; and
d. Documenting infection control activities including:
i. The collection and analysis of infection control data,
ii. The actions taken relating to infections and communicable diseases, and
iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documents are maintained for at least 12 months after the date of the documents;
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
a. Handling and disposal of biohazardous medical waste;
b. Sterilization and disinfection of medical equipment and supplies;
c. Use of personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a patient;
e. Training of personnel members in infection control practices; and

f. Work restrictions for a personnel member with a communicable disease or infected skin lesion;

4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures; and
5. A personnel member washes hands or use a hand disinfection product after each patient contact and after handling soiled linen, soiled clothing, or potentially infectious material.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-614 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-615. Food Services for a Hospice Inpatient Facility**

**A.** An administrator of a hospice inpatient facility shall ensure that:
1. Meals and snacks provided by the hospice inpatient facility are served according to a patient's dietary needs and preferences;
2. Meals and snacks for each day are planned using:
   a. The applicable guidelines in http://www.health.gov/dietaryguidelines/2010.asp, and
   b. Preferences for meals and snacks obtained from patients;
3. A patient requiring assistance to eat is provided with assistance that recognizes the patient's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
4. Water is available and accessible to patients at all times, unless otherwise stated in a patient's care plan.

**B.** An administrator of a hospice inpatient facility shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a patient, such as cut, chopped, ground, pureed, or thickened;
4. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below;
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
      i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
      ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
      iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
      v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
      vi. Leftovers are reheated to a temperature of at least 165° F;
5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, at the warmest part of the refrigerator;
6. Frozen foods are stored at a temperature of 0° F or below; and
7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**C.** An administrator shall ensure that:
1. For a hospice inpatient facility with a licensed capacity of more than 20 beds, the hospice inpatient facility:
   a. Has a license or permit as a food establishment under 9 A.A.C. 8, Article 1, and
   b. Maintains a copy of the hospice inpatient facility's food establishment license or permit;
2. If the hospice inpatient facility contracts with food establishment, as defined in 9 A.A.C. 8, Article 1, to prepare and deliver food to the hospice inpatient facility a copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the hospice inpatient facility; and
3. Food is stored, refrigerated, and reheated to meet the dietary needs of a patient.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-615 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-616. Emergency and Safety Standards for a Hospice Inpatient Facility**

**A.** An administrator of a hospice inpatient facility shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
   a. When, how, and where patients will be relocated, including:
      i. Instructions for the evacuation or transfer of patients,
      ii. Assigned responsibilities for each employee and personnel member, and
      iii. A plan for providing continuing services to meet patient's needs;
   b. How each patient's medical record will be available to individuals providing services to the patient during a disaster;
   c. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
   d. A plan for obtaining food and water for individuals present in the hospice inpatient facility or the hospice inpatient facility's relocation site during a disaster;
2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented; and
5. An evacuation path is conspicuously posted on each hallway of each floor of the hospice inpatient facility.

**B.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-616 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-617. Environmental Standards for a Hospice Inpatient Facility**

**A.** An administrator of a hospice inpatient facility shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
   a. Cleaning and storing of soiled linens and clothing,
   b. Housekeeping procedures that ensure a clean environment, and
   c. Isolation of a patient who may spread an infection;
2. The premises and equipment are:
   a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness or infection; and
   b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury or illness;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. Equipment used at the hospice inpatient facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in the hospice inpatient facility's policies and procedures; and
   c. Used according to the manufacturer's recommendations;
5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
6. Garbage and refuse are:
   a. Stored in covered containers lined with plastic bags, and
   b. Removed from the premises at least once a week;
7. Soiled linen and clothing are:
   a. Collected in a manner to minimize or prevent contamination;
   b. Bagged at the site of use; and
   c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
8. Heating and cooling systems maintain the hospice inpatient facility at a temperature between 70° F and 84° F at all times;
9. Common areas:
   a. Are lighted to assure the safety of patients, and

b. Have lighting sufficient to allow personnel members to monitor patient activity;

10. The supply of hot and cold water is sufficient to meet the personal hygiene needs of patients and the cleaning and sanitation requirements in this Article;
11. Oxygen containers are secured in an upright position;
12. Poisonous or toxic materials stored by the hospice inpatient facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
13. Except for medical supplies needed by a patient, combustible or flammable liquids and hazardous materials are stored by the hospice inpatient facility in the original labeled containers or safety containers in a locked area inaccessible to patients;
14. If pets or animals are allowed in the hospice inpatient facility, pets or animals are:
    a. Controlled to prevent endangering the patients and to maintain sanitation, and
    b. Licensed consistent with local ordinances;
15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
    a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
    b. If necessary, corrective action is taken to ensure the water is safe to drink, and
    c. Documentation of testing is retained for at least 12 months after the date of the test; and
16. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

**B.** An administrator of a hospice inpatient facility shall ensure that a patient is allowed to use and display personal belongings.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-617 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-618. Physical Plant Standards for a Hospice Inpatient Facility**

**A.** An administrator shall ensure that a hospice inpatient facility complies with applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01.

**B.** An administrator of a hospice inpatient facility shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the hospice inpatient facility's scope of services, and
2. An individual accepted as a patient by the hospice inpatient facility.

**C.** An administrator of a hospice inpatient facility shall ensure that a patient's sleeping area:
1. Is shared by no more than four patients;
2. Measures at least 80 square feet of floor space per patient, not including a closet;
3. Has walls from floor to ceiling;
4. Contains a door that opens into a hallway, common area, or outdoors;
5. Is at or above ground level;
6. Is vented to the outside of the hospice inpatient facility;
7. Has a working thermometer for measuring the temperature in the sleeping area;
8. For each patient, has a:
    a. Bed,
    b. Bedside table,
    c. Bedside chair,
    d. Reading light,
    e. Privacy screen or curtain, and
    f. Closet or drawer space;
9. Is equipped with a bell, intercom, or other mechanical means for a patient to alert a personnel member;
10. Is no farther than 20 feet from a room containing a toilet and a sink;
11. Is not used as a passageway to another sleeping area, a toilet room, or a bathing room;
12. Contains one of the following to provide sunlight:
    a. A window to the outside of the hospice inpatient facility, or
    b. A transparent or translucent door to the outside of the hospice inpatient facility; and
13. Has coverings for windows and for transparent or translucent doors that provide patient privacy.

**D.** An administrator of a hospice inpatient facility shall ensure that there is:
1. For every six patients, a toilet room that contains:
    a. At least one working toilet that flushes and has a seat;
    b. At least one working sink with running water;
    c. Soap for hand washing;
    d. Paper towels or a mechanical air hand dryer;

e. Grab bars attached to a wall that an individual may hold onto to assist the individual in becoming or remaining erect;
f. A mirror;
g. Lighting;
h. Space for a personnel member to assist a patient;
i. A bell, intercom, or other mechanical means for a patient to alert a personnel member; and
j. An operable window to the outside of the hospice inpatient facility or other means of ventilation;

2. For every 12 patients, at least one working bathtub or shower accessible to a wheeled shower chair, with a slip-resistant surface, located in a toilet room or in a separate bathing room;
3. For a patient occupying a sleeping area with one or more other patients, a separate room in which the patient can meet privately with family members;
4. Space in a lockable closet, drawer, or cabinet for a patient to store the patient's private or valuable items;
5. A room other than a sleeping area that can be used for social activities;
6. Sleeping accommodations for family members;
7. A designated toilet room, other than a patient toilet room, for personnel and visitors that:
   a. Provides privacy; and
   b. Contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue,
      iv. Soap for hand washing,
      v. Paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A window that opens or another means of ventilation;
8. If the hospice inpatient facility has a kitchen with a stove or oven, a mechanism to vent the stove or oven to the outside of the hospice inpatient facility; and
9. Space designated for administrative responsibilities that is separate from sleeping areas, toilet rooms, bathing rooms, and drug storage areas.

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-618 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-619. Repealed**

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-619 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

**R9-10-620. Repealed**

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-620 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

**R9-10-621. Repealed**

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Correction, subsection (H), after "... 105° F" added "nor more than 110° F" as certified effective November 6, 1978 (Supp. 87-2). Section R9-10-621 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

**R9-10-622. Repealed**

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-622 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

**R9-10-623. Repealed**

**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-623 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

## ARTICLE 9. OUTPATIENT SURGICAL CENTERS

**R9-10-901. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following apply in this Article, unless otherwise specified:

1. "Inpatient care" means postsurgical services provided in a hospital.
2. "Outpatient surgical services" means anesthesia and surgical services provided to a patient in an outpatient surgical center.
3. "Surgical suite" means an area of an outpatient surgical center that includes one or more operating rooms and one or more recovery rooms.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 3792, effective October 4, 2003 (Supp. 03-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-902. Administration**

**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of an outpatient surgical center;
2. Establish, in writing:
   a. An outpatient surgical center's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Grant, deny, suspend, or revoke clinical privileges of a physician and other members of the medical staff and delineate, in writing, the clinical privileges of each medical staff member, according to the medical staff bylaws;
5. Adopt a quality management plan according to R9-10-903;
6. Review and evaluate the effectiveness of the quality management plan at least once every 12 months;
7. Designate in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
   a. Expected not to be present on an outpatient surgical center's premises for more than 30 calendar days, or
   b. Not present on an outpatient surgical center's premises for more than 30 calendar days; and
8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:

1. Is directly accountable to the governing authority of an outpatient surgical center for the daily operation of the outpatient surgical center and for all services provided by or at the outpatient surgical center;
2. Has the authority and responsibility to manage the outpatient surgical center; and
3. Except as provided in subsection (A)(7), designates, in writing, an individual who is present on an outpatient surgical center's premises and accountable for the outpatient surgical center when the administrator is not present on the outpatient surgical center's premises.

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to patient care;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Include a method to identify a patient to ensure that the patient receives services as ordered;

f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
g. Cover specific steps for:
   i. A patient to file a complaint, and
   ii. The outpatient surgical center to respond to a patient complaint;
h. Cover health care directives;
i. Cover medical records, including electronic medical records;
j. Cover a quality management program, including incident reports and supporting documentation; and
k. Cover contracted services;

2. Policies and procedures for medical services and nursing services provided by an outpatient surgical center are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, transfer, and discharge;
   b. Cover the provision of medical services, nursing services, and health-related services in the outpatient surgical center's scope of services;
   c. Include when general consent and informed consent are required;
   d. Cover dispensing, administering, and disposing of medications;
   e. Cover prescribing a controlled substance to minimize substance abuse by a patient;
   f. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
   g. Cover infection control; and
   h. Cover environmental services that affect patient care;
3. Policies and procedures are:
   a. Available to personnel members, employees, volunteers, and students of the outpatient surgical center; and
   b. Reviewed at least once every three years and updated as needed;
4. A pharmacy maintained by the outpatient surgical center is licensed according to A.R.S. Title 32, Chapter 18;
5. Pathology services are provided by a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Act of 1967;
6. If the outpatient surgical center meets the definition of "abortion clinic" in A.R.S. § 36-449.01, abortions and related services are provided in compliance with the requirements in Article 15 of this Chapter; and
7. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient surgical center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient surgical center.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-903. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-904. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-905. Personnel**

**A.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are present on an outpatient surgical center's premises with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the outpatient surgical center's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient;
4. A personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with patients, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the outpatient surgical center, and
   b. As specified in R9-10-113;
5. A plan to provide orientation, specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
6. A personnel member completes orientation before providing physical health services or behavioral health services;
7. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
8. A plan to provide in-service education specific to the job duties of a personnel member is developed, documented, and implemented; and
9. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the in-service education.

**B.** An administrator shall ensure that a personnel member:

1. Is 18 years of age or older; and
2. Is certified in cardiopulmonary resuscitation within the first month of employment or volunteer service, and maintains current certification in cardiopulmonary resuscitation.

**C.** An administrator shall ensure that a personnel record for each personnel member, employee, volunteer, or student includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   f. Cardiopulmonary resuscitation training, if required for the individual according to subsection (B); and
   g. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(4).

**D.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout the individual's period of providing services in or for the outpatient surgical center, and
   b. For at least 24 months after the last date the individual provided services in or for the outpatient surgical center; and
   2. For a personnel member who has not provided physical health services or behavioral health services at or for the outpatient surgical center during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 3792, effective October 4, 2003 (Supp. 03-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-906. Medical Staff**

A governing authority shall ensure that:
1. The medical staff approve bylaws for the conduct of medical staff activities according to medical staff bylaws and governing authority requirements;
2. The medical staff physicians conduct medical peer review according to A.R.S. Title 36, Chapter 4, Article 5 and submit recommendations to the governing authority for approval; and
3. The medical staff establish written policies and procedures that define the extent of emergency treatment to be performed in the outpatient surgical center.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-907. Admission**

**A.** A medical staff member shall only admit patients to the outpatient surgical center who:
1. Do not require planned inpatient care, and
2. Are discharged from the outpatient surgical center within 24 hours.

**B.** Within 30 calendar days before a patient is admitted to an outpatient surgical center, a medical staff member shall complete a medical history and physical examination of the patient.

**C.** The individual who is responsible for performing a patient's surgical procedure shall document the preoperative diagnosis and the surgical procedure to be performed in the patient's medical record.

**D.** An administrator shall ensure that the following documents are in a patient's medical record before the patient's surgery:
1. A medical history and the physical examination required in subsection (B),
2. A preoperative diagnosis and the results of any laboratory tests or diagnostic procedures relative to the surgery and the condition of the patient,
3. Evidence of informed consent by the patient or patient's representative for the surgical procedure and care of the patient,
4. Health care directives, and
5. Physician orders.

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-908. Transfer**

Except for a transfer of a patient due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before the transfer;
   b. Information in the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the patient during a transfer.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 3792, effective October 4, 2003 (Supp. 03-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-909. Patient Rights**

**A.** An administrator shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
   b. Where patient rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by the outpatient surgical center's medical staff, personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and the associated risks and possible complications of the proposed psychotropic medication or surgical procedure;
   d. Is informed of the following:
      i. Policies and procedures on health care directives, and
      ii. The patient complaint process;
   e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient surgical center for identification and administrative purposes; and
   f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or

ii. Financial records.

**C.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient surgical center is not authorized or not able to provide physical health services needed by the patient;
6. To participate, or have the patient's representative participate, in the development of or decisions concerning treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, a patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-910. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for a patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by an individual authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical staff member according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical staff member issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
   c. As permitted by law; and
6. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If an outpatient surgical center maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
   a. The patient's name;
   b. The patient's address;
   c. The patient's date of birth; and
   d. Any known allergies, including medication allergies;
2. The admitting medical practitioner;
3. An admitting diagnosis;
4. Documentation of general consent and informed consent for treatment by the patient or the patient's representative, except in an emergency;
5. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or

ii. Is a legal guardian, a copy of the court order establishing guardianship;
6. The date of admission and, if applicable, date of discharge;
7. Documentation of medical history and results of a physical examination;
8. A copy of patient's health care directive, if applicable;
9. Orders;
10. Progress notes;
11. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
12. Documentation of outpatient surgical center services provided to the patient;
13. A discharge summary, if applicable;
14. Documentation of receipt of written discharge instructions by the patient or patient's representative;
15. If applicable:
    a. Laboratory reports,
    b. Radiologic report, and
    c. Diagnostic reports;
16. The anesthesia report, required in R9-10-911(C)(2);
17. The operative report of the surgical procedure, required in R9-10-911(C)(1); and
18. Documentation of a medication administered to the patient that includes:
    a. The date and time of administration;
    b. The name, strength, dosage, and route of administration;
    c. For a medication administered for pain:
        i. An assessment of the patient's pain before administering the medication, and
        ii. The effect of the medication administered;
    d. For a psychotropic medication:
        i. An assessment of the patient's behavior before administering the psychotropic medication, and
        ii. The effect of the psychotropic medication administered;
    e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and
    f. Any adverse reaction a patient has to the medication.

**Historical Note**

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-911. Surgical Services**

**A.** An administrator shall ensure that:
1. A current listing of surgical procedures offered by an outpatient surgical center is maintained on the outpatient surgical center's premises, and
2. A chronological register of surgical procedures performed in the outpatient surgical center is maintained for at least 24 months after the date of the last entry.

**B.** An administrator shall ensure that a roster of medical staff members who have clinical privileges at the outpatient surgical center is available to the medical staff, specifying the privileges and limitations of each medical staff member on the roster.

**C.** An administrator shall ensure that the individual responsible for:
1. Performing a surgical procedure completes an operative report of the surgical procedure and any necessary discharge instructions according to medical staff bylaws and policies and procedures, and
2. Administering anesthesia during a surgical procedure completes an anesthesia report and any necessary discharge instructions according to medical staff bylaws and policies and procedures.

**D.** An administrator shall ensure that a physician remains on the outpatient surgical center's premises until all patients are discharged from the recovery room.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-912. Nursing Services**

An administrator shall appoint a registered nurse as the director of nursing who:
1. Is responsible for the management of the outpatient surgical center's nursing services;

2. Ensures that policies and procedures are established, documented, and implemented for nursing services provided in the outpatient surgical center;
3. Ensures that the outpatient surgical center is staffed with sufficient nursing personnel, based on the number of patients, the health care needs of the patients, and the outpatient surgical center's scope of services;
4. Participates in quality management activities;
5. Designates a registered nurse, in writing, to manage an outpatient surgical center's nursing services when the director of nursing is not present on the outpatient surgical center's premises;
6. Ensures that a nurse who is not directly assisting the surgeon is responsible for the functioning of an operating room while a surgical procedure is being performed in the operating room;
7. Ensures that a registered nurse is present in the:
   a. Recovery room when a patient is present in the recovery room, and
   b. Outpatient surgical center until all patients are discharged; and
8. Ensures that a nurse documents in a patient's medical record that the patient or the patient's representative has received written discharge instructions.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-913. Behavioral Health Services**

If an outpatient surgical center is authorized to provide behavioral health services, an administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented that cover when informed consent is required and by whom informed consent may be given; and
2. The behavioral health services:
   a. Are provided under the direction of a behavioral health professional; and
   b. Comply with the requirements:
      i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
      ii. For an assessment, in R9-10-1011(B).

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-914. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:

1. Include:
   a. A process for providing information to a patient about medication prescribed for the patient including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse reaction to a medication, or
      iii. A medication overdose; and
   c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**B.** An administrator shall ensure that:

1. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner;
   b. Specify the individuals who may:
      i. Order medication, and

ii. Administer medication;
c. Ensure that medication is administered to a patient only as prescribed; and
d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a patient:
a. Is administered in compliance with an order, and
b. Is documented in the patient's medical record.

**C.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members; and
3. If pharmaceutical services are provided on the premises:
a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
i. Develop a drug formulary,
ii. Update the drug formulary at least once every 12 months,
iii. Develop medication usage and medication substitution policies and procedures, and
iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical staff member specifically orders otherwise;
b. The pharmaceutical services are provided under the direction of a pharmacist;
c. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
d. A copy of the pharmacy license is provided to the Department upon request.

**D.** When medication is stored at an outpatient surgical center, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
c. A medication recall and notification of patients who received recalled medication; and
d. Storing, inventorying, and dispensing controlled substances.

**E.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the outpatient surgical center's director of nursing.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-915. Infection Control**

An administrator shall ensure that:
1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
a. A method to identify and document infections occurring at the outpatient surgical center;
b. Analysis of the types, causes, and spread of infections and communicable diseases at the outpatient surgical center;
c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the outpatient surgical center; and
d. Documenting infection control activities including:
i. The collection and analysis of infection control data,
ii. The actions taken related to infections and communicable diseases, and
iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:
a. Compliance with the requirements in 9 A.A.C. 6 for reporting and control measures for communicable diseases and infestations;
b. Handling and disposal of biohazardous medical waste;
c. Sterilization, disinfection, distribution, and storage of medical equipment and supplies;
d. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
e. Training personnel members, employees, and volunteers in infection control practices; and

f. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
5. Soiled linen and clothing are:
   a. Collected in a manner to minimize or prevent contamination,
   b. Bagged at the site of use, and
   c. Maintained separate from clean linen and clothing; and
6. A personnel member, employee, or volunteer washes hands or uses a hand disinfection product after patient contact and after handling soiled linen, soiled clothing, or potentially infectious material.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-916. Emergency and Safety Standards**

**A.** An administrator shall ensure that policies and procedures for providing medical emergency treatment to a patient are established, documented, and implemented and include:
1. A list of the medications, supplies, and equipment required on the premises for the medical emergency treatment provided by the outpatient surgical center;
2. A system to ensure medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
3. A requirement that a cart or a container is available for medical emergency treatment that contains medications, supplies, and equipment specified in policies and procedures;
4. A method to verify and document that the contents of the cart or container are available for medical emergency treatment; and
5. A method for ensuring a patient may be transferred to a hospital or other health care institution to receive treatment for a medical emergency that the outpatient surgical center is not authorized or not able to provide.

**B.** An administrator shall ensure that medical emergency treatment is provided to a patient admitted to the outpatient surgical center according to policies and procedures.

**C.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to medical staff and employees, and, if necessary, implemented that includes:
   a. Procedures to be followed in the event of a fire or threat to patient safety;
   b. Assigned personnel responsibilities;
   c. Instructions for the evacuation or transfer of patients;
   d. Maintenance of patient medical records; and
   e. A plan to provide any other services related to patient care to meet the patients' needs;
2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (C)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, medical staff member, or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees is conducted at least once every six months for employees on the premises;
6. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for employees to evacuate the outpatient surgical center;
   c. Any problems encountered in conducting the evacuation drill; and
   d. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the outpatient surgical center and every room where patients may be present.

**D.** An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.

**E.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,

2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-917. Environmental Standards**

**A.** An administrator shall ensure that:
1. An outpatient surgical center's premises and equipment are:
   a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness or infection; and
   b. Free from a condition or situation that may cause a patient or an individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Equipment used at the outpatient surgical center to provide care to a patient is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
5. Garbage and refuse are:
   a. Stored in covered containers lined with plastic bags, and
   b. Removed from the premises at least once a week;
6. Heating and cooling systems maintain the outpatient surgical center at a temperature between 70° F and 84° F at all times;
7. Common areas:
   a. Are lighted to assure the safety of patients, and
   b. Have lighting sufficient to allow personnel members to monitor patient activity; and
8. The supply of hot and cold water is sufficient to meet the personal hygiene needs of patients and the cleaning and sanitation requirements in this Article.

**B.** An administrator shall ensure that an outpatient surgical center has a functional emergency power source.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-918. Physical Plant Standards**

**A.** An administrator shall ensure that the outpatient surgical center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the date the outpatient surgical center submitted architectural plans and specifications to the Department for approval according to R9-10-104.

**B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the outpatient surgical center's scope of services, and
2. An individual accepted as a patient by the outpatient surgical center.

**C.** An administrator shall ensure that:
1. There are two recovery beds for each operating room, for up to four operating rooms, whenever general anesthesia is administered;
2. One additional recovery bed is available for each additional operating room; and
3. Recovery beds are located in a space that provides for a minimum of 70 square feet per bed, allowing three feet or more between beds and between the sides of a bed and the wall.

**D.** An administrator may provide chairs in the recovery room area that allow a patient to recline for patients who have not received general anesthesia.

**E.** An administrator shall ensure that the following are available in the surgical suite:
1. Oxygen and the means of administration;
2. Mechanical ventilator assistance equipment including airways, manual breathing bag, and suction apparatus;
3. Cardiac monitor;
4. Defibrillator; and

5. Cardiopulmonary resuscitation drugs as determined by the policies and procedures.

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1). New Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-919. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1). New Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-920. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

**R9-10-921. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

**R9-10-922. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

**R9-10-923. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

**R9-10-924. Repealed**

**Historical Note**

Adopted effective June 2, 1983 (Supp. 82-5). Former Section R9-10-924 repealed, new Section R9-10-924 adopted effective November 6, 1985 (Supp. 85-6). Repealed effective February 17, 1995 (Supp. 95-1).

**R9-10-925. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

**Attachment 1. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

**Attachment 2. Repealed**

**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective November 6, 1985 (Supp. 85-6).

***Editor's Note: The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1). Subsequently, those Sections were repealed by final rulemaking (Supp. 99-2).***

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

## ARTICLE 10. OUTPATIENT TREATMENT CENTERS

**R9-10-1001. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

1. "Emergency room services" means medical services provided to a patient in an emergency.
2. "Pain management services" means medical services, nursing services, or health-related services provided to a patient to reduce or relieve the patient's chronic pain.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

**R9-10-1002. Supplemental Application and Documentation Submission Requirements**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for a license as an outpatient treatment center shall submit, in a Department-provided format:

1. The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation; and
2. A request to provide one or more of the following services:
   a. Behavioral health services and, if applicable;
      i. Behavioral health observation/stabilization services,
      ii. Children's behavioral health services,
      iii. Court-ordered evaluation,
      iv. Court-ordered treatment,
      v. Counseling,
      vi. Crisis services,
      vii. Opioid treatment services,
      viii. Pre-petition screening,
      ix. Respite services,
      x. Respite services for children on the premises,
      xi. DUI education,
      xii. DUI screening,
      xiii. DUI treatment, or
      xiv. Misdemeanor domestic violence offender treatment;
   b. Diagnostic imaging services;
   c. Clinical laboratory services;
   d. Dialysis services;
   e. Emergency room services;
   f. Pain management services;
   g. Physical health services;
   h. Rehabilitation services;
   i. Sleep disorder services; or
   j. Urgent care services provided in a freestanding urgent care center setting.

**B.** In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an:

1. Affiliated outpatient treatment center applying for a license for the affiliated outpatient treatment center shall submit, in a Department-provided format, the following information for each counseling facility for which the affiliated outpatient treatment center is providing administrative support:
   a. Name, and
   b. Either:
      i. The license number assigned to the counseling facility by the Department; or
      ii. If the counseling facility is not currently licensed, the:
         (1) Counseling facility's street address, and
         (2) Date the counseling facility submitted to the Department an application for a health care institution license; and
2. Outpatient treatment center, applying for a license that includes a request for authorization to provide respite services for children on the premises, shall include the requested respite capacity.

**C.** A licensee of an affiliated outpatient treatment center shall submit to the Department the information required in subsection (B)(1) with the relevant fees required in R9-10-106(C) or (D), as applicable.

**D.** A licensee of an outpatient treatment center authorized to provide respite services for children on the premises shall submit to the Department with the relevant fees in R9-10-106(C) or (D), as applicable:

1. The respite capacity, and
2. The specific 10 continuous hours per day during which the outpatient treatment center provides respite services on the premises.

**E.** A licensee of an outpatient treatment center authorized to operate as a collaborating outpatient treatment center shall submit to the Department with the relevant fees in R9-10-106(C) or (D), as applicable:
1. The information and documentation required in R9-10-1031(D)(1); and
2. A floor plan that shows:
   a. Each colocator's proposed treatment area, and
   b. The areas of the collaborating outpatient treatment center shared by a colocator and collaborating outpatient treatment center.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1003. Administration**

**A.** If an outpatient treatment center is operating under a single group license issued to a hospital according to A.R.S. § 36-422(F) or (G), the hospital's governing authority is the governing authority for the outpatient treatment center.

**B.** A governing authority shall:
1. Consist of one or more individuals accountable for the organization, operation, and administration of an outpatient treatment center;
2. Establish, in writing:
   a. An outpatient treatment center's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (B)(2)(b);
4. Adopt a quality management program according to R9-10-1004;
5. Review and evaluate the effectiveness of the quality management program in R9-10-1004 at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (B)(2)(b) if the administrator is:
   a. Expected not to be present on an outpatient treatment center's premises for more than 30 calendar days, or
   b. Not present on an outpatient treatment center's premises for more than 30 calendar days; and
7. Except as provided in subsection (B)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in an administrator and identify the name and qualifications of the new administrator.

**C.** An administrator:
1. Is directly accountable to the governing authority for the daily operation of the outpatient treatment center and all services provided by or at the outpatient treatment center;
2. Has the authority and responsibility to manage the outpatient treatment center; and
3. Except as provided in subsection (B)(6), designates, in writing, an individual who is present on the outpatient treatment center's premises and accountable for the outpatient treatment center when the administrator is not available.

**D.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a patient;
   d. Cover the requirements in Title 36, Chapter 4, Article 11;
   e. Cover cardiopulmonary resuscitation training including:
      i. The method and content of cardiopulmonary resuscitation training which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation,
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
      iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
      iv. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
   f. Cover first aid training;
   g. Include a method to identify a patient to ensure the patient receives the services ordered for the patient;
   h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;

i. Cover health care directives;
j. Cover medical records, including electronic medical records;
k. Cover quality management, including incident report and supporting documentation; and
l. Cover contracted services;

2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, assessment, transport, transfer, discharge plan, and discharge;
   b. Cover the provision of medical services, nursing services, behavioral health services, health-related services, and ancillary services;
   c. Include when general consent and informed consent are required;
   d. Cover obtaining, administering, storing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
   e. Cover prescribing a controlled substance to minimize substance abuse by a patient;
   f. Cover infection control;
   g. Cover telemedicine, if applicable;
   h. Cover environmental services that affect patient care;
   i. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. An outpatient treatment center to respond to a complaint;
   j. Cover smoking tobacco products on an outpatient treatment center's premises; and
   k. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
3. Outpatient treatment center policies and procedures are:
   a. Reviewed at least once every three years and updated as needed, and
   b. Available to personnel members and employees;
4. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient treatment center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient treatment center;
5. The following are conspicuously posted:
   a. The current license for the outpatient treatment center issued by the Department;
   b. The name, address, and telephone number of the Department;
   c. A notice that a patient may file a complaint with the Department about the outpatient treatment center;
   d. One of the following:
      i. A schedule of rates according to A.R.S. § 36-436.01(C), or
      ii. A notice that the schedule of rates required in A.R.S. § 36-436.01(C) is available for review upon request;
   e. A list of patient rights;
   f. A map for evacuating the facility; and
   g. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(D), with patient information redacted, are available; and
6. Patient follow-up instructions are:
   a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the outpatient treatment center unless the patient leaves against a personnel member's advice; and
   b. Documented in the patient's medical record.

**E.** If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from an outpatient treatment center's employee or personnel member, an administrator shall y report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:
1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
2. For a patient under 18 years of age, according to A.R.S. § 13-3620.

**F.** If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from an outpatient treatment center's employee or personnel member, an administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the patient as follows:
   a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
   b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (F)(1); and

c. The report in subsection (F)(2);

4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**G.** If an outpatient treatment center is an affiliated outpatient treatment center, an administrator shall ensure that the outpatient treatment center complies with the requirements for an affiliated outpatient treatment center in 9 A.A.C. 10, Article 19.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1004. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1005. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1006. Personnel**

An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and

ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and

b. Include:

i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,

ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and

iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are present on an outpatient treatment center's premises with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the outpatient treatment center's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient;
4. A personnel member only provides physical health services or behavioral health services the personnel member is qualified to provide;
5. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;
6. A personnel member completes orientation before providing medical services, nursing services or health-related services to a patient;
7. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
8. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;
9. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the in-service education, and
   c. The subject or topics covered in the in-service education;
10. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;
11. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:
    a. The individual's name, date of birth, and contact telephone number;
    b. The individual's starting date of employment or volunteer service, and if applicable, the ending date;
    c. Documentation of:
       i. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
       ii. The individual's education and experience applicable to the individual's job duties;
       iii. The individual's completed orientation and in-service education as required by policies and procedures;
       iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
       v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
       vi. The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable; and
       vii. Cardiopulmonary resuscitation training, if the individual is required to have cardiopulmonary resuscitation training according to this Article or policies and procedures; and
12. The record in subsection (A)(11) is:
    a. Maintained while an individual provides services for or at the outpatient treatment center and for at least 24 months after the last date the employee or volunteer provided services for or at the outpatient treatment center; and
    b. If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1007. Transport; Transfer**

**A.** Except as provided in subsection (B), an administrator shall ensure that:
1. A personnel member coordinates the transport and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before and after the transport,
   b. Information from the patient's medical record is provided to a receiving health care institution,
   c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative; and
   d. A personnel member communicates or documents why the personnel member did not communicate with an individual at a receiving health care institution;
3. The patient's medical record includes documentation of:
   a. Communication or lack of communication with an individual at a receiving health care institution;
   b. The date and time of the transport;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the patient during a transport.

**B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a patient by the patient or the patient's representative,
3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative, or
4. A transport to another licensed health care institution in an emergency.

**C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before the transfer;
   b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the patient during a transfer.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1008. Patient Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
   b. Where patient rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed in R9-10-1012(B), restraint or seclusion;
   i. Retaliation for submitting a complaint to the Department or another entity; or
   j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and

3. A patient or the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
   d. Is informed of the following:
      i. The outpatient treatment center's policy on health care directives, and
      ii. The patient complaint process;
   e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
   f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records.

**C.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1009. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
   c. As permitted by law;
6. Policies and procedures include the maximum time-frame to retrieve a patient's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If an outpatient treatment center maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
   a. Except as specified in A.A.C. R9-6-1005, the patient's name and address;
   b. The patient's date of birth; and

c. Any known allergies, including medication allergies;
2. A diagnosis or reason for outpatient treatment center services;
3. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
4. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
5. Documentation of medical history and, if applicable, results of a physical examination;
6. Orders;
7. Assessment;
8. Treatment plans;
9. Interval notes;
10. Progress notes;
11. Documentation of outpatient treatment center services provided to the patient;
12. The name of each individual providing treatment or a diagnostic procedure;
13. Disposition of the patient upon discharge;
14. Documentation of the patient's follow-up instructions provided to the patient;
15. A discharge summary;
16. If applicable:
   a. Laboratory reports,
   b. Radiologic reports,
   c. Sleep disorder reports,
   d. Diagnostic reports, and
   e. Consultation reports;
17. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual, other than actions taken while providing behavioral health observation/stabilization services; and
18. Documentation of a medication administered to the patient that includes:
   a. The date and time of administration;
   b. The name, strength, dosage, and route of administration;
   c. For a medication administered for pain:
      i. An assessment of the patient's pain before administering the medication, and
      ii. The effect of the medication administered;
   d. For a psychotropic medication:
      i. An assessment of the patient's behavior before administering the psychotropic medication, and
      ii. The effect of the psychotropic medication administered;
   e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication;
   f. Any adverse reaction a patient has to the medication; and
   g. For prepacked or sample medication provided to the patient for self-administration, the name, strength, dosage, amount, route of administration, and expiration date.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1010. Medication Services**

**A.** If an outpatient treatment center provides medication administration or assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication services:
1. Include:
   a. A process for providing information to a patient about medication prescribed for the patient including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and

iv. Potential adverse reactions that could result from not taking the medication as prescribed;
b. Procedures for preventing, responding to, and reporting:
i. A medication error,
ii. An adverse reaction to a medication, or
iii. A medication overdose;
c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner and meets the patient's needs;
d. Procedures for documenting medication administration and assistance in the self-administration of medication;
e. Procedures for assisting a patient in obtaining medication; and
f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. Specify a process for review through the quality management program of:
a. A medication administration error, and
b. An adverse reaction to a medication.

**B.** If an outpatient treatment center provides medication administration, an administrator shall ensure that:
1. Policies and procedures for medication administration:
a. Are reviewed and approved by a medical practitioner;
b. Specify the individuals who may:
i. Order medication, and
ii. Administer medication;
c. Ensure that medication is administered to a patient only as prescribed; and
d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a patient is:
a. Administered in compliance with an order, and
b. Documented in the patient's medical record.

**C.** If an outpatient treatment center provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A patient's medication is stored by the outpatient treatment center;
2. The following assistance is provided to a patient:
a. A reminder when it is time to take the medication;
b. Opening the medication container for the patient;
c. Observing the patient while the patient removes the medication from the container;
d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
i. The patient taking the medication is the individual stated on the medication container label,
ii. The patient is taking the dosage of the medication stated on the medication container label, and
iii. The patient is taking the medication at the time stated on the medication container label; or
e. Observing the patient while the patient takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
b. Includes:
i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a patient is:
a. In compliance with an order, and
b. Documented in the patient's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members;
3. If pharmaceutical services are provided:
a. The pharmaceutical services are provided under the direction of a pharmacist;
b. The pharmaceutical services comply with ARS Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
c. A copy of the pharmacy license is provided to the Department upon request.

**E.** When medication is stored at an outpatient treatment center, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of patients who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the outpatient treatment center's clinical director.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1011. Behavioral Health Services**

**A.** An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:
1. The outpatient treatment center does not provide a behavioral health service the outpatient treatment center is not authorized to provide;
2. The behavioral health services provided by or at the outpatient treatment center:
   a. Are provided under the direction of a behavioral health professional; and
   b. Comply with the requirements:
      i. For behavioral health paraprofessionals and behavioral health technicians in R9-10-115, and
      ii. For an assessment, in subsection (B);
3. A personnel member who provides behavioral health services is at least 18 years old; and
4. If an outpatient treatment center provides behavioral health services to a patient who is less than 18 years of age, the owner and an employee or a volunteer comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.

**B.** An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:
1. Except as provided in subsection (B)(2), a behavioral health assessment for a patient is completed before treatment for the patient is initiated;
2. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the outpatient treatment center or the outpatient treatment center has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission:
   a. The patient's assessment information is reviewed and updated if additional information that affects the patient's assessment is identified, and
   b. The review and update of the patient's assessment information is documented in the patient's medical record within 48 hours after the review is completed;
3. If a behavioral health assessment is conducted by a:
   a. Behavioral health technician or a registered nurse, within 72 hours a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the patient; or
   b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the behavioral health services needed by the patient;
4. A behavioral health assessment:
   a. Documents a patient's:
      i. Presenting issue;
      ii. Substance abuse history;
      iii. Co-occurring disorder;
      iv. Medical condition and history;
      v. Legal history, including:
         (1) Custody,
         (2) Guardianship, and
         (3) Pending litigation;
      vi. Criminal justice record;

vii. Family history;
viii. Behavioral health treatment history; and
ix. Symptoms reported by the patient and referrals needed by the patient, if any;
b. Includes:
i. Recommendations for further assessment or examination of the patient's needs;
ii. The behavioral health services, physical health services, or ancillary services that will be provided to the patient; and
iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
c. Is documented in patient's medical record;
5. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
6. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
7. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;
8. Documentation of the request in subsection (B)(6) and the opportunity in subsection (B)(7) is in the patient's medical record;
9. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;
10. If information in subsection (B)(4)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;
11. Counseling is:
a. Offered as described in the outpatient treatment center's scope of services,
b. Provided according to the frequency and number of hours identified in the patient's assessment, and
c. Provided by a behavioral health professional or a behavioral health technician;
12. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
13. Each counseling session is documented in the patient's medical record to include:
a. The date of the counseling session;
b. The amount of time spent in the counseling session;
c. Whether the counseling was individual counseling, family counseling, or group counseling;
d. The treatment goals addressed in the counseling session; and
e. The signature of the personnel member who provided the counseling and the date signed.

**C.** An administrator of an outpatient treatment center authorized to provide behavioral health services may request to provide any of the following to individuals required to attend by a referring court:
1. DUI screening,
2. DUI education,
3. DUI treatment, or
4. Misdemeanor domestic violence offender treatment.

**D.** An administrator of an outpatient treatment center authorized to provide the services in subsection (C):
1. Shall comply with the requirements for the specific service in 9 A.A.C. 20, and
2. May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1011 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1011 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1012. Behavioral Health Observation/Stabilization Services**

**A.** An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:
1. Behavioral health observation/stabilization services are available 24 hours a day, every calendar day;
2. Behavioral health observation/stabilization services are provided in a designated area that:
a. Is used exclusively for behavioral health observation/stabilization services;

b. Has the space for a patient to receive privacy in treatment and care for personal needs; and
c. For every 15 observation chairs or less, has at least one bathroom that contains:
i. A working sink with running water,
ii. A working toilet that flushes and has a seat,
iii. Toilet tissue,
iv. Soap for hand washing,
v. Paper towels or a mechanical air hand dryer,
vi. Lighting, and
vii. A means of ventilation;

3. If the outpatient treatment center is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age:
a. There is a separate designated area for providing behavioral health observation/stabilization services to individuals under 18 years of age that:
i. Meets the requirements in subsection (B)(2), and
ii. Has floor to ceiling walls that separate the designated area from other areas of the outpatient treatment center;
b. A registered nurse is present in the separate designated area; and
c. A patient under 18 years of age does not share any space, participate in any activity or treatment, or have verbal or visual interaction with a patient 18 years of age or older;
4. A medical practitioner is available;
5. If the medical practitioner present at the outpatient treatment center is a registered nurse practitioner or a physician assistant, a physician is on-call;
6. A registered nurse is present and provides direction for behavioral health observation/stabilization services in the designated area;
7. A nurse monitors each patient at the intervals determined according to subsection (A)(12) and documents the monitoring in the patient's medical record;
8. An individual who arrives at the designated area for behavioral health observation/stabilization services in the outpatient treatment center is screened within 30 minutes after entering the designated area to determine whether the individual is in need of immediate physical health services;
9. If a screening indicates that an individual needs immediate physical health services that the outpatient treatment center is:
a. Able to provide according to the outpatient treatment center's scope of services, the individual is examined by a medical practitioner within 30 minutes after being screened; or
b. Not able to provide, the individual is transferred to a health care institution capable of meeting the individual's immediate physical health needs;
10. If a screening indicates that an individual needs behavioral health observation/stabilization services and the outpatient treatment center has the capabilities to provide the behavioral health observation/stabilization services, the individual is admitted to the designated area for behavioral health observation/stabilization services and may remain in the designated area and receive observation/stabilization services for up to 23 hours and 59 minutes;
11. Before a patient is discharged from the designated area for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be:
a. If the behavioral health observation/stabilization services are provided in a health care institution that also provides inpatient services and is capable of meeting the patient's needs, admitted to the health care institution as an inpatient;
b. Transferred to another health care institution capable of meeting the patient's needs;
c. Provided a referral to another entity capable of meeting the patient's needs; or
d. Discharged and provided patient follow-up instructions;
12. When a patient is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the patient includes the interval for monitoring the patient based on the patient's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the patient;
13. If a patient is not being admitted as an inpatient to a health care institution, before discharging the patient from a designated area for behavioral health observation/stabilization services, a personnel member:
a. Identifies the specific needs of the patient after discharge necessary to assist the patient to function independently;
b. Identifies any resources, including family members, community social services, peer support services, and Regional Behavioral Health Agency staff, that may be available to assist the patient; and
c. Documents the information in subsection (A)(13)(a) and the resources in subsection (A)(13)(b) in the patient's medical record;
14. When a patient is discharged from a designated area for behavioral health observation/stabilization services, a personnel member:
a. Provides the patient with discharge information that includes:
i. The identified specific needs of the patient after discharge, and
ii. Resources that may be available for the patient; and
b. Contacts any resources identified as required in subsection (A)(13)(b);

15. Except as provided in subsection (A)(16), a patient is not re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge from a designated area for behavioral health observation/stabilization services;
16. A patient may be re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge if:
    a. It is at least one hour since the time of the patient's discharge;
    b. A law enforcement officer or the patient's case manager accompanies the patient to the outpatient treatment center;
    c. Based on a screening of the patient, it is determined that re-admission for behavioral health observation/stabilization is necessary for the patient; and
    d. The name of the law enforcement officer or the patient's case manager and the reasons for the determination in subsection (A)(16)(c) are documented in the patient's medical record;
17. A patient admitted for behavioral health observation/stabilization services is provided:
    a. An observation chair; or
    b. A separate piece of equipment for the patient to use to sit or recline that:
        i. Is at least 12 inches from the floor; and
        ii. Has sufficient space around the piece of equipment to allow a personnel member to provide behavioral health services and physical health services, including emergency services, to the patient;
18. If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety, which may include:
    a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services;
    b. Establishing a method to notify the individual when there is an observation chair available;
    c. Referring or providing transportation to the individual to another health care institution;
    d. Assisting the individual to contact the individual's support system; and
    e. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual;
19. Personnel members establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken;
20. The log required in subsection (A)(19) is maintained for at least 12 months after the date of documentation in the log;
21. An observation chair or, as provided in subsection (A)(17)(b), a piece of equipment used by a patient to sit or recline is visible to a personnel member;
22. Except as provided in subsection (A)(23), a patient admitted to receive behavioral health observation/stabilization services is visible to a personnel member;
23. A patient admitted to receive behavioral health observation/stabilization services may use the bathroom and not be visible to a personnel member, if the personnel member:
    a. Determines that the patient is capable of using the bathroom unsupervised,
    b. Is aware of the patient's location, and
    c. Is able to intervene in the patient's actions to ensure the patient's health and safety; and
24. An observation chair:
    a. Effective until July 1, 2015, has space around the observation chair that allows a personnel member to provide behavioral health services and physical health services, including emergency services, to a patient in the observation chair; and
    b. Effective on July 1, 2015, has at least three feet of clear floor space:
        i. On at least two sides of the observation chair, and
        ii. Between the observation chair and any other observation chair.

**B.** An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall:
1. Have a room used for seclusion that complies with requirements for seclusion rooms in R9-10-316, and
2. Comply with the requirements for restraint and seclusion in R9-10-316.

**C.** An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
    a. Cover the process for:
        i. Evaluating a patient previously admitted to the designated area to determine whether the patient is ready for admission to an inpatient setting or discharge, including when to implement the process;
        ii. Contacting other health care institutions that provide behavioral health observation/stabilization services to determine if the patient could be admitted for behavioral health observation/stabilization services in another health care institution, including when to implement the process; and

iii. Ensuring that sufficient personnel members, space, and equipment are available to provide behavioral health observation/stabilization services to patients admitted to receive behavioral health observation/stabilization services; and

b. Establish a maximum capacity of the number of patients for whom the outpatient treatment center is capable of providing behavioral health observation/stabilization services;

2. The outpatient treatment center does not:
   a. Exceed the maximum capacity established by the outpatient treatment center in subsection (C)(1)(b); or
   b. Admit an individual if the outpatient treatment center does not have personnel members, space, and equipment available to provide behavioral health observation/stabilization services to the individual; and
3. Effective on July 1, 2015:
   a. If an admission of an individual causes the outpatient treatment center to exceed the outpatient treatment center's licensed occupancy, the individual is only admitted for behavioral health observation/stabilization services after:
      (i.) A behavioral health professional reviews the individual's screening and determines the admission is an emergency; and
      (ii.) Documents the determination in the individual's medical record; and
   b. The outpatient treatment center's quality management program's plan, required in R9-10-1004(1), includes a method to identify and document each occurrence of exceeding licensed occupancy, to evaluate the occurrences of exceeding licensed occupancy, and to review the actions taken to reduce future occurrences of exceeding licensed occupancy.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1012 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1012 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1013. Court-ordered Evaluation**

An administrator of an outpatient treatment center that is authorized to provide court-ordered evaluation shall comply with the requirements for court-ordered evaluation in A.R.S. Title 36, Chapter 5, Article 4.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1013 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1013 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1014. Court-ordered Treatment**

An administrator of an outpatient treatment center that is authorized to provide court-ordered treatment shall comply with the requirements for court-ordered treatment in A.R.S. Title 36, Chapter 5, Article 5.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1014 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1014 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1015. Clinical Laboratory Services**

An administrator of an outpatient treatment center that is authorized to provide clinical laboratory services shall ensure that:

1. If clinical laboratory services are provided on the premises or at another location, the clinical laboratory services are provided by a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the U.S. Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. 263a, as amended by Public Law 100-578, October 31, 1988; and
2. A clinical laboratory test result is documented in a patient's medical record including:
   a. The name of the clinical laboratory test;
   b. The patient's name;
   c. The date of the clinical laboratory test;
   d. The results of the clinical laboratory test; and
   e. If applicable, any adverse reaction related to or as a result of the clinical laboratory test.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1015 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1015 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1016. Crisis Services**

**A.** An administrator of an outpatient treatment center that is authorized to provide crisis services shall comply with the requirements for behavioral health services in R9-10-1011.

**B.** An administrator of an outpatient treatment center that is authorized to provide crisis services shall ensure that:
1. Crisis services are available during clinical hours of operation;
2. A behavioral health technician, qualified to provide crisis services according to the outpatient treatment center's policies and procedures, is present in the outpatient treatment center during clinical hours of operation; and
3. The following individuals, qualified to provide crisis services according to policies and procedures, are available during clinical hours of operation:
   a. A behavioral health professional,
   b. A medical practitioner, and
   c. A registered nurse.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1016 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1016 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1017. Diagnostic Imaging Services**

An administrator of an outpatient treatment center that is authorized to provide diagnostic imaging services shall:
1. Designate an individual to provide direction for diagnostic imaging services who is a:
   a. Radiologic technologist, certified under A.R.S. Title 32, Chapter 28, Article 2, who has at least 12 months experience in an outpatient treatment center;
   b. Physician; or
   c. Radiologist; and
2. Ensure that:
   a. Diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
   b. A copy of a certificate documenting compliance with subsection (2)(a) is maintained;
   c. Diagnostic imaging services are provided to a patient according to an order that includes:
      i. The patient's name,
      ii. The name of the ordering individual,
      iii. The diagnostic imaging procedure ordered, and
      iv. The reason for the diagnostic imaging procedure;

d. A physician or radiologist interprets the diagnostic image; and
e. A diagnostic imaging patient report is completed that includes:
   i. The patient's name,
   ii. The date of the procedure, and
   iii. A physician's or radiologist's interpretation of the diagnostic image.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1017 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1017 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1018. Dialysis Services**

**A.** In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:
1. "Caregiver" means an individual designated by a patient or a patient's representative to perform self-dialysis in the patient's stead.
2. "Chief clinical officer" means a physician appointed to provide direction for dialysis services provided by an outpatient treatment center.
3. "Long-term care plan" means a written plan of action for a patient with kidney failure that is developed to achieve long-term optimum patient outcome.
4. "Modality" means a method of treatment for kidney failure, including transplant, hemodialysis, and peritoneal dialysis.
5. "Nutritional assessment" means an analysis of a patient's weight, height, lifestyle, medication, mobility, food and fluid intake, and diagnostic procedures to identify conditions and behaviors that indicate whether the patient's nutritional needs are being met.
6. "Patient care plan" means a written document for a patient receiving dialysis that identifies the patient's needs for medical services, nursing services, and health-related services and the process by which the medical services, nursing services, or health-related services will be provided to the patient.
7. "Peritoneal dialysis" means the process of using the peritoneal cavity for removing waste products by fluid exchange.
8. "Psychosocial evaluation" means an analysis of an individual's mental and social conditions to determine the individual's need for social work services.
9. "Reprocessing" means cleaning and sterilizing a dialyzer previously used by a patient so that the dialyzer can be reused by the same patient.
10. "Self-dialysis" means dialysis performed by a patient or a caregiver on the patient's body.
11. "Social worker" means an individual licensed according to A.R.S. Title 32, Chapter 33 to engage in the "practice of social work" as defined in A.R.S. § 32-3251.
12. "Stable means" that a patient's blood pressure, temperature, pulse, respirations, and diagnostic procedure results are within medically recognized acceptable ranges or consistent with the patient's usual medical condition so that medical intervention is not indicated.
13. "Transplant surgeon" means a physician who:
    a. Is board eligible or board certified in general surgery or urology by a professional credentialing board, and
    b. Has at least 12 months of training or experience performing renal transplants and providing care for patients with renal transplants.

**B.** A governing authority of an outpatient treatment center that is authorized to provide dialysis services shall:
1. Ensure that the administrator appointed as required in R9-10-1003(B)(3) has at least 12 months of experience in an outpatient treatment center providing dialysis services; and
2. Appoint a chief clinical officer to direct the dialysis services provided by or at the outpatient treatment center who is a physician who:
   a. Is board eligible or board certified in internal medicine or pediatrics by a professional credentialing board, and
   b. Has at least 12 months of experience or training in providing dialysis services.

**C.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:
1. In addition to the policies and procedures required in R9-10-1003(D), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
   a. Long-term care plans and patient care plans,
   b. Assigning a patient an identification number,
   c. Personnel members' response to a patient's adverse reaction during dialysis, and

d. Personnel members' response to an equipment malfunction during dialysis;

2. A personnel member complies with the requirements in A.R.S. § 36-423 and R9-10-114 for hemodialysis technicians and hemodialysis technician trainees, if applicable;
3. A personnel member completes basic cardiopulmonary resuscitation training specific to the age of the patients receiving dialysis from the outpatient treatment center:
   a. Before providing dialysis services, and
   b. At least once every 12 months after the initial date of employment or volunteer service;
4. A personnel member wears a name badge that displays the individual's first name, job title, and professional license or certification; and
5. At least one registered nurse or medical practitioner is on the premises while a patient receiving dialysis services is on the premises.

**D.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:

1. The premises of the outpatient treatment center where dialysis services are provided complies with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01, that were in effect on the date listed on the building permit or zoning clearance submitted, as required by R9-10-104, as part of the application for approval of the architectural plans and specifications submitted before initial approval of the inclusion of dialysis services in the outpatient treatment center's scope of services;
2. Before a modification of the premises of an outpatient treatment center where dialysis services are provided is made, an application for approval of the architectural plans and specifications of the outpatient treatment center required in R9-10-104(A):
   a. Is submitted to the Department; and
   b. Demonstrates compliance with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01, in effect on the date:
      i. Listed on the building permit or zoning clearance submitted as part of the application for approval of the architectural plans and specifications for the modification, or
      ii. The application for approval of the architectural plans and specifications of the modification of the outpatient treatment center required in R9-10-104(A) is submitted to the Department; and
3. A modification of the outpatient treatment center complies with applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01 in effect on the date:
   a. Listed on the building permit or zoning clearance submitted as part of the application for approval of the architectural plans and specifications for the modification, or
   b. The application for approval of the architectural plans and specifications required in R9-10-104(A) is submitted to the Department.

**E.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that for a patient receiving dialysis services:

1. The dialysis services provided to the patient meet the needs of the patient;
2. A physician:
   a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
   b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;
3. If the patient's medical history and physical examination required in subsection (E)(2) is not performed by the patient's nephrologist, the patient's nephrologist, within 30 calendar days after the date of the medical history and physical examination:
   a. Reviews and authenticates the patient's medical history and physical examination, documents concurrence with the medical history and physical examination, and includes information specific to nephrology; or
   b. Performs a medical history and physical examination that includes information specific to nephrology;
4. The patient's nephrologist or the nephrologist's designee:
   a. Performs a medical history and physical examination on the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center, and
   b. Documents monthly notes related to the patient's progress in the patient's medical record;
5. A registered nurse responsible for the nursing services provided to the patient receiving dialysis services:
   a. Reviews with the patient the results of any diagnostic tests performed on the patient;
   b. Assesses the patient's medical condition before the patient begins receiving hemodialysis and after the patient has received hemodialysis;
   c. If the patient returns to another health care institution after receiving dialysis services at the outpatient treatment center, provides an oral or written notice of information related to the patient's medical condition to the registered nurse responsible for the nursing services provided to the patient at the health care institution or, if there is not a registered nurse responsible, the individual responsible for the medical services, nursing services, or health-related services provided to the patient at the health care institution;
   d. Informs the patient's nephrologist of any changes in the patient's medical condition or needs; and
   e. Documents in the patient's medical record:
      i. Any notice provided as required in subsection (E)(5)(c), and

ii Monthly notes related to the patient's progress;

6. If the patient is not stable, before dialysis is provided to the patient, a nephrologist is notified of the patient's medical condition and dialysis is not provided until the nephrologist provides direction;
7. The patient:
   a. Is under the care of a nephrologist;
   b. Is assigned a patient identification number according to the policy and procedure in subsection (C)(1)(b);
   c. Is identified by a personnel member before beginning dialysis;
   d. Receives the dialysis services ordered for the patient by a medical practitioner;
   e. Is monitored by a personnel member while receiving dialysis at least once every 30 minutes; and
   f. If the outpatient treatment center reprocesses and reuses dialyzers, is informed that the outpatient treatment center reprocesses and reuses dialyzers before beginning hemodialysis;
8. Equipment used for hemodialysis is inspected and tested according to the manufacturer's recommendations or the outpatient treatment center's policies and procedures before being used to provide hemodialysis to a patient;
9. The equipment inspection and testing required in subsection (E)(8) is documented in the patient's medical record;
10. Supplies and equipment used for dialysis services for the patient are used, stored, and discarded according to manufacturer's recommendations;
11. If hemodialysis is provided to the patient, a personnel member:
    a. Inspects the dialyzer before use to ensure that the:
       i. External surface of the dialyzer is clean;
       ii. Dialyzer label is intact and legible;
       iii. Dialyzer, blood port, and dialysate port are free from leaks and cracks or other structural damage; and
       iv. Dialyzer is free of visible blood and other foreign material;
    b. Verifies the order for the dialyzer to ensure the correct dialyzer is used for the correct patient;
    c. Verifies the duration of dialyzer storage based on the type of germicide used or method of sterilization or disinfection used;
    d. If the dialyzer has been reprocessed and is being reused, verifies that the label on the dialyzer includes:
       i. The patient's name and the patient's identification number,
       ii. The number of times the dialyzer has been used in patient treatments,
       iii. The date of the last use of the dialyzer by the patient, and
       iv. The date of the last reprocessing of the dialyzer;
    e. If the patient's name is similar to the name of another patient receiving dialysis in the same outpatient treatment center, informs other personnel members, employees, and volunteers, of the similar names to ensure that the name or other identifying information on the label corresponds to the correct patient; and
    f. Ensures that a patient's vascular access is visible to a personnel member during dialysis;
12. A patient receiving dialysis is visible to a nurse at a location used by nurses to coordinate patients and treatment;
13. If the patient has an adverse reaction during dialysis, a personnel member responds by implementing the policy and procedure required in subsection (C)(1)(c);
14. If the equipment used during the patient's dialysis malfunctions, a personnel member responds by implementing the policy and procedure required in subsection (C)(1)(d); and
15. After a patient's discharge from an outpatient treatment center, the nephrologist responsible for the dialysis services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
    a. A description of the patient's medical condition and the dialysis services provided to the patient, and
    b. The signature of the nephrologist.

**F.** If an outpatient treatment center provides support for self-dialysis services, an administrator shall ensure that:

1. A patient or the patient's caregiver is:
   a. Instructed to use the equipment to perform self-dialysis by a personnel member trained to provide the instruction, and
   b. Monitored in the patient's home to assess the patient's or patient caregiver's ability to use the equipment to perform self-dialysis;
2. Instruction provided to a patient as required in subsection (F)(1)(a) and monitoring in the patient's home as required in subsection (F)(1)(b) is documented in the patient's medical record;
3. All supplies for self-dialysis necessary to meet the needs of the patient are provided to the patient;
4. All equipment necessary to meet the needs of the patient's self-dialysis is provided for the patient and maintained by the outpatient treatment center according to the manufacturer's recommendations;
5. The water used for hemodialysis is tested and treated according to the requirements in subsection (N);
6. Documentation of the self-dialysis maintained by the patient or the patient's caregiver is:
   a. Reviewed to ensure that the patient is receiving continuity of care, and
   b. Placed in the patient's medical record; and
7. If a patient uses self-dialysis and self-administers medication:

a. The medical practitioner responsible for the dialysis services provided to the patient reviews the patient's diagnostic laboratory tests;
b. The patient and the patient's caregiver are informed of any potential:
   i. Side effects of the medication; and
   ii. Hazard to a child having access to the medication and, if applicable, a syringe used to inject the medication; and
c. The patient or the patient's caregiver is:
   i. Taught the route and technique of administration and is able to administer the medication, including injecting the medication;
   ii. Taught and able to perform sterile techniques if the patient or the patient's caregiver will be injecting the medication;
   iii. Provided with instructions for the administration of the medication, including the specific route and technique the patient or the patient's caregiver has been taught to use;
   iv. Able to read and understand the directions for using the medication;
   v. Taught and able to self-monitor the patient's blood pressure; and
   vi. Informed how to store the medication according to the manufacturer's instructions.

**G.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a social worker is employed by the outpatient treatment center to meet the needs of a patient receiving dialysis services including:
1. Conducting an initial psychosocial evaluation of the patient within 30 calendar days after the patient's admission to the outpatient treatment center;
2. Participating in reviewing the patient's need for social work services;
3. Recommending changes in treatment based on the patient's psychosocial evaluation;
4. Assisting the patient and the patient's representative in obtaining and understanding information for making decisions about the medical services provided to the patient;
5. Identifying community agencies and resources and assisting the patient and the patient's representative to utilize the community agencies and resources;
6. Documenting monthly notes related to the patient's progress in the patient's medical record; and
7. Conducting a follow-up psychosocial evaluation of the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center.

**H.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a registered dietitian is employed by the outpatient treatment center to assist a patient receiving dialysis services to meet the patient's nutritional and dietetic needs including:
1. Conducting an initial nutritional assessment of the patient within 30 calendar days after the patient's admission to the outpatient treatment center;
2. Consulting with the patient's nephrologist and recommending a diet to meet the patient's nutritional needs;
3. Providing advice to the patient and the patient's representative regarding a diet prescribed by the patient's nephrologist;
4. Monitoring the patient's adherence and response to a prescribed diet;
5. Reviewing with the patient any diagnostic test performed on the patient that is related to the patient's nutritional or dietetic needs;
6. Documenting monthly notes related to the patient's progress in the patient's medical record; and
7. Conducting a follow-up nutritional assessment of the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center.

**I.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a long-term care plan for each patient:
1. Is developed by a team that includes at least:
   a. The chief clinical officer of the outpatient treatment center;
   b. If the chief clinical officer is not a nephrologist, the patient's nephrologist;
   c. A transplant surgeon or the transplant surgeon's designee;
   d. A registered nurse responsible for nursing services provided to the patient;
   e. A social worker;
   f. A registered dietitian; and
   g. The patient or patient's representative, if the patient or patient's representative chooses to participate in the development of the long-term care plan;
2. Identifies the modality of treatment and dialysis services to be provided to the patient;
3. Is reviewed and approved by the chief clinical officer;
4. Is signed and dated by each personnel member participating in the development of the long-term care plan;
5. Includes documentation signed by the patient or the patient's representative that the patient or the patient's representative was provided an opportunity to participate in the development of the long-term care plan;
6. Is signed and dated by the patient or the patient's representative; and
7. Is reviewed at least once every 12 months by the team in subsection (I)(1) and updated according to the patient's needs.

**J.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a patient care plan for each patient:
1. Is developed by a team that includes at least:

a. The patient's nephrologist;
b. A registered nurse responsible for nursing services provided to the patient;
c. A social worker;
d. A registered dietitian; and
e. The patient or the patient's representative, if the patient or patient's representative chooses to participate in the development of the patient care plan;
2. Includes an assessment of the patient's need for dialysis services;
3. Identifies treatment and treatment goals;
4. Is signed and dated by each personnel member participating in the development of the patient care plan;
5. Includes documentation signed by the patient or the patient's representative that the patient or the patient's representative was provided an opportunity to participate in the development of the patient care plan;
6. Is signed and dated by the patient or the patient's representative;
7. Is implemented;
8. Is evaluated by:
a. The registered nurse responsible for the dialysis services provided to the patient,
b. The registered dietitian providing services to the patient related to the patient's nutritional or dietetic needs, and
c. The social worker providing services to the patient related to the patient's psychosocial needs;
9. Includes documentation of interventions, resolutions, and outcomes related to treatment goals; and
10. Is reviewed and updated according to the needs of the patient:
a. At least once every six months for a patient whose medical condition is stable, and
b. At least once every 30 calendar days for a patient whose medical condition is not stable.

**K.** In addition to the requirements in R9-10-1009(C), an administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a medical record for each patient contains:
1. An annual medical history;
2. An annual physical examination;
3. Monthly notes related to the patient's progress by a medical practitioner, registered dietitian, social worker, and registered nurse;
4. If applicable, documentation of:
a. The equipment inspection and testing required in subsection (E)(9), and
b. The self-dialysis required in subsection (F)(2); and
5. If applicable, documentation of the patient's discharge.

**L.** For a patient who received dialysis services, an administrator shall ensure that after the patient's discharge from an outpatient treatment center that is authorized to provide dialysis services, the nephrologist responsible for the dialysis services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
1. A description of the patient's medical condition and the dialysis services provided to the patient, and
2. The signature of the nephrologist.

**M.** If an outpatient treatment center reuses dialyzers or other dialysis supplies, an administrator shall ensure that the outpatient treatment center complies with the guidelines adopted by the Association for the Advancement of Medical Instrumentation in Reprocessing of Hemodialyzers, ANSI/AAMI RD47:2008/(R)2013, incorporated by reference, available through http://my.aami.org/store/, on file with the Department, and including no future editions or amendments.

**N.** A chief clinical officer shall ensure that the quality of water used in dialysis conforms to the guidelines adopted by the Association for the Advancement of Medical Instrumentation in Dialysis Water and Dialysate Recommendations: A User Guide, incorporated by reference, available through http://my.aami.org/store/, on file with the Department, and including no future editions or amendments.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1018 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1018 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-1019. Emergency Room Services**

An administrator of an outpatient treatment center that is authorized to provide emergency room services shall ensure that:
1. Emergency room services are:
a. Available on the premises:
i. At all times, and

ii. To stabilize an individual's emergency medical condition; and
b. Provided:
i. In a designated area, and
ii. Under the direction of a physician;
2. Clinical laboratory services are available on the premises;
3. Diagnostic imaging services are available on the premises;
4. An area designated for emergency room services complies with the physical plant codes and standards for a freestanding emergency care facility in R9-10-104.01;
5. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that specify requirements for the use of a room used for seclusion that meets the requirements in R9-10-217(D);
6. A physician is present in an area designated for emergency room services;
7. A registered nurse is present in an area designated for emergency room services and provides direction for nursing services in the designated area;
8. The outpatient treatment center has a documented transfer agreement with a general hospital;
9. Emergency room services are provided to an individual, including a woman in active labor, requesting medical services in an emergency;
10. If emergency room services cannot be provided at the outpatient treatment center, measures and procedures are implemented to minimize the risk to the patient until the patient is transferred to the general hospital with which the outpatient treatment center has a transfer agreement as required in subsection (8);
11. There is a chronological log of emergency room services provided to a patient that includes:
a. The patient's name;
b. The date, time, and mode of arrival; and
c. The disposition of the patient, including discharge or transfer; and
12. The chronological log required in subsection (11) is maintained:
a. In the designated area for emergency room services for at least 12 months after the date the emergency room services were provided; and
b. By the outpatient treatment center for a total of at least 24 months after the date the emergency room services were provided.

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**R9-10-1020. Opioid Treatment Services**

**A.** A governing authority of an outpatient treatment center that is authorized to provide opioid treatment services shall:
1. Ensure that the outpatient treatment center obtains certification by the Substance Abuse and Mental Health Services Administration before providing opioid treatment,
2. Maintain a current Substance Abuse and Mental Health Services Administration certificate for the outpatient treatment center on the premises, and
3. Ensure that the administrator appointed as required in R9-10-1003(B)(3) is named on the Substance Abuse and Mental Health Services Administration certificate as the individual responsible for the opioid treatment services provided by or at the outpatient treatment center.

**B.** An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that:
1. In addition to the policies and procedures required in R9-10-1003(D), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
a. Include the criteria for receiving opioid treatment services and address:
i. Comprehensive maintenance treatment consisting of dispensing or administering an opioid agonist treatment medication at stable dosage levels to a patient for a period in excess of 21 calendar days and providing medical and health-related services to the patient, and
ii. Detoxification treatment that occurs over a continuous period of more than 30 calendar days;
b. Include the criteria and procedures for discontinuing opioid treatment services;
c. Address the needs of specific groups of patients, such as patients who:
i. Are pregnant;
ii. Are children;

iii. Have chronic or acute medical conditions such as HIV infection, hepatitis, diabetes, tuberculosis, or cardiovascular disease;
iv. Have a mental disorder;
v. Abuse alcohol or other drugs; or
vi. Are incarcerated or detained;
d. Contain a method of patient identification to ensure the patient receives the opioid treatment services ordered;
e. Contain methods to assess whether a patient is receiving concurrent opioid treatment services from more than one health care institution;
f. Contain methods to ensure that the opioid treatment services provided to a patient by or at the outpatient treatment center meet the patient's needs;
g. Include relapse prevention procedures;
h. Include for laboratory testing:
i. Criteria for the assessment of a patient's opioid agonist blood levels,
ii. Procedures for specimen collection and processing to reduce the risk of fraudulent results, and
iii. Procedures for conducting random drug testing of patients receiving an opioid agonist treatment medication;
i. Include procedures for the response of personnel members to a patient's adverse reaction during opioid treatment; and
j. Include criteria for dispensing one or more doses of an opioid agonist treatment medication to a patient for use off the premises and address:
i. Who may authorize dispensing,
ii. Restrictions on dispensing, and
iii. Information to be provided to a patient or the patient's representative before dispensing;
2. A physician provides direction for the opioid treatment services provided at the outpatient treatment center;
3. If a patient requires administration of an opioid agonist treatment medication as a result of chronic pain, the patient:
a. Receives consultation with or a referral for consultation with a physician or registered nurse practitioner who specializes in chronic pain management, and
b. Is not admitted for opioid treatment services:
i. Unless the patient is physically addicted to an opioid drug, as manifested by the symptoms of withdrawal in the absence of the opioid drug; and
ii. A medical practitioner at the outpatient treatment center coordinates with the physician or registered nurse practitioner who is providing chronic pain management to the patient; and
4. In addition to the requirements in R9-10-1009(C), a medical record for each patient contains:
a. If applicable, documentation of the dispensing of doses of an opioid agonist treatment medication to the patient for use off the premises; and
b. If applicable, documentation of the patient's discharge from receiving opioid treatment services.

**C.** An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that for a patient receiving opioid treatment services:
1. The opioid treatment services provided to the patient meet the needs of the patient;
2. A physician or a medical practitioner under the direction of a physician:
a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;
3. Before receiving opioid treatment, the patient is informed of the following:
a. The progression of opioid addiction and the patient's apparent stage of opioid addiction;
b. The goal and benefits of opioid treatment;
c. The signs and symptoms of overdose and when to seek emergency assistance;
d. The characteristics of opioid agonist treatment medication, including common side-effects and potential interaction effects with other drugs;
e. The requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;
f. Confidentiality requirements;
g. Drug screening and urinalysis procedures;
h. Requirements for dispensing to a patient one or more doses of an opioid agonist treatment medication for use by the patient off the premises;
i. Testing and treatment available for HIV and other communicable diseases; and
j. The patient complaint process;
4. Documentation of the provision of the information specified in subsection (C)(3) is included in the patient's medical record;
5. The patient receives a dose of an opioid agonist treatment medication only on the order of a medical practitioner;

6. The patient begins detoxification treatment only at the request of the patient or according to the outpatient treatment center's policy and procedure for discontinuing opioid treatment services required in subsection (B)(1)(b);
7. If the patient has an adverse reaction during opioid treatment, a personnel member and, if appropriate, a medical practitioner responds by implementing the policy and procedure required in subsection (B)(1)(i);
8. Before the patient's discharge from opioid treatment services, the patient is provided with patient follow-up instructions that:
   a. Include information that may reduce the risk of relapse; and
   b. May include a referral for counseling, support groups, or medication for depression or sleep disorders; and
9. After the patient's discharge from opioid treatment services provided by or at the outpatient treatment center, the medical practitioner responsible for the opioid treatment services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
   a. A description of the patient's medical condition and the opioid treatment services provided to the patient, and
   b. The signature of the medical practitioner.

**D.** An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that an assessment for each patient receiving opioid treatment services:
1. Includes, in addition to the information in R9-10-1010(B):
   a. An assessment of the patient's need for opioid treatment services,
   b. An assessment of the patient's medical conditions that may be affected by opioid treatment,
   c. An assessment of other medications being taken by the patient and conditions that may be affected by opioid treatment, and
   d. A plan to prevent relapse;
2. Identifies the treatment to be provided to the patient and treatment goals; and
3. Specifies whether the patient may receive an opioid agonist treatment medication for use off the premises and, if so, the number of doses that may be dispensed.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1020 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1020 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1021. Pain Management Services**

A medical director of an outpatient treatment center that is authorized to provide pain management services shall ensure that:
1. Pain management services are provided under the direction of:
   a. A physician; or
   b. A nurse practitioner licensed according to A.R.S. Title 32, Chapter 15 with advanced pain management certification from a nationally recognized accreditation or certification entity;
2. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise;
3. If a controlled substance is used to provide pain management services:
   a. A medical practitioner discusses the risks and benefits of using a controlled substance with a patient;
   b. If the controlled substance is an opioid, the outpatient treatment center complies with the requirements in R9-10-2006; and
   c. The following information is included in a patient's medical record:
      i. The patient's history of substance use disorder,
      ii. Documentation of the discussion in subsection (3)(a),
      iii. The nature and intensity of the patient's pain, and
      iv. The objectives used to determine whether the patient is being successfully treated; and
4. If an injection or a nerve block is used to provide pain management services:
   a. Before the injection or nerve block is initially used on a patient, an evaluation of the patient is performed by a physician or nurse anesthetist;
   b. An injection or nerve block is administered by a physician or nurse anesthetist; and
   c. The following information is included in a patient's medical record:
      i. The evaluation of the patient required in subsection (4)(a),
      ii. A record of the administration of the injection or nerve block, and
      iii. Any resuscitation measures taken; and
5. An outpatient treatment center that meets the definition of a pain management clinic in A.R.S. § 36-448.01 and complies with 9 Article 20 of this Chapter.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former

Section R9-10-1021 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1021 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

**R9-10-1022. Physical Health Services**

An administrator of an outpatient treatment center that is authorized to provide physical health services shall ensure that:

1. Medical services provided at or by the outpatient treatment center are provided under the direction of a physician or a registered nurse practitioner,
2. Nursing services provided at or by the outpatient treatment center are provided under the direction of a registered nurse, and
3. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1022 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1022 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1023. Pre-petition Screening**

An administrator of an outpatient treatment center that is authorized to provide pre-petition screening shall comply with the requirements for pre-petition screening in A.R.S. Title 36, Chapter 5, Article 4.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1023 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1023 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1024. Rehabilitation Services**

An administrator shall ensure that if an outpatient treatment center is authorized to provide:

1. Occupational therapy services, an occupational therapist provides direction for the occupational therapy services provided at or by the outpatient treatment center;
2. Physical therapy services, a physical therapist provides direction for the physical therapy services provided at or by the outpatient treatment center; or
3. Speech-language pathology services, a speech-language pathologist provides direction for the speech-language pathology services provided at or by the outpatient treatment center.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). New Section R9-10-1024 adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1024 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1025. Respite Services**

**A.** In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:

1. "Emergency safety response" has the same meaning as in R9-10-701.
2. "Outing" means travel by a child, who is receiving respite services provided by an outpatient treatment center, to a location away from the outpatient treatment center premises or, if applicable, the child's residence for a specific activity.
3. "Parent" means a child's:
   a. Mother or father, or
   b. Legal guardian.

**B.** An administrator of an outpatient treatment center that is authorized to provide respite services shall ensure that:
1. Respite services are not provided in a personnel member's residence unless the personnel member's residence is licensed as a behavioral health respite home;
2. Except for an outpatient treatment center that is authorized to provide respite services for children on the premises, respite services are provided:
   a. In a patient's residence; or
   b. Up to 10 continuous hours in a 24-hour time period while the individual who is receiving the respite services is:
      i. Supervised by a personnel member;
      ii. Awake;
      iii. Except as stated in subsection (B)(3), provided food;
      iv. Allowed to rest;
      v. Provided an opportunity to use the toilet and meet the individual's hygiene needs; and
      vi. Participating in activities in the community but is not in a licensed health care institution or child care facility; and
3. If a child is provided respite services according to subsection (B)(2)(b), the child is provided the appropriate meals or snacks in subsection (J)(1) for the amount of time the child is receiving respite services from the outpatient treatment center.

**C.** If an outpatient treatment center that is authorized to provide respite services for children includes outings in the outpatient treatment center's scope of services, an administrator shall ensure that:
1. Before a personnel member takes a child receiving respite services on an outing, written permission is obtained from the child's parent that includes:
   a. The child's name;
   b. A description of the outing;
   c. The name of the outing destination, if applicable;
   d. The street address and, if available, the telephone number of the outing destination;
   e. Either:
      i. The date or dates of the outing; or
      ii. The time period, not to exceed 12 months, during which the permission is given;
   f. The projected time of departure from the outpatient treatment center or, if applicable, the child's residence;
   g. The projected time of arrival back at the outpatient treatment center or, if applicable, the child's residence; and
   h. The dated signature of the child's parent;
2. Each motor vehicle used on an outing by a personnel member for a child receiving respite services from the outpatient treatment center:
   a. Is maintained in a mechanically safe condition;
   b. Is free from hazards;
   c. Has an operational heating system;
   d. Has an operational air-conditioning system; and
   e. Is equipped with:
      i. A first-aid kit that meets the requirements in subsection (S)(1), and
      ii. Two large, clean towels or blankets;
3. On an outing, a child does not ride in a truck bed, camper, or trailer attached to a motor vehicle;
4. The Department is notified within 24 hours after a motor vehicle accident that involves a child who is receiving respite services while riding in the motor vehicle on an outing; and
5. A personnel member who drives a motor vehicle with children receiving respite services from the outpatient treatment center in the motor vehicle:
   a. Requires that each door be locked before the motor vehicle is set in motion and keeps the doors locked while the motor vehicle is in motion;
   b. Does not permit a child to be seated in front of a motor vehicle's air bag;
   c. Requires that a child remain seated and entirely inside the motor vehicle while the motor vehicle is in motion;
   d. Requires that a child is secured, as required in A.R.S. § 28-907 or A.R.S. § 28-909, before the motor vehicle is set in motion and while the motor vehicle is in motion;
   e. Assists a child into or out of the motor vehicle away from moving traffic at curbside or in a driveway, parking lot, or other location designated for this purpose;
   f. Carries drinking water in an amount sufficient to meet the needs of each child on the outing and a sufficient number of cups or other drinking receptacles so that each child can drink from a different cup or receptacle; and
   g. Accounts for each child while on the outing.

**D.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:

1. Respite services are only provided on the premises for up to 10 continuous hours per day between the hours of 6:00 a.m. and 10:00 p.m.;
2. The specific 10 continuous hours per day during which the outpatient treatment center provides respite services on the premises is stated in the outpatient treatment center's hours of operation that is submitted as part of the outpatient treatment center's license application and according to R9-10-1002(D);
3. A personnel member, who is expected to provide respite services eight or more hours a week, complies with the requirements for tuberculosis screening in R9-10-113;
4. At least one personnel member who has current training in first aid and cardiopulmonary resuscitation is available on the premises when a child is receiving respite services on the premises;
5. At least one personnel member who has completed training in crisis intervention according to R9-10-716(F) is available on the premises when a child is receiving respite services on the premises;
6. A personnel member does not use or possess any of the following items when a child receiving respite services is on the premises:
   a. A controlled substance as listed in A.R.S. Title 36, Chapter 27, Article 2, except where used as a prescription medication in the manner prescribed;
   b. A dangerous drug as defined in A.R.S. § 13-3401, except where used as a prescription medication in the manner prescribed;
   c. A prescription medication as defined in A.R.S. § 32-1901, except where used in the manner prescribed; or
   d. A firearm as defined in A.R.S. § 13-105;
7. An unannounced fire and emergency evacuation drill is conducted at least once a month, and at different times of the day, and each personnel member providing respite services for children on the premises and each child receiving respite services on the premises participates in the fire and emergency evacuation drill;
8. Each fire and emergency evacuation drill is documented, and the documentation is maintained for at least 12 months after the date of the fire and emergency evacuation drill;
9. Before a child receives respite services on the premises of the outpatient treatment center, in addition to the requirements in R9-10-1009, the following information is obtained and maintained in the child's medical record;
   a. The name, home address, city, state, zip code, and contact telephone number of each parent of the child;
   b. The name and contact telephone number of at least two additional individuals authorized by the child's parent to collect the child from the outpatient treatment center;
   c. The name and contact telephone number of the child's health care provider;
   d. The written authorization for emergency medical care of the child when the parent cannot be contacted at the time of an emergency;
   e. The name of the individual to be contacted in case of injury or sudden illness of the child;
   f. If applicable, a description of any dietary restrictions or needs due to a medical condition or diagnosed food sensitivity or allergy;
   g. A written record completed by the child's parent or health care provider noting the child's susceptibility to illness, physical conditions of which a personnel member should be aware, and any specific requirements for health maintenance; and
10. Documentation is obtained and maintained in the child's medical record each time the child receives respite services on the premises that includes:
    a. The date and time of each admission to and discharge from receiving respite services; and
    b. A signature, which contains at least a first initial of a first name and the last name of the child's parent or other individual designated by the child's parent, each time the child is admitted or discharged from receiving respite services on the premises;
11. Policies and procedures are developed, documented, and implemented to ensure that the identity of an individual is known to a personnel member or is verified with picture identification before the personnel member discharges a child to the individual;
12. A child is not discharged to an individual other than the child's parent or other individual designated according to subsection (D)(9)(b), except:
    a. When the child's parent authorizes the administrator by telephone or electronic means to release the child to an individual not so designated, and
    b. The administrator can verify the telephone or electronic authorization using a means of verification that has been agreed to by the administrator and the child's parent and documented in the child's medical record; and
13. The number of personnel members providing respite services for children on the premises is determined by the needs of the children present, with a minimum of at least:
    a. One personnel member providing supervision for every five children receiving respite services on the premises; and
    b. Two personnel members on the premises when a child is receiving respite services on the premises.

**E.** If swimming activities are conducted at a swimming pool for a child receiving respite services on the premises of an outpatient treatment center, an administrator shall ensure that there is an individual at the swimming pool on the premises who has current lifeguard

certification that includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation. If the individual is a personnel member, the personnel member cannot be counted in the personnel member-to-children ratio required by subsection (D)(13).

**F.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that in each area designated for providing respite services:

1. Drinking water is provided sufficient for the needs of and accessible to each child in both indoor and outdoor areas;
2. Indoor areas used by children are decorated with age-appropriate articles such as bulletin boards, pictures, and posters;
3. Storage space is provided for indoor and outdoor toys, materials, and equipment in areas accessible to children;
4. Clean clothing is available to a child when the child needs a change of clothing;
5. At least one indoor area in the outpatient treatment center where respite services are provided for children is equipped with at least one cot or mat, a sheet, and a blanket, where a child can rest quietly away from the other children;
6. Except as provided in subsection (AA)(2)(a), outdoor or large muscle development activities are scheduled to allow not less than 75 square feet for each child occupying the outdoor area or indoor area substituted for outdoor area at any time;
7. The premises, including the buildings, are maintained free from hazards;
8. Toys and play equipment, required in this Section, are maintained:
   a. Free from hazards, and
   b. In a condition that allows the toy or play equipment to be used for the original purpose of the toy or play equipment;
9. Temperatures are maintained between 70° F and 84° F in each room or indoor area used by children;
10. Except when a child is napping or sleeping or for a child who has a sensory issue documented in the child's behavioral health assessment, each room or area used by a child is maintained at a minimum of 30 foot candles of illumination;
11. When a child is napping or sleeping in a room, the room is maintained at a minimum of five foot candles of illumination;
12. Each child's toothbrush, comb, washcloth, and cloth towel that are provided for the child's use by the child's parent are maintained in a clean condition and stored in an identified space separate from those of other children;
13. Except as provided in subsection (F)(14), the following are stored separate from food storage areas and are inaccessible to a child:
    a. All materials and chemicals labeled as a toxic or flammable substance;
    b. All substances that have a child warning label and may be a hazard to a child; and
    c. Lawn mowers, ladders, toilet brushes, plungers, and other equipment that may be a hazard to a child;
14. Hand sanitizers:
    a. When being stored, are stored separate from food storage areas and are inaccessible to children; and
    b. When being provided for use, are accessible to children; and
15. Except when used as part of an activity, the following are stored in an area inaccessible to a child:
    a. Garden tools, such as a rake, trowel, and shovel; and
    b. Cleaning equipment and supplies, such as a mop and mop bucket.

**G.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that a personnel member:

1. Supervises each child at all times;
2. Does not smoke or use tobacco:
   a. In any area where respite services may be provided for a child, or
   b. When transporting or transferring a child;
3. Except for a child who can change the child's own clothing, changes a child's clothing when wet or soiled;
4. Empties clothing soiled with feces into a toilet without rinsing;
5. Places a child's soiled clothing in a plastic bag labeled with the child's name, stores the clothing in a container used for this purpose, and sends the clothing home with the child's parent;
6. Prepares and posts in each indoor area, before the first child arrives to receive respite services that day, a current schedule of age-appropriate activities that meet the needs of the children receiving respite services that day, including the times the following are provided:
   a. Meals and snacks,
   b. Naps,
   c. Indoor activities,
   d. Outdoor or large muscle development activities,
   e. Quiet and active activities,
   f. Personnel member-directed activities,
   g. Self-directed activities, and
   h. Activities that develop small muscles;
7. Provides activities and opportunities, consistent with a child's behavioral health assessment, for each child to:
   a. Gain a positive self-concept;
   b. Develop and practice social skills;
   c. Acquire communication skills;
   d. Participate in large muscle physical activity;

e. Develop habits that meet health, safety, and nutritional needs;
f. Express creativity;
g. Learn to respect cultural diversity of children and staff;
h. Learn self-help skills; and
i. Develop a sense of responsibility and independence;

8. Implements the schedule in subsection (G)(6);
9. If an activity on the schedule in subsection (G)(6) is not implemented, writes on the schedule the activity that was not implemented and what activity was substituted;
10. Ensures that each indoor area has a supply of age-appropriate toys, materials, and equipment, necessary to implement the schedule required in subsection (G)(6), in a quantity sufficient for the number of children receiving respite services at the outpatient treatment center that day, including:
    a. Art and crafts supplies;
    b. Books;
    c. Balls;
    d. Puzzles, blocks, and toys to enhance manipulative skills;
    e. Creative play toys;
    f. Musical instruments; and
    g. Indoor and outdoor equipment to enhance large muscle development;
11. Does the following when a parent permits or asks a personnel member to apply personal products, such as petroleum jelly, diaper rash ointments, sun screen or sun block preparations, toothpaste, and baby diapering preparations on the parent's child:
    a. Obtains the child's personal products and written approval for use of the personal products from the child's parent;
    b. Labels the personal products with the child's name; and
    c. Keeps the personal products inaccessible to children; and
12. Monitors a child for overheating or overexposure to the sun.

**H.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises and includes in the outpatient treatment center's scope of respite services for children wearing diapers shall ensure that there is a diaper changing space in the area designated for providing respite services for children that contains:

1. A nonabsorbent, sanitizable diaper changing surface that is:
    a. Seamless and smooth, and
    b. Kept clear of items not required for diaper changing;
2. A hand-washing sink adjacent to the diaper changing surface, for a personnel member's use when changing diapers and for washing a child during or after diapering, that provides:
    a. Running water,
    b. Soap from a dispenser, and
    c. Single-use paper hand towels from a dispenser;
3. At least one waterproof, sanitizable container with a waterproof liner and a tight-fitting lid for soiled diapers; and
4. At least one waterproof, sanitizable container with a waterproof liner and a tight-fitting lid for soiled clothing.

**I.** In a diaper changing space, an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:

1. A diaper changing procedure is established, documented, and implemented that states that a child's diaper is changed as soon as it is soiled and that a personnel member when diapering:
    a. Washes and dries the child, using a separate wash cloth and towel only once for each child;
    b. If applicable, applies the child's individual personal products labeled with the child's name;
    c. Uses single-use non-porous gloves;
    d. Washes the personnel member's own hands with soap and running water according to the requirements in R9-10-1028(5);
    e. Washes each child's hands with soap and running water after each diaper change; and
    f. Cleans, sanitizes, and dries the diaper changing surface following each diaper change; and
2. A personnel member:
    a. Removes disposable diapers and disposable training pants from a diaper changing space as needed or at least twice every 24 hours to a waste receptacle outside the building; and
    b. Does not:
        i. Permit a bottle, formula, food, eating utensil, or food preparation in a diaper changing space;
        ii. Draw water for human consumption from the hand-washing sink adjacent to a diaper changing surface, required in subsection (H)(2); or
        iii. If responsible for food preparation, change diapers until food preparation duties have been completed for the day.

**J.** Except as provided in subsection (K)(3), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:

1. Serve the following meals or snacks to a child receiving respite services on the premises:

a. For the following periods of time:
i. Two to four hours, one or more snacks;
ii. Four to eight hours, one or more snacks and one or more meals; and
iii. More than eight hours, two snacks and one or more meals;
b. Make breakfast available to a child receiving respite services on the premises before 8:00 a.m.;
c. Serve lunch to a child who is receiving respite services on the premises between 11:00 a.m. through 1:00 p.m.; and
d. Serve dinner to a child who is receiving respite services on the premises from 5:00 p.m. through 7:00 p.m. and who will remain on the premises after 7:00 p.m.;
2. Ensure that a meal or snack provided by the outpatient treatment center meets the meal pattern requirements in Table 10.1; and
3. If the outpatient treatment center provides a meal or snack to a child:
a. Make a second serving of a food component of a provided snack or meal available to a child who requests a second serving, and
b. Substitute a food that is equivalent to a specific food component if a requested second serving of a specific food component is not available.

**K.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:
1. May serve food provided for a child by the child's parent;
2. If a child's parent does not provide a sufficient number of meals or snacks to meet the requirements in subsection (J)(1), shall supplement, according to the requirements in Table 10.1, the meals or snacks provided by the child's parent; and
3. If applicable, shall serve food to a child at the times and in quantities consistent with the information documented according to subsection (D)(9)(f) for the child and the child's behavioral health assessment, to meet the child's dietary and nutritional needs.

**L.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises that has a respite capacity of more than 10 shall obtain a food establishment license or permit according to the requirements in 9 A.A.C. 8, Article 1, and, if applicable, maintain documentation of the current food establishment license or permit.

**M.** If an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises serves food to a child receiving respite services on the premises that is not prepared by the outpatient treatment center or provided by the child's parent, the administrator shall ensure that the food was prepared by a food establishment, as defined according to A.A.C. R9-8-101.

**N.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. Children, except infants and children who cannot wash their own hands, wash their hands with soap and running water before and after handling or eating food;
2. A personnel member:
a. Washes the hands of an infant or a child who cannot wash the child's own hands before and after the infant or child handles or eats food, using:
i. A washcloth,
ii. A single-use paper towel, or
iii. Soap and running water; and
b. If using a washcloth, uses each washcloth on only one child and only one time before it is laundered or discarded;
3. Non-single-use utensils and equipment used in preparing, eating, or drinking food are:
a. After each use:
i. Washed in an automatic dishwasher and air dried or heat dried; or
ii. Washed in hot soapy water, rinsed in clean water, sanitized, and air dried or heat dried; and
b. Stored in a clean area protected from contamination;
4. Single-use utensils and equipment are disposed of after being used;
5. Perishable foods are covered and stored in a refrigerator at a temperature of 41° F or less;
6. A refrigerator at the outpatient treatment center maintains a temperature of 41° F or less, as shown by a thermometer kept in the refrigerator at all times;
7. A freezer at the outpatient treatment center maintains a temperature of 0° F or less, as shown by a thermometer kept in the freezer at all times; and
8. Foods are prepared as close as possible to serving time and, if prepared in advance, are either:
a. Cold held at a temperature of 45° F or less or hot held at a temperature of 130° F or more until served, or
b. Cold held at a temperature of 45° F or less and then reheated to a temperature of at least 165° F before being served.

**O.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:
1. May allow a personnel member to separate a child who is receiving respite services on the premises from other children for unacceptable behavior for no longer than three minutes after the child has regained self-control, but not more than 10 minutes without the personnel member interacting with the child, consistent with the child's behavioral health assessment;
2. Shall ensure that:
a. A personnel member, consistent with the child's behavioral health assessment:
i. Defines and maintains consistent and reasonable guidelines and limitations for a child's behavior;
ii. Teaches, models, and encourages orderly conduct, personal control, and age-appropriate behavior; and

iii. Explains to a child why a particular behavior is not allowed, suggests an alternative, and assists the child to become engaged in an alternative activity;

b. An emergency safety response is:
   i. Only used:
      (1) By a personnel member trained according to R9-10-716(F)(1) to use an emergency safety response,
      (2) For the management of a child's violent or self-destructive behavior, and
      (3) When less restrictive interventions have been determined to be ineffective; and
   ii. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;

c. If an emergency safety response was used for a child, a personnel member, when the child is discharged to the child's parent:
   i. Notifies the child's parent of the use of the emergency safety response for the child and the behavior, event, or environmental factor that caused the need for the emergency safety response; and
   ii. Documents in the child's medical record that the child's parent was notified of the use of the emergency safety response;

d. Within 24 hours after an emergency safety response is used for a child receiving respite services on the premises, the following information is entered into the child's medical record:
   i. The date and time the emergency safety response was used;
   ii. The name of each personnel member who used an emergency safety response;
   iii. The specific emergency safety response used;
   iv. The behavior, event, or environmental factor that caused the need for the emergency safety response; and
   v. Any injury that resulted from the use of the emergency safety response;

e. Within 10 working days after an emergency safety response is used for a child receiving respite services on the premises, a behavioral health professional reviews the information in subsection (O)(2)(d) and documents the review in the child's medical record;

f. After the review required in subsection (O)(2)(e), the following information is entered into the child's medical record:
   i. Actions taken or planned to prevent the need for a subsequent use of an emergency safety response for the child,
   ii. A determination of whether the child is appropriately placed at the outpatient treatment center providing respite services for children on the premises, and
   iii. Whether the child's treatment plan was reviewed or needs to be reviewed and amended to ensure that the child's treatment plan is meeting the child's treatment needs;

g. Emergency safety response training is documented according to the requirements in R9-10-716(F)(2); and

h. Materials used for emergency safety response training are maintained according to the requirements in R9-10-716(F)(3); and

3. A personnel member does not use or permit:
   a. A method of discipline that could cause harm to the health, safety, or welfare of a child;
   b. Corporal punishment;
   c. Abusive language;
   d. Discipline associated with:
      i. Eating, napping, sleeping, or toileting;
      ii. Medication; or
      iii. Mechanical restraint; or
   e. Discipline administered to any child by another child.

**P.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:

1. Provide each child who naps or sleeps on the premises with a separate cot or mat and ensure that:
   a. A cot or mat used by the child accommodates the child's height and weight;
   b. A personnel member covers each cot or mat with a clean sheet that is laundered when soiled, or at least once every seven days and before use by a different child;
   c. A clean blanket or sheet is available for each child;
   d. A rug, carpet, blanket, or towel is not used as a mat; and
   e. Each cot or mat is maintained in a clean and repaired condition;
2. Not use bunk beds or waterbed mattresses for a child receiving respite services;
3. Provide an unobstructed passageway at least 18 inches wide between each row of cots or mats to allow a personnel member access to each child;
4. Ensure that if a child naps or sleeps while receiving respite services at the outpatient treatment center, the administrator:
   a. Does not permit the child to lie in direct contact with the floor while napping or sleeping;
   b. Prohibits the operation of a television in a room where the child is napping or sleeping; and
   c. Requires that a personnel member remain awake while supervising the napping or sleeping child; and
5. Ensure that storage space is provided on the premises for cots, mats, sheets, and blankets, that is:

a. Accessible to an area used for napping or sleeping; and
b. Separate from food service and preparation areas, toilet rooms, and laundry rooms.

**Q.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall, in the area of the premises where the respite services are provided:
1. Maintain the premises and furnishings:
   a. Free of insects and vermin,
   b. In a clean condition, and
   c. Free from odor; and
2. Ensure that:
   a. Floor coverings are:
      i. Clean; and
      ii. Free from:
         (1) Dampness,
         (2) Odors, and
         (3) Hazards;
   b. Toilet bowls, lavatory fixtures, and floors in toilet rooms and kitchens are cleaned and sanitized as often as necessary to maintain them in a clean and sanitized condition or at least once every 24 hours;
   c. Each toilet room used by children receiving respite services on the premises contains, within easy reach of children:
      i. Mounted toilet tissue;
      ii. A sink with running water;
      iii. Soap contained in a dispenser; and
      iv. Disposable, single-use paper towels, in a mounted dispenser, or a mechanical hand dryer;
   d. Personnel members wash their hands with soap and running water after toileting;
   e. A child's hands are washed with soap and running water after toileting;
   f. Except for a cup or receptacle used only for water, food waste is stored in a covered container and the container is clean and lined with a plastic bag;
   g. Food waste and other refuse is removed from the area of the premises where respite services are provided for children at least once every 24 hours or more often as necessary to maintain a clean condition and avoid odors;
   h. A personnel member or a child does not draw water for human consumption from a toilet room hand-washing sink;
   i. Toys, materials, and equipment are maintained in a clean condition;
   j. Plumbing fixtures are maintained in a clean and working condition; and
   k. Chipped or cracked sinks and toilets are replaced or repaired.

**R.** If laundry belonging to an outpatient treatment center providing respite services for children on the premises is done on the premises, an administrator shall:
1. Not use a kitchen or food storage area for sorting, handling, washing, or drying laundry;
2. Locate the laundry equipment in an area that is separate from areas used by children and inaccessible to children;
3. Not permit a child to be in a laundry room or use a laundry area as a passageway for children; and
4. Ensure that laundry soiled by vomitus, urine, feces, blood, or other body fluid is stored, cleaned, and sanitized separately from other laundry.

**S.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that there is a first aid kit in the designated area of the outpatient treatment center where respite services are provided that:
1. Contains first aid supplies in a quantity sufficient to meet the needs of the children receiving respite services, including the following:
   a. Sterile bandages including:
      i. Self-adhering bandages of assorted sizes,
      ii. Sterile gauze pads, and
      iii. Sterile gauze rolls;
   b. Antiseptic solution or sealed antiseptic wipes;
   c. A pair of scissors;
   d. Self-adhering tape;
   e. Single-use, non-porous gloves; and
   f. Reclosable plastic bags of at least one-gallon size; and
2. Is accessible to personnel members but inaccessible to children receiving respite services on the premises.

**T.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:
1. Prepare and date a written fire and emergency plan that contains:
   a. The location of the first aid kit;
   b. The names of personnel members who have first aid training;
   c. The names of personnel members who have cardiopulmonary resuscitation training;
   d. The directions for:

i. Initiating notification of a child's parent by telephone or other equally expeditious means within 60 minutes after a fire or emergency; and
ii. Providing written notification to the child's parent within 24 hours after a fire or emergency; and

e. The outpatient treatment center's street address and the emergency telephone numbers for the local fire department, police department, ambulance service, and poison control center;

2. Maintain the plan required in subsection (T)(1) in the area designated for providing respite services;
3. Post the plan required in subsection (T)(1) in any indoor area where respite services are provided that does not have an operable telephone service or two-way voice communication system that connects the indoor area where respite services are provided with an individual who has direct access to an in-and-out operable telephone services; and
4. Update the plan in subsection (T)(1) at least once every 12 months after the date of initial preparation of the plan or when any information changes.

**U.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall in the area designated for providing respite services:

1. Post, near a room's designated exit, a building evacuation plan that details the designated exits from the room and the facility where the outpatient treatment center is located; and
2. Maintain and use a communication system that contains:
   a. A direct-access, in-and-out, operating telephone service in the area where respite services are provided; or
   b. A two-way voice communication system that connects the area where respite services are provided with an individual who has direct access to an in-and-out, operating telephone service.

**V.** If, while receiving respite services at an outpatient treatment center authorized to provide respite services for children on the premises, a child has an accident, injury, or emergency that, based on an evaluation by a personnel member, requires medical treatment by a health care provider, an administrator shall ensure that a personnel member:

1. Notifies the child's parent immediately after the accident, injury, or emergency;
2. Documents:
   a. A description of the accident, injury, or emergency, including the date, time, and location of the accident, injury, or emergency;
   b. The method used to notify the child's parent; and
   c. The time the child's parent was notified; and
3. Maintains the documentation required in subsection (V)(2) for at least 12 months after the date the child last received respite services on the outpatient treatment center's premises.

**W.** If a parent of a child who received respite services at an outpatient treatment center authorized to provide respite services for children on the premises informs a personnel member that the child's parent obtained medical treatment for the child from a health care provider for an accident, injury, or emergency the child had while on the premises, an administrator shall ensure that a personnel member:

1. Documents any information about the child's accident, injury, or emergency received from the child's parent; and
2. Maintains the documentation required in subsection (W)(1) for at least 12 months after the date the child last received respite services on the outpatient treatment center's premises.

**X.** If a child exhibits signs of illness or infestation at an outpatient treatment center authorized to provide respite services for children on the premises, an administrator shall ensure that a personnel member:

1. Immediately separates the child from other children,
2. Immediately notifies the child's parent by telephone or other expeditious means to arrange for the child's discharge from the outpatient treatment center,
3. Documents the notification required in subsection (X)(2), and
4. Maintains documentation of the notification required in subsection (X)(3) for at least 12 months after the date of the notification.

**Y.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall comply with the following physical plant requirements:

1. Toilets and hand-washing sinks are available to children in the area designated for providing respite services or on the premises as follows:
   a. At least one flush toilet and one hand-washing sink for 10 or fewer children;
   b. At least two flush toilets and two hand-washing sinks for 11 to 25 children; and
   c. At least one flush toilet and one hand-washing sink for each additional 20 children;
2. A hand-washing sink provides running water with a drain connected to a sanitary sewer as defined in A.R.S. § 45-101;
3. A glass mirror, window, or other glass surface that is located within 36 inches of the floor is made of safety glass that has been manufactured, fabricated, or treated to prevent the glass from shattering or flying when struck or broken, or is shielded by a barrier to prevent impact by or physical injury to a child; and
4. There is at least 30 square feet of unobstructed indoor space for each child who may be receiving respite services on the premises, which excludes floor space occupied by:
   a. The interior walls;

b. A kitchen, a bathroom, a closet, a hallway, a stair, an entryway, an office, an area designated for isolating a child from other children, a storage room, or a room or floor space designated for the sole use of personnel members;
c. Room space occupied by desks, file cabinets, storage cabinets, or hand-washing sinks for a personnel member's use; or
d. Indoor area that is substituted for required outdoor area.

**Z.** An administrator of an outpatient treatment center authorized to provide respite services for children on the premises shall ensure that, in addition to the policies and procedures required in this Article, policies and procedures are established, documented, and implemented for the children's use of a toilet and hand-washing sink that ensure the children's health and safety and include:
1. Supervision requirements for children using the toilet, based on a child's age, gender, and behavioral health issue; and
2. If the outpatient treatment center does not have a toilet and hand-washing sink available for the exclusive use of children receiving respite services, a method to ensure that an individual, other than a child receiving respite services or a personnel member providing respite services, is not present in the toilet and hand-washing sink area when a child receiving respite services is present in the toilet and hand-washing sink area.

**AA.** To provide activities that develop large muscles and an opportunity to participate in structured large muscle physical activities, an administrator of an outpatient treatment center authorized to provide respite services for children on the premises shall:
1. Provide at least 75 square feet of outdoor area per child for at least 50% of the outpatient treatment center's respite capacity; or
2. Comply with one of the following:
a. If no child receives respite services on the premises for more than four hours per day, provide at least 50 square feet of indoor area for each child, based on the outpatient treatment center's respite capacity;
b. If a child receives respite services on the premises for more than four hours but less than six hours per day, provide at least 75 square feet of indoor area per child for at least 50% of the outpatient treatment center's respite capacity, in addition to the indoor area required in subsection (Y)(4); or
c. Provide at least 37.5 square feet of outdoor area and 37.5 square feet of indoor area per child for at least 50% of the outpatient treatment center's respite capacity, in addition to the activity area required in subsection (Y)(4).

**BB.** If an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises is substituting indoor area for outdoor area, the administrator shall:
1. Designate, on the site plan and the floor plan submitted with the license application or a request for an intended change or modification, the indoor area that is being substituted for an outdoor area; and
2. In the indoor area substituted for outdoor area, install and maintain a mat or pad designed to provide impact protection in the fall zone of indoor swings and climbing equipment.

**CC.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. An outdoor area used by children receiving respite services:
a. Is enclosed by a fence:
i. A minimum of 4.0 feet high,
ii. Secured to the ground, and
iii. With either vertical or horizontal open spaces on the fence or gate that do not exceed 4.0 inches;
b. Is maintained free from hazards, such as exposed concrete footings and broken toys; and
c. Has gates that are kept closed while a child is in the outdoor area;
2. The following is provided and maintained within the fall zones of swings and climbing equipment in an outdoor area:
a. A shock-absorbing unitary surfacing material manufactured for such use in outdoor activity areas; or
b. A minimum depth of 6.0 inches of a nonhazardous, resilient material such as fine loose sand or wood chips;
3. Hard surfacing material such as asphalt or concrete is not installed or used under swings or climbing equipment unless used as a base for shock-absorbing unitary surfacing material;
4. A swing or climbing equipment is not located in the fall zone of another swing or climbing equipment; and
5. A shaded area for each child occupying an outdoor area at any time of the day is provided.

**DD.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall install and maintain a portable, pressurized fire extinguisher that meets, at a minimum, a 2A-10-BC rating of the Underwriters Laboratories in an outpatient treatment center's kitchen and any other location required for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01.

**EE.** In addition to the requirements in R9-10-1029(F), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. Combustible material, such as paper, boxes, or rags, is not permitted to accumulate inside or outside the premises;
2. An unvented or open-flame space heater or portable heater is not used on the premises;
3. A gas valve on an unused gas outlet is removed and capped where it emerges from the wall or floor;
4. Heating and cooling equipment is inaccessible to a child;
5. Fans are mounted and inaccessible to a child;
6. Toilet rooms are ventilated to the outside of the building, either by a screened window open to the outside air or by an exhaust fan and duct system that is operated when the toilet room is in use;
7. A toilet room with a door that opens to the exterior of a building is equipped with a self-closing device that keeps the door closed except when an individual is entering or exiting; and

8. A toilet room door does not open into a kitchen or laundry.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1025 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1025 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Sequential numbering corrections made under subsection R9-10-1025(G) at the request of the Department of Health Services on June 27, 2016; file number M16-185 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**Table 10.1 Meal Pattern Requirements for Children**

**Meal Pattern Requirements for Children**

| Food Components | Ages 1 through 2 years | Ages 3 through 5 years | Ages 6 and older |
|---|---|---|---|
| Breakfast: | | | |
| 1. Milk, fluid | 1/2 cup | 3/4 cup | 1 cup |
| 2. Vegetable, fruit, or full-strength juice | 1/4 cup | 1/2 cup | 1/2 cup |
| 3. Bread and bread alternates (whole grain or enriched): | | | |
| Bread | 1/2 slice | 1/2 slice | 1 slice |
| or cornbread, rolls, muffins, or biscuits | 1/2 serving | 1/2 serving | 1 serving |
| or cold dry cereal (volume or weight, whichever is less) | 1/4 cup | 1/3 cup | 3/4 cup |
| or cooked cereal, pasta, noodle products, or cereal grains | 1/4 cup | 1/4 cup | 1/2 cup |
| Lunch or Supper: | | | |
| 1. Milk, fluid | 1/2 cup | 3/4 cup | 1 cup |
| 2. Vegetable and/or fruit (2 or more kinds) | 1/4 cup total | 1/2 cup total | 3/4 cup total |
| 3. Bread and bread alternates (whole grain or enriched): | | | |
| Bread | 1/2 slice | 1/2 slice | 1 slice |
| or cornbread, rolls, muffins, or biscuits | 1/2 serving | 1/2 serving | 1 serving |
| or cold dry cereal (volume or weight, whichever is less) | 1/4 cup | 1/3 cup | 3/4 cup |
| or cooked cereal, pasta, noodle products, or cereal grains | 1/4 cup | 1/4 cup | 1/2 cup |
| 4. Meat or meat alternates: | | | |
| Lean meat, fish, or poultry (edible portion as served) | 1 oz. | 1 1/2 oz. | 2 oz. |
| or cheese | 1 oz. | 1 1/2 oz. | 2 oz. |
| or egg | 1/2 egg | 3/4 egg | 1 egg |
| or cooked dry beans or peas* | 1/4 cup | 3/8 cup | 1/2 cup |
| or peanut butter, soy nut butter, or other nut or seed butters | 2 tbsp.** | 3 tbsp.** | 4 tbsp.** |
| or peanuts, soy nuts, tree nuts, or seeds | 1/2 oz.** | 3/4 oz.** | 1 oz.** |
| or an equivalent quantity of any combination of the above meat/meat alternates | | | |
| or yogurt | 4 oz. | 6 oz. | 8 oz. |
| Lunch or Supper: | | | |
| 1. Milk, fluid | 1/2 cup | 1/2 cup | 1 cup |
| 2. Vegetable and/or fruit (2 or more kinds) | 1/2 cup | 1/2 cup | 3/4 cup |
| 3. Bread and bread alternates (whole grain or enriched): | | | |
| Bread | 1/2 slice | 1/2 slice | 1 slice |
| or cornbread, rolls, muffins, or biscuits | 1/2 serving | 1/2 serving | 1 serving |
| or cold dry cereal (volume or weight, whichever is less) | 1/4 cup | 1/3 cup | 3/4 cup |
| or cooked cereal, pasta, noodle products, or cereal grains | 1/4 cup | 1/4 cup | 1/2 cup |
| 4. Meat or meat alternates: | | | |
| Lean meat, fish, or poultry (edible portion as served) | 1/2 oz. | 1/2 oz. | 1 oz. |
| or cheese | 1/2 oz. | 1/2 oz. | 1 oz. |
| or egg | 1/2 egg | 1/2 egg | 1/2 egg |
| or cooked dry beans or peas* | 1/8 cup | 1/8 cup | 1/4 cup |
| or peanut butter, soy nut butter, or other nut or seed butters | 1 tbsp. | 1 tbsp. | 2 tbsp. |
| or peanuts, soy nuts, tree nuts, or seeds | 1/2 oz. | 1/2 oz. | 1 oz. |
| or an equivalent quantity of any combination of the above meat/meat alternates | | | |
| or yogurt | 2 oz. | 2 oz. | 4 oz. |

* In the same meal service, dried beans or dried peas may be used as a meat alternate or as a vegetable; however, such use does not satisfy the requirement for both components.

** At lunch and supper, no more than 50% of the requirement shall be met with nuts, seeds, or nut butters. Nuts, seeds, or nut butters shall be combined with another meat or meat alternative to fulfill the requirement. Two tablespoons of nut butter or one ounce of nuts or seeds equals one ounce of meat.

*** Juice may not be served when milk is served as the only other component.

**Historical Note**

Table 10.1 made by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

**R9-10-1026. Sleep Disorder Services**

An administrator of an outpatient treatment center that is authorized to provide sleep disorder services shall ensure that:

1. A physician provides direction for the sleep disorder services provided by the outpatient treatment center;
2. At least one of the following is present on the premise of the outpatient treatment center:
   a. A polysomnographic technician certified by the Board of Registered Polysomnographic Technologists (BRPT),
   b. A polysomnographic technician accepted by the BRPT to sit for the BRPT certification examination, or
   c. A respiratory therapist;
3. There is at least one patient testing room having a minimum of 140 square feet and no dimension less than 10 feet;
4. There is a bathroom available for use by a patient that contains:
   a. A working sink with running water,
   b. A working toilet that flushes and has a seat,
   c. Toilet tissue,
   d. Soap for hand washing,
   e. Paper towels or a mechanical air hand dryer,
   f. Lighting, and
   g. A means of ventilation;
5. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise; and
6. Equipment for the delivery of continuous positive airway pressure and bi-level positive airway pressure, including remote control of the airway pressure, is available on the premises of the outpatient treatment center.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1026 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1026 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1027. Urgent Care Services Provided in a Freestanding Urgent Care Setting**

An administrator of an outpatient treatment center that is authorized to provide urgent care services in a freestanding urgent care setting shall ensure that:

1. In addition to the policies and procedures required in R9-10-1003(D)(1), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover basic life support training and pediatric basic life support training including:
   a. Method and content of training,
   b. Qualifications of individuals providing the training, and
   c. Documentation that verifies a medical practitioner has received the training;
2. A medical practitioner is on the premises during hours of clinical operation to provide the medical services, nursing services, and health-related services included in the outpatient treatment center's scope of services;
3. If a physician is not on the premises during hours of operation, a notice stating this fact is conspicuously posted in the waiting room according to A.R.S. § 36-432;
4. If a patient's death occurs at the outpatient treatment center, a written report is submitted to the Department as required in A.R.S. § 36-445.04;
5. A medical practitioner completes basic life support training and pediatric basic life support training:
   a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center, and
   b. At least once every 24 months after the initial date of employment;
6. Except as provided in subsection (5), a personnel member completes basic adult and pediatric cardiopulmonary resuscitation training:
   a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center; and
   b. At least once every 24 months after the initial date of employment or volunteer service; and
7. In addition to the requirements in R9-10-1006(11), a medical practitioner's record includes documentation of completion of basic life support training and pediatric basic life support training.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1027 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1027 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1028. Infection Control**

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to the outpatient treatment center's policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
   a. A method to identify and document infections occurring at the outpatient treatment center;
   b. Analysis of the types, causes, and spread of infections and communicable diseases at the outpatient treatment center;
   c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the outpatient treatment center; and
   d. Documentation of infection control activities including:
      i. The collection and analysis of infection control data,
      ii. The actions taken related to infections and communicable diseases, and
      iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
   a. If applicable:
      i. Handling and disposal of biohazardous medical waste;
      ii. Isolation of a patient;
      iii. Sterilization and disinfection of medical equipment and supplies;
      iv. Use of personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable; and
      v. Collection, storage, and cleaning of soiled linens and clothing;
   b. Cleaning an individual's hands when the individual's hands are visibly soiled;
   c. Training of personnel members, employees, and volunteers in infection control practices; and
   d. Work restrictions for a personnel member, employee, or volunteer with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures; and
5. A personnel member, employee, or volunteer washes his or her hands with soap and water or uses a hand disinfection product before and after each patient contact and after handling soiled linen, soiled clothing, or a potentially infectious material.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1028 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1028 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1029. Emergency and Safety Standards**

**A.** An administrator shall ensure that policies and procedures for providing emergency treatment are established, documented, and implemented that protect the health and safety of patients and include:

1. A list of the medications, supplies, and equipment required on the premises for the emergency treatment provided by the outpatient treatment center;
2. A system to ensure medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
3. A requirement that a cart or a container is available for emergency treatment that contains the medication, supplies, and equipment specified in the outpatient treatment center's policies and procedures; and
4. A method to verify and document that the contents of the cart or container are available for emergency treatment.

**B.** An administrator shall ensure that emergency treatment is provided to a patient admitted to the outpatient treatment center according to the outpatient treatment center's policies and procedures.

**C.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members, and, if necessary, implemented that includes:
   a. Procedures for protecting the health and safety of patients and other individuals on the premises;
   b. Assigned responsibilities for each personnel member, employee, or volunteer;
   c. Instructions for the evacuation of patients and other individuals on the premises; and
   d. Arrangements to provide medical services, nursing services, and health-related services to meet patients' needs;
2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;
3. An evacuation drill is conducted on each shift at least once every 12 months;
4. A disaster plan review required in subsection (C)(2) or an evacuation drill required in subsection (C)(3) is documented as follows:
   a. The date and time of the evacuation drill or disaster plan review;
   b. The name of each personnel member, employee, or volunteer participating in the evacuation drill or disaster plan review;
   c. A critique of the evacuation drill or disaster plan review; and
   d. If applicable, recommendations for improvement;
5. Documentation required in subsection (C)(4) is maintained for at least 12 months after the date of the evacuation drill or disaster plan review; and
6. An evacuation path is conspicuously posted on each hallway of each floor of the outpatient treatment center.

**D.** An administrator shall ensure that an outpatient treatment center has either:
1. Both of the following that are tested and serviced at least once every 12 months:
   a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and
   b. A sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order; or
2. The following:
   a. A smoke detector installed in each hallway of the outpatient treatment center that is:
      i. Maintained in an operable condition;
      ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and
      iii. Tested monthly; and
   b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
      i. Is available at the outpatient treatment center;
      ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;
      iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
      iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person.

**E.** An administrator shall ensure that documentation of a test required in subsection (D) is maintained for at least 12 months after the date of the test.

**F.** An administrator shall ensure that:
1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit signs;
2. Except as provided in subsection (G), a corridor in the outpatient treatment center is at least 44 inches wide;
3. Corridors and exits are kept clear of any obstructions;
4. A patient can exit through any exit during hours of operation;
5. An extension cord is not used instead of permanent electrical wiring;
6. Each electrical outlet and electrical switch has a cover plate that is in good repair;
7. If applicable, a sign is placed at the entrance of a room or an area indicating that oxygen is in use; and
8. Oxygen and medical gas containers:
   a. Are maintained in a secured, upright position; and
   b. Are stored in a room with a door:
      i. In a building with sprinklers, at least five feet from any combustible materials; or
      ii. In a building without sprinklers, at least 20 feet from any combustible materials.

**G.** If an outpatient treatment center licensed before October 1, 2013 has a corridor less than 44 inches wide, an administrator shall ensure that:
1. The corridor is wide enough to allow for:
   a. Unobstructed movement of patients within the outpatient treatment center, and

b. The safe evacuation of patients from the outpatient treatment center; and
2. The corridor is used only as a passageway.

**H.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1029 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1029 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-1030. Physical Plant, Environmental Services, and Equipment Standards**

**A.** An administrator shall ensure that:
1. An outpatient treatment center's premises are:
   a. Sufficient to provide the outpatient treatment center's scope of services;
   b. Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and
   c. Free from a condition or situation that may cause an individual to suffer physical injury;
2. If an outpatient treatment center collects urine or stool specimens from a patient, except as provided in subsection (B), or is authorized to provide respite services for children on the premises, the outpatient treatment center has at least one bathroom on the premises that:
   a. Contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue,
      iv. Soap for hand washing,
      v. Paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A means of ventilation; and
   b. Is for the exclusive use of the outpatient treatment center;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. A tobacco smoke-free environment is maintained on the premises;
5. A refrigerator used to store a medication is:
   a. Maintained in working order, and
   b. Only used to store medications;
6. Equipment at the outpatient treatment center is:
   a. Sufficient to provide the outpatient treatment center's scope of services;
   b. Maintained in working condition;
   c. Used according to the manufacturer's recommendations; and
   d. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
7. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of testing, calibration, or repair.

**B.** An outpatient treatment center may have a bathroom used for the collection of a patient's urine or stool that is not for the exclusive use of the outpatient treatment center if:
1. The bathroom is located in the same contiguous building as the outpatient treatment center's premises,
2. The bathroom is of a sufficient size to support the outpatient treatment center's scope of services, and
3. There is a documented agreement between the licensee and the owner of the building stating that the bathroom complies with the requirements in this Section and allowing the Department access to the bathroom to verify compliance.

**C.** If an outpatient treatment center has a bathroom that is not for the exclusive use of the outpatient treatment center as allowed in subsection (B), an administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to:
   a. Protect the health and safety of an individual using the bathroom; and

b. Ensure that the bathroom is cleaned and sanitized to prevent, minimize, and control illness and infection;
2. Documented instructions are provided to a patient that cover:
a. Infection control measures when a patient uses the bathroom, and
b. The safe return of a urine or stool specimen to the outpatient treatment center;
3. The bathroom complies with the requirements in subsection (A)(2)(a); and
4. The bathroom is free from a condition or situation that may cause an individual using the bathroom to suffer a physical injury.

**Historical Note**

Adopted effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-1031. Colocation Requirements**

**A.** In addition to the definitions in A.R.S. §§ 36-401 and 36-439 and R9-10-101 and R9-10-1001, the following definition applies in this Section:
"Patient" means an individual who enters the premises of a collaborating outpatient treatment center to obtain physical health services or behavioral health services from the collaborating outpatient treatment center or a colocator that shares areas of the collaborating outpatient treatment center's premises.

**B.** Only one outpatient treatment center in a facility may be designated as a collaborating outpatient treatment center for the facility.

**C.** The following health care institutions are not permitted to be a collaborating outpatient treatment center or a colocator in a collaborating outpatient treatment center:
1. An affiliated counseling facility;
2. An outpatient treatment center authorized by the Department to provide dialysis services according to R9-10-1018;
3. An outpatient treatment center authorized by the Department to provide emergency room services according to R9-10-1019; or
4. An outpatient treatment center operating under a single group license according to A.R.S. § 36-422(F) or (G).

**D.** In addition to the requirements for a license application in R9-10-105, a governing authority of an outpatient treatment center requesting authorization to operate or continue to operate as a collaborating outpatient treatment center shall submit, in a Department-provided format:
1. The following information for each proposed colocator that may share an area of the collaborating outpatient treatment center's premises and nontreatment personnel at the collaborating outpatient treatment center:
a. For each proposed associated licensed provider:
i. Name,
ii. The associated licensed provider's license number or the date the associated licensed provider submitted to the Department a license application for an outpatient treatment center or a counseling facility license,
iii. Proposed scope of services, and
iv. A copy of the written agreement with the collaborating outpatient treatment center required in subsection (E); and
b. For each exempt health care provider:
i. Name,
ii. Current health care professional license number,
iii. Proposed scope of services, and
iv. A copy of the written agreement required in subsection (F) with the collaborating outpatient treatment center; and
2. In addition to the requirements in R9-10-105(A)(5)(b)(vi), a floor plan that shows:
a. Each colocator's proposed treatment area, and
b. The areas of the collaborating outpatient treatment center's premises shared with a colocator.

**E.** An administrator of a collaborating outpatient treatment center shall have a written agreement with each associated licensed provider that includes:
1. In a Department-provided format:
a. The associated licensed provider's name;
b. The name of the associated licensed provider's governing authority;
c. Whether the associated licensed provider plans to share medical records with the collaborating outpatient treatment center;
d. If the associated licensed provider plans to share medical records with the collaborating outpatient treatment center, specific information about which party will obtain a patient's:
i. General consent or informed consent, as applicable;
ii. Consent to allow a colocator access to the patient's medical record; and

iii. Advance directives;

e. How the associated licensed provider will transport or transfer a patient to another colocator within the collaborating outpatient treatment center;

f. How the associated licensed provider will ensure controlled substances stored in the associated licensed provider's licensed premises are not diverted;

g. How the associated licensed provider will ensure environmental services in the associated licensed provider's licensed premises will not affect patient care in the collaborating outpatient treatment center;

h. How the associated licensed provider's personnel members will respond to a patient's sudden, intense, or out-of-control behavior, in the associated licensed provider's treatment area, to prevent harm to the patient or another individual in the collaborating outpatient treatment center;

i. A statement that, if any of the colocators include children's behavioral health services in the colocator's scope of services, the associated licensed provider will ensure that all employees and personnel members of the associated licensed provider comply the fingerprint clearance card requirements in A.R.S. § 36-425.03;

j. A statement that the associated licensed provider will:

i. Document the following each time another colocator provides emergency health care services in the associated licensed provider's treatment area:

(1) The name of the colocator;

(2) If different from the name of the colocator, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;

(3) A description of the emergency health care services provided; and

(4) The date and time the emergency health care services were provided;

ii. Maintain the documentation in subsection (E)(1)(j)(i) for at least 12 months after the emergency health care services were provided; and

iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;

k. A statement that the associated licensed provider will:

i. Document the following each time the associated licensed provider provides emergency health care services in another colocator's treatment area:

(1) If different from the name of the associated licensed provider, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;

(2) The name of the colocator;

(3) A description of the emergency health care services provided; and

(4) The date and time the emergency health care services were provided;

ii. Maintain the documentation in subsection (E)(1)(k)(i) for at least 12 months after the emergency health care services were provided; and

iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;

l. An attestation that the associated licensed provider will comply with the written agreement;

m. The signature of the associated licensed provider's governing authority according to A.R.S. § 36-422(B) and the date signed; and

n. The signature of the collaborating outpatient treatment center's governing authority according to A.R.S. § 36-422(B) and the date signed; and

2. A copy of the associated licensed provider's scope of services, including whether the associated licensed provider plans to provide behavioral health services for children.

**F.** An administrator of a collaborating outpatient treatment center shall have a written agreement with each exempt health care provider that includes:

1. In a Department-provided format:

a. The exempt health care provider's name;

b. The exempt health care provider license type and license number;

c. Whether the exempt health care provider plans to share medical records with the collaborating outpatient treatment center;

d. If the exempt health care provider plans to share medical records with the collaborating outpatient treatment center, specific information about which party will obtain a patient's:

i. General consent or informed consent, as applicable;

ii. Consent to allow a colocator access to the patient's medical record; and

iii. Advance directives;

e. How the exempt health care provider will transport or transfer a patient to another colocator within the collaborating outpatient treatment center;

f. How the exempt health care provider will ensure controlled substances stored in the exempt health care provider's designated premises are not diverted;

g. How the exempt health care provider will ensure environmental services in the exempt health care provider's licensed premises will not affect patient care in the collaborating outpatient treatment center;
h. How the exempt health care provider and any staff of the exempt health care provider will respond to a patient's sudden, intense, or out-of-control behavior, in the exempt health care provider's treatment area, to prevent harm to the patient or another individual in the collaborating outpatient treatment center;
i. A statement that, if any of the colocators include children's behavioral health services in the colocator's statement of services, the exempt health care provider will ensure that all employees and staff of the exempt health care provider comply with the fingerprint clearance card requirements A.R.S. § 36-425.03;
j. A statement that the exempt health care provider will:
i. Document the following each time another colocator provides emergency health care services in the exempt health care provider's treatment area:
(1) The name of the colocator;
(2) If different from the name of the colocator, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
(3) A description of the emergency health care services provided; and
(4) The date and time the emergency health care services were provided;
ii. Maintain the documentation in subsection (F)(1)(j)(i) for at least 12 months after the emergency health care services were provided; and
iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
k. A statement that the exempt health care provider will:
i. Document the following each time the exempt health care provider provides emergency health care services in another colocator's treatment area:
(1) If different from the name of the exempt health care provider, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
(2) The name of the colocator;
(3) A description of the emergency health care services provided; and
(4) The date and time the emergency health care services were provided;
ii. Maintain the documentation in subsection (F)(1)(k)(i) for at least 12 months after the emergency health care services were provided; and
iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
l. An attestation that the exempt health care provider will comply with the written agreement;
m. The signature of the exempt health care provider and the date signed; and
n. The signature of the collaborating outpatient treatment center's governing authority according to A.R.S. § 36-422(B) and the date signed; and

2. A copy of the exempt health care provider's scope of services, including whether the exempt health care provider plans to provide behavioral health services for children.

**G.** As part of the policies and procedures required in this Article, an administrator of a collaborating outpatient treatment center shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient based on the scopes of services of all colocators that:

1. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for nontreatment personnel who may provide services in the areas of the collaborating outpatient treatment center's premises shared with a colocator;
2. Cover orientation and in-service education for nontreatment personnel who may provide services in the areas of the collaborating outpatient treatment center's premises shared with a colocator;
3. Cover cardiopulmonary resuscitation training, including:
a. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
b. The qualifications for an individual to provide cardiopulmonary resuscitation training;
c. The time-frame for renewal of cardiopulmonary resuscitation training; and
d. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
4. Cover first aid training;
5. Cover patient screening, including a method to ensure that, if a patient identifies a specific colocator, the patient is directed to the identified colocator;
6. Cover the provision of emergency treatment to protect the health and safety of a patient or individual present in an area of the collaborating outpatient treatment center's premises shared with a colocator according to the requirements for emergency treatment policies and procedures in R9-10-1029(A);

7. If medication is stored in an area of the collaborating outpatient treatment center's premises shared with a colocator, cover obtaining, storing, accessing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
8. Cover biohazardous wastes, if applicable;
9. Cover environmental services in an area of the collaborating outpatient treatment center's premises shared with a colocator that affect patient care; and
10. Cover how personnel members and nontreatment personnel will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual in an area of the collaborating outpatient treatment center's premises shared with a colocator.

**H.** An administrator of a collaborating outpatient treatment center shall ensure that:
1. Areas of the collaborating outpatient treatment center's premises shared with a colocator are:
   a. Sufficient to accommodate the outpatient treatment center's and any colocators' scopes of services;
   b. Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and
   c. Free from a condition or situation that may cause an individual to suffer physical injury;
2. A written log is maintained that documents the date, time, and circumstances each time a colocator provides emergency health care services in another colocator's designated treatment area; and
3. The documentation in the written log required in subsection (H)(2) is maintained for at least 12 months after the date the colocator provides emergency health care services in another colocator's designated treatment area.

**I.** If any colocator at a collaborating outpatient treatment center includes children's behavioral health services as part of the colocator's scope of services, an administrator of the collaborating outpatient treatment center shall ensure that the governing authority, employees, personnel members, nontreatment personnel, and volunteers of the collaborating outpatient treatment center comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.

**Historical Note**

New Section made by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

## ARTICLE 11. ADULT DAY HEALTH CARE FACILITIES

### R9-10-1101. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article, unless otherwise specified:

"Care plan" means a written program of action for a participant's care based upon an assessment of the participant's physical, nutritional, psychosocial, economic, and environmental strengths and needs and implemented according to established short- and long-term goals.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

### R9-10-1102. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as an adult day health care facility shall include on the application the number of participants for whom the applicant is requesting authorization to provide adult day health services.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1102 renumbered to Section R9-10-1103; new Section R9-10-1102 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

### R9-10-1103. Administration

**A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of an adult day health care facility;
2. Establish, in writing:
   a. An adult day health care facility's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1104;

5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate in writing, an acting administrator, who has the qualifications established in subsection (A)(2)(b) if the administrator is:
   a. Expected not to be present on an adult day health care facility's premises for more than 30 calendar days, or
   b. Not present on an adult day health care facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I), when there is a change in an administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:
1. Is 21 years of age or older;
2. Is directly accountable to the governing authority of an adult day health care facility for the daily operation of the adult day health care facility and all services provided by or at the adult day health care facility;
3. Has the authority and responsibility to manage the adult day health care facility; and
4. Except as provided in subsection (A)(6), designates, in writing, an individual who is 21 years of age or older and present on the adult day health care facility's premises and accountable for the adult day health care facility when the administrator is not present on the adult day health care facility premises and participants are present on the adult day health care facility's premises.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Cover certification in cardiopulmonary resuscitation and first aid training;
   d. Include how a personnel member may submit a complaint relating to services provided to a participant;
   e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   f. Include a method to identify a participant to ensure that the participant receives the appropriate services;
   g. Cover participant rights, including assisting a participant who does not speak English or who has a disability to become aware of participant rights;
   h. Cover specific steps for:
      i. A participant to file a complaint, and
      ii. The adult day health care facility to respond to a participant complaint;
   i. Cover medical records, including electronic medical records; and
   j. Cover a quality management program, including incident reports and supporting documentation;
2. Policies and procedures for services provided by an adult day health care facility are established, documented, and implemented to protect the health and safety of a participant that:
   a. Cover screening, enrollment, and discharge;
   b. Cover the provision of the services in the adult day health care facility's scope of services;
   c. Cover dispensing, administering, and disposing of medications, including provisions for inventory control and preventing diversion of controlled substances;
   d. Cover how personnel members will respond to a participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual;
   e. Cover food services;
   f. Cover environmental services;
   g. Cover infection control;
   h. Cover contracted services;
   i. Cover emergency treatment provided at the adult day health care facility; and
   j. Designate which employees or personnel members are required to have current certification in cardiopulmonary resuscitation and first aid training;
3. Policies and procedures are:
   a. Available to personnel members, employees, volunteers, and students, and
   b. Reviewed at least once every three years and updated as needed; and
4. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of an adult day health care facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the adult day health care facility.

**D.** An administrator shall:
1. Maintain, and make available to individuals upon request, a schedule of rates and charges;
2. Ensure that a monthly calendar of planned activities is:
   a. Posted before the beginning of a month, and

b. Maintained on the premises for at least 90 calendar days after the end of the month;
3. Ensure that materials, supplies, and equipment are provided for the planned activities; and
4. Assist in the formation of a participants' council according to R9-10-1112.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1103 renumbered to Section R9-10-1104; new Section R9-10-1103 renumbered from Section R9-10-1102 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1104. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to participants;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to participant care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to participant care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to participant care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to participant care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1104 renumbered to Section R9-10-1105; new Section R9-10-1104 renumbered from Section R9-10-1103 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1105. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1105 renumbered to Section R9-10-1106; new Section R9-10-1105 renumbered from Section R9-10-1104 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1106. Personnel**

**A.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the participants receiving physical health services or behavioral health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:

a. Before the personnel member provides physical health services or behavioral health services, and
b. According to policies and procedures;

3. Sufficient personnel members are present on an adult day health care facility's premises when participants are present and have the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the adult day health care facility's scope of services,
   b. Meet the needs of a participant, and
   c. Ensure the health and safety of a participant; and
4. A personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a participant for more than eight hours a week, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the adult day health care facility, and
   b. As specified in R9-10-113.

**B.** An administrator shall ensure that a personnel member:
1. Is 18 years of age or older, and
2. Is not a participant of the adult day health care facility.

**C.** An administrator shall ensure that a personnel record for each personnel member, employee, volunteer, or student:
1. Includes:
   a. The individual's name, date of birth, and contact telephone number;
   b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
   c. Documentation of:
      i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
      ii. The individual's education and experience applicable to the individual's job duties;
      iii. The individual's completed orientation and in-service education as required by policies and procedures;
      iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
      v. Cardiopulmonary resuscitation training, if required for the individual according to this Article and policies and procedures;
      vi. First aid training, if required for the individual according to this Article and policies and procedures; and
      vii. Evidence of freedom from infectious tuberculosis, if required for the individual according to this Article or policies and procedures;
2. Is maintained:
   a. Throughout the individual's period of providing services in or for the adult day health care facility, and
   b. For at least 24 months after the last date the individual provided service in or for the adult day health care facility; and
3. For a personnel member who has not provided physical health services or behavioral health services at or for the adult day health care facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.

**D.** An administrator shall ensure that:
1. At least two personnel members are present on the premises whenever two or more participants are in the adult day health care facility;
2. At least one personnel member with cardiopulmonary resuscitation and first-aid certification is on the premises at all times;
3. A registered nurse manages the nursing services and provides direction for health-related services provided by the adult day health care facility; and
4. A nurse is on the premises daily to:
   a. Administer medications and treatments, and
   b. Monitor a participant's health status.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1106 renumbered to Section R9-10-1107; new Section R9-10-1106 renumbered from Section R9-10-1105 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1107. Enrollment**

**A.** An administrator shall ensure that a participant provides evidence of freedom from infectious tuberculosis:
1. Before or within seven calendar days after the participant's enrollment, and
2. As specified in R9-10-113.

**B.** Before or at the time of enrollment, an administrator shall ensure that a participant or the participant's representative signs a written agreement with the adult day health care facility that includes:
1. The participant's name and date of birth,
2. Enrollment requirements,
3. A list of the customary services that the adult day health care facility provides,

4. A list of services that are available at an additional cost,
5. A list of fees and charges,
6. Procedures for termination of the agreement,
7. The requirements of the adult day health care facility,
8. The names and telephone numbers of individuals designated by the participant to be notified in the event of an emergency, and
9. A copy of the adult day health care facility's procedure on health care directives.

**C.** An administrator shall give a copy of the agreement in subsection (B) to the participant or the participant's representative and keep the original in the participant's medical record.

**D.** An administrator shall ensure that a participant has a signed written medical assessment that:
1. Was completed by the participant's medical practitioner within 60 calendar days before enrollment; and
2. Includes:
   a. Information that addresses the participant's:
      i. Physical health;
      ii. Cognitive awareness of self, location, and time; and
      iii. Deficits in cognitive awareness;
   b. Physical, mental, and emotional problems experienced by the participant;
   c. A schedule of the participant's medications;
   d. A list of treatments the participant is receiving;
   e. The participant's special dietary needs; and
   f. The participant's known allergies.

**E.** At the time of enrollment, an administrator shall ensure that the participant or participant's representative:
1. Documents whether the participant may sign in and out of the adult day health care facility; and
2. Provides the following:
   a. The name and telephone number of the:
      i. Participant's representative;
      ii. Family member to be contacted in an emergency;
      iii. Participant's medical practitioner; and
      iv. Adult who provides the participant with supervision and assistance in the preparation of meals, housework, and personal grooming, if applicable; and
   b. If applicable, a copy of the participant's health care directive.

**F.** An administrator shall ensure that a comprehensive assessment of the participant:
1. Is completed by a registered nurse before the participant's tenth visit or within 30 calendar days after enrollment, whichever comes first;
2. Documents the participant's:
   a. Physical health,
   b. Mental and emotional status, and
   c. Social history; and
3. Includes:
   a. Medical practitioner orders,
   b. Adult day health care services recommended for the participant's care plan, and
   c. The signature of the registered nurse conducting the comprehensive assessment and date signed.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1107 renumbered to Section R9-10-1108; new Section R9-10-1107 renumbered from Section R9-10-1106 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1108. Care Plan**

An administrator shall ensure that a care plan for a participant:
1. Is developed within seven calendar days after the completion of the participant's comprehensive assessment;
2. Has input from:
   a. The participant or participant's representative,
   b. The registered nurse who performed the comprehensive assessment, and
   c. Personnel who have provided services to the participant;
3. Is based on the participant's comprehensive assessment;
4. Includes:
   a. A summary of the participant's medical or health problems, including physical, mental, and emotional disabilities or impairments;
   b. Adult day health services to be provided;

c. Goals and objectives of care that are time-limited and measurable;
d. Interventions required to achieve objectives, including recommendations for therapy and referrals to other service providers; and
e. Discharge instructions according to R9-10-1109(B); and

5. Is reviewed and updated at least once every six months and whenever there is a significant change in the participant's condition.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1108 renumbered to Section R9-10-1109; new Section R9-10-1108 renumbered from Section R9-10-1107 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1109. Discharge**

**A.** An administrator may discharge a participant from an adult day health care facility by terminating the agreement in R9-10-1107(B):
1. After giving the participant or participant's representative five working days written notice; and
2. For any of the following reasons:
   a. Evidence of repeated failure to comply with the requirements of the adult day health care facility,
   b. Documented proof of failure to pay,
   c. Behavior that is dangerous to self or that interferes with the physical or psychological well-being of other participants, or
   d. The participant requires services not in the adult day health care facility's scope of services.

**B.** An administrator shall ensure that discharge instructions for a participant are:
1. Developed that:
   a. Identify any specific needs of the participant after discharge,
   b. Are completed before discharge occurs,
   c. Include a description of the level of care that may meet the participant's assessed and anticipated needs after discharge, and
   d. Are documented in the participant's medical record within 48 hours after the discharge instructions are completed; and
2. Provided to the participant or the participant's representative before the discharge occurs.

**Historical Note**

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1109 renumbered to Section R9-10-1110; new Section R9-10-1109 renumbered from Section R9-10-1108 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1110. Participant Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the participant rights in subsection (C) are conspicuously posted on the premises;
2. At the time of enrollment, a participant or the participant's representative receives a written copy of the requirements in subsection (B) and the participant rights in subsection (C); and
3. Policies and procedures include:
   a. How and when a participant or the participant's representative is informed of participant rights in subsection (C), and
   b. Where participant rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A participant is treated with dignity, respect, and consideration;
2. A participant is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by the adult day health care facility's personnel members, employees, volunteers, or students; and
3. A participant or the participant's representative:
   a. Except in an emergency, either consents to or refuses treatment;

b. May refuse or withdraw consent for treatment before treatment is initiated;
c. Except in an emergency, is informed of proposed alternatives to the treatment, associated risks, and possible complications;
d. Is informed of the following:
i. The policy on health care directives,
ii. The participant complaint process,
iii. Rates and charges for participating at the adult day health care facility, and
iv. The process for contacting the local office of Adult Protective Services;
e. Consents to photographs of the participant before the participant is photographed, except that a participant may be photographed when enrolled at an adult day health care facility for identification and administrative purposes; and
f. Except as otherwise permitted by law, provides written consent to the release of information in the participant's:
i. Medical record, or
ii. Financial records.

**C.** A participant has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the participant's individuality, choices, strengths, and abilities;
3. To communicate, associate, and meet privately with individuals of the participant's choice;
4. To have access to a telephone, to make and receive calls, and to send and receive correspondence without interception or interference by the adult day health care facility;
5. To arrive and depart from the adult day health care facility, consistent with the participant's care plan and personal safety;
6. To receive privacy in treatment and care for personal needs;
7. To review, upon written request, the participant's own records;
8. To receive a referral to another health care institution if the adult day health care facility is not authorized or not able to provide physical health services or behavioral health services needed by the participant;
9. To participate or have the participant's representative participate in the development of a care plan or decisions concerning treatment;
10. To participate or refuse to participate in research or experimental treatment; and
11. To receive assistance from a family member, the participant's representative, or other individual in understanding, protecting, or exercising the participant's rights.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1110 renumbered to Section R9-10-1111; new Section R9-10-1110 renumbered from Section R9-10-1109 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1111. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for a participant according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a participant's medical record is:
a. Recorded only by an individual authorized by policies and procedures to make the entry;
b. Dated, legible, and authenticated; and
c. Not changed to make the initial entry illegible;
3. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
4. A participant's medical record is available to an individual:
a. Authorized according to policies and procedures to access the participant's medical record;
b. If the individual is not authorized according to policies and procedures, with the written consent of the participant or the participant's representative; or
c. As permitted by law; and
5. A participant's medical record is protected from loss, damage, or unauthorized use.

**B.** If an adult day health care facility maintains participant's medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a participant's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a participant's medical record contains:
1. Participant information that includes:
a. The participant's name;
b. The participant's address;
c. The participant's date of birth; and

d. Any known allergies, including medication allergies;
2. The name of the participant's medical practitioner or other individuals involved in the care of the participant;
3. An enrollment agreement and date of the participant's first visit;
4. If applicable, documented general consent and informed consent by the participant or the participant's representative;
5. If applicable, the name and contact information of the participant's representative and:
   a. The document signed by the participant consenting for the participant's representative to act on the participant's behalf; or
   b. If the participant's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
6. Documentation of medical history;
7. A copy of the participant's health care directive, if applicable;
8. Orders;
9. The medical assessment required in R9-10-1107(D);
10. A care plan;
11. The comprehensive assessment required in R9-10-1107(F);
12. Progress notes;
13. If applicable, documentation of any actions taken to control the participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual;
14. Documentation of adult day health services provided to the participant;
15. The disposition of the participant upon discharge;
16. The discharge date, if applicable;
17. Documentation of a medication administered to the participant that includes:
    a. The date and time of administration;
    b. The name, strength, dosage, and route of administration;
    c. The identification and signature of the individual administering, providing assistance in the self-administration of medication, or observing the participant's self-administration of the medication;
    d. If medication for pain is administered on a PRN basis to a participant:
       i. An identification of the participant's pain before administering the medication, and
       ii. The effect of the medication administered; and
    e. Any adverse reaction a participant has to the medication;
18. If applicable, documentation of:
    a. A significant change in the participant's condition,
    b. An injury or accident that occurred at the adult day health care facility and required medical services, and
    c. Notification provided to the participant's medical practitioner or the participant's representative of the significant change in subsection (C)(18)(a) or the injury or accident in subsection (C)(18)(b);
19. Documentation of whether the participant may sign in or out of the adult day health care facility;
20. Documentation of freedom from infectious tuberculosis required in R9-10-1107(A); and
21. Names and telephone numbers of individuals to be notified in the event of an emergency.

**Historical Note**

Amended effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1111 renumbered to Section R9-10-1112; new Section R9-10-1111 renumbered from Section R9-10-1110 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1112. Participant's Council**

**A.** A participants' council:
1. Is composed of participants, who are willing to serve on the council and take part in scheduled meetings;
2. May develop guidelines that govern the council's activities;
3. May meet quarterly;
4. May record minutes of the meetings; and
5. May provide written input on planned activities and policies of the adult day health care facility.

**B.** A participants' council may invite personnel or the administrator to attend their meetings.

**C.** An administrator shall act as a liaison between the participants' council and personnel members, employees, and volunteers.

**Historical Note**

Amended effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1112 renumbered to Section R9-10-1113;

new Section R9-10-1112 renumbered from Section R9-10-1111 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1113. Adult Day Health Services**

**A.** An administrator shall ensure that a personnel member provides supervision for a participant, except during periods of the day when the participant signs out or is signed out according to policies and procedures.

**B.** An administrator shall ensure that a personnel member provides assistance with activities of daily living and supervision of personal hygiene according to the participant's care plan and policies and procedures.

**C.** An administrator shall ensure that a personnel member provides a participant with planned therapeutic individual and group activities:
1. According to the:
   a. Participant's care plan,
   b. Policies and procedures, and
   c. Monthly calendar of planned activities required in R9-10-1103(D)(2); and
2. That include:
   a. Physical activities,
   b. Group discussion,
   c. Techniques a participant may use to maintain or improve the participant's independence in performing activities of daily living,
   d. Assessment of deficits in cognitive awareness and reinforcement of remaining cognitive awareness,
   e. Activities of daily living,
   f. Participants' council meetings, and
   g. Leisure time.

**D.** An administrator shall ensure that a nurse monitors the health status of a participant according to the participant's care plan and policies and procedures by:
1. Observing the participant's mental and physical condition, including monthly monitoring of the participant's vital signs and nutritional status;
2. Documenting changes in the participant's mental and physical condition in the participant's medical record; and
3. Reporting any changes to the participant's representative or medical practitioner.

**E.** If an adult day health care facility administers medication or provides assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication administration or assistance in the self-administration of medication:
1. Include:
   a. A process for providing information to a participant about medication prescribed for the participant including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse response to a medication, or
      iii. A medication overdose; and
   c. Procedures for documenting medication services and assistance in the self-administration of medication; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**F.** An administrator shall ensure that:
1. Policies and procedures for medication administration:
   a. Are reviewed and approved by a pharmacist, medical practitioner, or registered nurse; and
   b. Ensure that medication is administered to a participant only as prescribed;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a participant:
   a. Is administered in compliance with an order, and
   b. Is documented in the participant's medical record.

**G.** If an adult day health care facility provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A participant's medication is stored by the adult day health care facility;
2. The following assistance is provided to a participant:
   a. A reminder when it is time to take the medication;
   b. Opening the medication container for the participant;
   c. Observing the participant while the participant removes the medication from the container;
   d. Verifying that the medication is taken as ordered by the participant's medical practitioner by confirming that:
      i. The participant taking the medication is the individual stated on the medication container label,

ii. The participant is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
iii. The participant is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
e. Observing the participant while the participant takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a pharmacist, medical practitioner, or registered nurse;
4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
b. Includes:
i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (G)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a participant:
a. Is in compliance with an order, and
b. Is documented in the participant's medical record.

**H.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members, and
2. A current toxicology reference guide is available for use by personnel members.

**I.** When medication is stored at an adult day health care facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant for:
a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication; and
b. Storing, inventorying, and dispensing controlled substances.

**J.** A medication error or a participant's refusal to take a medication is:
1. Reported to the participant's representative within 12 hours, and
2. Documented in the participant's medical record within 24 hours.

**K.** An adverse reaction is:
1. Reported to the participant's representative and medical practitioner within 12 hours, and
2. Documented in the participant's medical record within 24 hours.

**L.** An administrator shall:
1. Immediately notify a participant's representative and medical practitioner of an injury that may require medical services;
2. Report an injury to Adult Protective Services according to A.R.S. § 46-454, when applicable;
3. Prepare a written report on the day of occurrence or when any injury of unknown origin is detected that includes the:
a. Name of the participant;
b. Type of injury;
c. Names of witnesses, if applicable; and
d. Action taken;
4. Investigate the injury within 24 hours and documenting any corrective action in the report; and
5. Retain the report for at least 12 months after the date of the injury.

**M.** For a participant whose care plan includes counseling on an individual or group basis, an administrator shall ensure that:
1. If the counseling needed by the participant is within the adult day health care facility's scope of services, a personnel member provides the counseling to the participant according to policies and procedures; or
2. If the counseling needed by the participant is not within the adult day health care facility's scope of services, a personnel member assists the participant or the participant's representative to obtain counseling for the participant according to policies and procedures.

**Historical Note**

Amended effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1113 renumbered to Section R9-10-1114; new Section R9-10-1113 renumbered from Section R9-10-1112 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1114. Food Services**

**A.** An administrator shall:
1. Designate a food service supervisor who is responsible for food service in an adult day health care facility; and
2. If an adult day health care facility provides a therapeutic diet to participants, ensure that:
   a. The therapeutic diet is prescribed in writing by:
      i. The participant's medical practitioner, or
      ii. A registered dietitian; and
   b. A current therapeutic diet reference manual is available to the food service supervisor.

**B.** A food service supervisor shall ensure that:
1. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the adult day health care facility are served according to posted menus;
3. Meals and snacks for each day are planned using the applicable guidelines in http://www.health.gov/dietaryguidelines/2010.asp;
4. A participant is provided a diet that meets the participant's nutritional needs as specified in the participant's comprehensive assessment, under R9-10-1107(F), or the participant's care plan;
5. Water is available and accessible to participants at all times, unless otherwise stated by the participant's medical practitioner; and
6. A participant requiring assistance to eat is provided with assistance that recognizes the participant's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the participant.

**C.** An administrator shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a participant, such as cut, chopped, ground, pureed, or thickened;
4. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below;
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
      i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
      ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
      iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
      v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
      vi. Leftovers are reheated to a temperature of at least 165° F;
5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, at the warmest part of the refrigerator;
6. Frozen foods are stored at a temperature of 0° F or below; and
7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**D.** An administrator shall ensure that:
1. If an adult day health care facility is licensed to provide adult day health services to more than 15 participants, the adult day health care facility:
   a. Has a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
   b. Maintains a copy of the adult day health care facility's food establishment license or permit;
2. If the adult day health care facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the adult day health care facility, a copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the adult day health care facility; and
3. The adult day health care facility is able to store, refrigerate, and reheat food to meet the dietary needs of a participant.

**Historical Note**

Amended effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1114 renumbered to Section R9-10-1115; new Section R9-10-1114 renumbered from Section R9-10-1113 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1115. Emergency and Safety Standards**

**A.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and employees, and, if necessary, implemented that includes:
   a. Procedures for protecting the health and safety of participants and other individuals on the premises;
   b. Assigned responsibilities for each personnel member and employee;
   c. Instructions for the evacuation of participants, including:
      i. When, how, and where participants will be relocated; and
      ii. A plan for notifying the emergency contact for each participant;
   d. A plan to ensure each participant's medications will be available to administer to the participant during a disaster; and
   e. A plan for providing water, food, and needed services to participants present in the adult day health care facility or the adult day health care facility's relocation site during a disaster;
2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement; and
4. A disaster drill for assigned personnel is conducted on each shift at least once every three months and documented.

**B.** An administrator shall ensure that:
1. A participant receives orientation to the exits from the adult day health care facility and the route to be used when evacuating participants within two visits after the participant's enrollment, and
2. A participant's orientation is documented in the participant's medical record.

**C.** An administrator shall ensure that:
1. An evacuation drill for employees and participants is conducted at least once every six months;
2. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for all employees and participants to evacuate to a designated area;
   d. Any problems encountered in conducting the evacuation drill; and
   e. Recommendations for improvement, if applicable; and
   3. An evacuation path is conspicuously posted on each hallway of each floor of the adult day health care facility.

**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1115 renumbered to Section R9-10-1116; new Section R9-10-1115 renumbered from Section R9-10-1114 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1116. Environmental Standards**

**A.** An administrator shall ensure that:
1. The adult day health care facility's premises are:
   a. Cleaned and disinfected according to policies and procedures to prevent, minimize, and control illness and infection; and
   b. Free from a condition or situation that may cause a participant or an individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Windows and doors opening to the outside are screened if they are kept open at any time for ventilation or other purposes;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
5. Equipment used at the adult day health care facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
6. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
7. Garbage and refuse are:
   a. Stored in covered containers lined with plastic bags, and
   b. Removed from the premises at least once a week;

8. Heating and cooling systems maintain the adult day health care facility at a temperature between 70° F and 84° F;
9. The supply of hot and cold water is sufficient to meet the personal hygiene needs of participants and the cleaning and sanitation requirements in this Article;
10. Soiled linen and soiled clothing stored by the adult day health care facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
11. Oxygen containers are secured in an upright position;
12. Poisonous or toxic materials stored by the adult day health care facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to participants;
13. Combustible or flammable liquids and hazardous materials stored by the adult day health care facility are stored in the original labeled containers or safety containers in a locked area inaccessible to participants; and
14. Pets or animals are:
    a. Controlled to prevent endangering the participants and to maintain sanitation;
    b. Not allowed in treatment, food storage, food preparation, or dining areas;
    c. Licensed consistent with local ordinances; and
    d. For a dog or cat, vaccinated against rabies.

**B.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. On a day that a participant uses the swimming pool, an employee:
    a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
        i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
        ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
        iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
    b. Records the results of the water quality tests in a log that includes the date tested and test result;
2. Documentation of the water quality test is maintained for at least 12 months after the date of the test;
3. A swimming pool is not used by a participant if a water quality test shows that the swimming pool water does not comply with subsection (B)(1)(a);
4. At least one personnel member with cardiopulmonary resuscitation training, required in R9-10-1106(D), is present in the pool area when a participant is in the pool area; and
5. At least two personnel members are present in the pool area if two or more participants are in the pool area.

**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1116 renumbered to Section R9-10-1117; new Section R9-10-1116 renumbered from Section R9-10-1115 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-1117. Physical Plant Standards**

**A.** An administrator shall ensure that an adult day health care facility complies with the physical plant health and safety codes and standards incorporated by reference in R9-10-104.01, in effect on the date the adult day health care facility submitted architectural plans and specifications to the Department for approval, according to R9-10-104.

**B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the adult day health care facility's scope of services, and
2. An individual accepted as a participant by the adult day health care facility.

**C.** An administrator shall ensure that an adult day health care facility has at least 40 square feet of indoor activity space for each participant, excluding bathrooms, halls, storage areas, kitchens, wall thicknesses, and rooms designated for use by individuals who are not participants.

**D.** An administrator shall ensure that an outside activity space is provided and available that:
1. Is on the premises,
2. Has a hard-surfaced section for wheelchairs,
3. Has an available shaded area, and
4. Has a means of egress without entering the adult day health care facility.

**E.** An administrator shall ensure that:
1. There is at least one working toilet that flushes and has a seat and one sink with running water for each ten participants;
2. A bathroom for use by participants provides privacy when in use and contains in a location accessible to participants:
    a. A mirror;
    b. Toilet paper for each toilet;
    c. Soap accessible from each sink;
    d. Paper towels in a dispenser or an air hand dryer; and
    e. Grab bars for the toilet and other assistive devices, if required, to provide for participant safety;

3. A bathroom has a window that opens or another means of ventilation;
4. If a bathing facility is provided:
   a. The bathing facility provides privacy when in use,
   b. Shower enclosures have nonporous surfaces,
   c. Showers and tubs have grab bars for participant safety, and
   d. Tub and shower floors have slip-resistant surfaces;
5. Dining areas are furnished with dining tables and chairs and large enough to accommodate participants;
6. There is a wall or other means of physical separation between dining facilities and food preparation areas;
7. If the adult day health care facility serves food, areas are designated for food preparation, storage, and handling and are not used as a passageway by participants; and
8. All flooring is slip-resistant.

**F.** If the adult day health care facility has a swimming pool on the premises, an administrator shall ensure that:
1. The swimming pool is equipped with the following:
   a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
      i. A removable strainer,
      ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
      iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
   b. An operational vacuum cleaning system;
2. The swimming pool is enclosed by a wall or fence that:
   a. Is at least five feet in height as measured on the exterior of the wall or fence;
   b. Has no vertical openings greater that four inches across;
   c. Has no horizontal openings, except as described in subsection (C)(2)(e);
   d. Is not chain-link;
   e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
   f. Has a self-closing, self-latching gate that:
      i. Opens away from the swimming pool,
      ii. Has a latch located at least 54 inches from the ground; and
      iii. Is locked when the swimming pool is not in use;
3. A life preserver or shepherd's crook is available and accessible in the pool area; and
4. If the swimming pool is used by participants, pool safety requirements are conspicuously posted in the pool area.

## ARTICLE 13. BEHAVIORAL HEALTH SPECIALIZED TRANSITIONAL FACILITY

**R9-10-1301. Definitions**

Definitions in A.R.S. § 36-401 and R9-10-101 apply in this Article unless otherwise specified.

**R9-10-1302. Administration**

**A.** The governing authority for a behavioral health specialized transitional facility:
1. Is the superintendent of the state hospital; and
2. Shall:
   a. Establish, in writing:
      i. A behavioral health specialized transitional facility's scope of services, and
      ii. Qualifications for an administrator;
   b. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(a)(ii);
   c. Adopt a quality management program according to R9-10-1303;
   d. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
   e. Designate an acting administrator, in writing, who has the qualifications established in subsection (A)(2)(a)(ii), if the administrator is:
      i. Expected not to be present on the behavioral health specialized transitional facility's premises for more than 30 calendar days, or
      ii. Not present on the behavioral health specialized transitional facility's premises for more than 30 calendar days; and
   f. Except as provided in subsection (A)(2)(e), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:
1. Is directly accountable to the superintendent of the state hospital for the daily operation of the behavioral health specialized transitional facility and for all services provided by or at the behavioral health specialized transitional facility;
2. Has the authority and responsibility to manage the behavioral health specialized transitional facility; and

3. Except as provided in subsection (A)(2)(e), designates, in writing, an individual who is present on the behavioral health specialized transitional facility's premises and accountable for the behavioral health specialized transitional facility when the administrator is not present on the behavioral health specialized transitional facility's premises.

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Cover patient admission, assessment, treatment plan, transfer, discharge planning, and recordkeeping;
   d. Cover discharge, including the amount of medication provided to a patient at discharge, based on an assessment of the patient's medical condition;
   e. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
   f. Cover the requirements in A.R.S. §§ 36-3708, 36-3709, and 36-3714;
   g. Establish the process for warning an identified or identifiable individual, as described in A.R.S. § 36-517.02 (B) through (C), if a patient communicates to a personnel member a threat of imminent serious physical harm or death to the identified or identifiable individual and the patient has the apparent intent and ability to carry out the threat;
   h. Cover when informed consent is required and how informed consent is obtained;
   i. Cover the criteria and process for conducting research using patients or patients' medical records;
   j. Include the establishment of, disbursing from, and recordkeeping for a patient personal funds account;
   k. Include a method of patient identification to ensure a patient receives the services ordered for the patient;
   l. Cover contracted services;
   m. Cover health care directives;
   n. Cover medical records, including electronic medical records;
   o. Cover medication procurement, storage, inventory monitoring and control, and disposal;
   p. Cover infection control;
   q. Cover and designate which personnel members or employees are required to have current certification in cardiopulmonary resuscitation and first aid training;
   r. Cover environmental services that affect patient care;
   s. Cover reporting suspected or alleged abuse, neglect, exploitation, or other criminal activity;
   t. Cover quality management, including incident reports and supporting documentation;
   u. Cover emergency treatment and disaster plan;
   v. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
   w. Include security of the facility, patients and their possessions, personnel members, and visitors at the behavioral health specialized transitional facility;
   x. Include preventing unauthorized patient absences;
   y. Cover transportation of patients, including the criteria for using a locking mechanism to restrict a patient's movement during transportation;
   z. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. The behavioral health specialized transitional facility to respond to a patient's complaint;
   aa. Cover visitation, telephone usage, sending or receiving mail, computer usage, and other recreational activities; and
   bb. Include equipment inspection and maintenance;
2. Policies and procedures are available to each personnel member;
3. Laboratory services are provided by a laboratory that holds a certificate of accreditation or certificate of compliance issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
4. Food services are provided as specified in R9-10-1314;
5. The following individuals have access to a patient:
   a. The patient's representative,
   b. An individual assigned by a court of law to provide services to the patient, and
   c. An attorney hired by the patient or patient's family;
6. Labor performed by a patient for the behavioral health specialized transitional facility is consistent with A.R.S. § 36-510 and applicable state and federal law; and
7. The following information is posted in an area easily viewed by a patient or an individual entering or leaving the behavioral health specialized transitional facility:
   a. Patient rights,
   b. Telephone number for the Department and the Office of Human Rights,
   c. Location of inspection reports,

d. Complaint procedures, and
e. Visitation hours and procedures.

**D.** An administrator shall:
1. Provide written notification to the Department of a patient's:
   a. Death, if the patient's death is required to be reported according to A.R.S. § 11-593, within one working day after the patient's death;
   b. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical service provider; and
   c. Absence, within one working day after an unauthorized patient absence from the behavioral health specialized transitional facility is discovered;
2. Maintain the documentation required in subsection (D)(1) for at least 12 months after the date of the notification; and
3. Ensure that sufficient personnel are present at the behavioral health specialized transitional facility at all times to maintain safe and secure conditions.

**E.** If an administrator has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while the patient is receiving services from an employee or personnel member of the behavioral health specialized transitional facility, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 46-454;
3. Document:
   a. The suspected abuse, neglect, or exploitation of the patient;
   b. Any action taken according to subsection (E)(1); and
   c. The report in subsection (E)(2);
4. Maintain the documentation required in subsection (E)(3) for at least 12 months after the date of the report;
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (E)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the patient related to the abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (E)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**F.** An administrator shall:
1. Unless otherwise stated, ensure that:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health specialized transitional facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health specialized transitional facility;
2. Appoint a medical director, to direct the medical and nursing services provided by or at the behavioral health specialized transitional facility, who:
   a. Is a medical staff member, and
   b. Has at least two years of experience providing services in an organized psychiatric services unit of a hospital or in a behavioral health facility; and
3. Appoint a clinical director, to provide direction for the behavioral health services provided by or at the behavioral health specialized transitional facility, who:
   a. Is a psychiatrist or a psychologist;
   b. Has at least two years of experience providing services in an organized psychiatric services unit of a hospital or in a behavioral health facility; and
   c. May, if qualified, also serve as the medical director.

**G.** A medical director:
1. Is responsible for the medical services, nursing services, and physical health-related services provided to patients consistent with the patients behavioral treatment plan; and
2. Shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
   a. Restraint and seclusion, according to R9-10-225;
   b. The process for patient assessments, including the identification of and criteria for the on-going monitoring of a patient's physical health conditions;

c. Dispensing and administration of medications, including the process and criteria for determining whether a patient is capable of and eligible to self-administer medication;
d. The process by which emergency medical treatment will be provided to a patient; and
e. The requirements for completion of medication records and recording of adverse events.

**H.** A clinical director:
1. Is responsible for the behavioral health services provided to patients;
2. Shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
   a. Assessing the competency and proficiency of a behavioral health personnel member for each type of service the personnel member provides and each type of patient to which the personnel member is assigned;
   b. Providing:
      i. Supervision to behavioral health paraprofessionals, according to R9-10-115(1); and
      ii. Clinical oversight to behavioral health technicians, according to R9-10-115(2);
   c. The qualifications for personnel members who provide clinical oversight;
   d. The process for patient assessments, including the identification of and criteria for the on-going monitoring of a patient's behavioral health issues;
   e. The process for developing and implementing a patient's treatment plan;
   f. The frequency of and process for reviewing and modifying a patient's treatment plan, based on the ongoing monitoring of the patient's response to treatment; and
   g. The process for determining whether a patient is eligible for discharge or conditional release to a less restrictive alternative;
3. Shall ensure that patient services are provided by personnel competent and proficient in providing the services; and
4. Shall ensure that clinical oversight of personnel members is provided according to the policies and procedures.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1302 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

**R9-10-1303. Quality Management**

An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1303 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1304. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted without change effective November 25, 1992 (Supp. 92-4). Section R9-10-1304 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1305. Personnel Requirements and Records**

**A.** An administrator shall ensure that a personnel member:
1. Is at least 18 years old; and
2. Either:
   a. Holds a valid fingerprint clearance card issued under A.R.S. Title 41, Chapter 12, Article 3.1; or
   b. Submits to the administrator a copy of a fingerprint clearance card application showing that the personnel member submitted the application to the fingerprint division of the Department of Public Safety under A.R.S. § 41-1758.02 within seven working days after becoming a personnel member.

**B.** An administrator shall ensure that each personnel member submits to the administrator a copy of the individual's valid fingerprint clearance card:
1. Except as provided in subsection (A)(2)(b), before the personnel member's starting date of employment; and
2. Each time the fingerprint clearance card is issued or renewed.

**C.** If a personnel member holds a fingerprint clearance card that was issued before the individual became a personnel member, an administrator shall:
1. Contact the Department of Public Safety within seven working days after the individual becomes a personnel member to determine whether the fingerprint clearance card is valid; and
2. Make a record of this determination, including the name of the personnel member, the date of the contact with the Department of Public Safety, and whether the fingerprint clearance card is valid.

**D.** An administrator shall ensure:
1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures; and
3. Personnel members are present on a behavioral health specialized transitional facility's premises with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the behavioral health specialized transitional facility's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient.

**E.** An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.

**F.** An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a patient for more than eight hours a week, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing service at or on behalf of the behavioral health specialized transition facility, and
2. As specified in R9-10-113.

**G.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   f. Cardiopulmonary resuscitation training, if required for the individual according to this Article or policies and procedures;
   g. First aid training, if required for the individual according to this Article or policies and procedures; and
   h. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).

**H.** An administrator shall ensure that personnel records are maintained:
1. Throughout an individual's period of providing services in or for the behavioral health specialized transitional facility; and
2. For at least 24 months after the last date the individual provided services in or for the behavioral health specialized transitional facility.

**I.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented and implemented; and
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1305 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1306. Admission Requirements**

**A.** An administrator shall ensure that, before a patient is admitted to the behavioral health specialized transitional facility, a court of competent jurisdiction has ordered the patient to be:
1. Detained under A.R.S. § 36-3705(B) or § 36-3713(B); or
2. Committed under A.R.S. § 36-3707.

**B.** An administrator shall ensure that, at the time a patient is admitted to the behavioral health specialized transitional facility:
1. The administrator receives a copy of the court order for the patient to be detained at or committed to the behavioral health specialized transitional facility,

2. The patient's possessions are taken to the bedroom to which the patient has been assigned, and
3. The patient is provided with a written list and verbal explanation of the patient's rights and responsibilities.

**C.** Within seven calendar days after a patient is admitted to the behavioral health specialized transitional facility, a medical director shall ensure that:
1. A medical history is taken from and a physical examination performed on the patient;
2. Except as specified in subsection (C)(3), a patient provides evidence of freedom from infectious tuberculosis as required in R9-10-113;
3. A patient is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
   a. Fewer than 12 months have passed since the patient was screened for tuberculosis, and
   b. The documentation of freedom from infectious tuberculosis required in subsection (C)(2) accompanies the patient at the time of the patient's admission to the behavioral health specialized transitional facility; and
4. An assessment for the patient is completed:
   a. According to the behavioral health specialized transitional facility's policies and procedures;
   b. That includes the patient's:
      i. Legal history, including criminal justice record;
      ii. Behavioral health treatment history;
      iii. Medical conditions and history; and
      iv. Symptoms reported by the patient and referrals needed by the patient, if any; and
   c. That includes:
      i. Recommendations for further assessment or examination of the patient's needs,
      ii. The physical health services or ancillary services that will be provided to the patient until the patient's treatment plan is completed; and
      iii. The signature of the personnel member conducting the assessment and the date signed.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1306 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-10-1307. Discharge or Conditional Release to a Less Restrictive Alternative**

**A.** An administrator shall ensure that annual written notice is given to a patient of the patient's right to petition for:
1. Conditional release to a less restrictive alternative under A.R.S. § 36-3709, or
2. Discharge under A.R.S. § 36-3714.

**B.** An administrator shall ensure that a patient who is detained at or committed to the behavioral health specialized transitional facility is transported to a hearing to determine the patient's continued detention at or commitment to the behavioral health specialized transitional facility.

**C.** An administrator shall ensure that a patient is not discharged or conditionally released to a less restrictive alternative before the behavioral health specialized transitional facility receives documentation from a court of competent jurisdiction of the patient's:
1. Conditional release to a less restrictive alternative, or
2. Discharge including the disposition of the patient upon discharge.

**D.** A clinical director shall ensure that before a patient is discharged or conditionally released to a less restrictive alternative:
1. The clinical director or the clinical director's designee, as specified in the behavioral health specialized transitional facility's discharge policies and procedures, receives the name of the health care provider or behavioral health professional to whom a copy of the patient's discharge summary will be sent; and
2. The patient receives:
   a. Written follow-up instructions including as applicable to the patient:
      i. On-going behavioral health issues and physical health conditions;
      ii. A list of the patient's medications and, for each medication, directions for taking the medication, possible side-effects, and possible results of not taking the medication; and
      iii. Counseling goals; and
   b. A supply of medications determined according to the policies and procedures specified in R9-10-1302(C)(1)(d).

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1307 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

**R9-10-1308. Transportation**

An administrator of a behavioral health specialized transitional facility that uses a vehicle owned or leased by the behavioral health specialized transitional facility to provide transportation to a patient shall ensure that:

1. The vehicle:
   a. Is safe and in good repair,
   b. Contains a locked first aid kit,
   c. Contains a working heating and air conditioning system, and
   d. Contains drinking water sufficient to meet the needs of each patient present in the vehicle;
2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
3. A driver of the vehicle:
   a. Is 21 years of age or older,
   b. Has a valid driver license,
   c. Operates the vehicle in a manner that does not endanger a patient in the vehicle,
   d. Does not leave a patient in the vehicle unattended, and
   e. Ensures the safe and hazard-free loading and unloading of patients; and
4. Transportation safety is maintained as follows:
   a. Each individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
   b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a patient's body.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1308 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1309. Patient Rights**

An administrator shall ensure that:

1. A patient:
   a. Has privacy in treatment and personal care needs;
   b. Has the opportunity for and privacy in correspondence, communications, and visitation unless:
      i. Restricted by court order; or
      ii. Contraindicated on the basis of clinical judgment, as documented in the patient's medical record;
   c. Is given the opportunity to seek, speak to, and be assisted by legal counsel:
      i. Whom the court assigns to the patient, or
      ii. Whom the patient obtains at the patient's own expense; and
   d. Is not subjected to:
      i. Abuse;
      ii. Neglect;
      iii. Exploitation;
      iv. Coercion;
      v. Manipulation;
      vi. Seclusion, if not necessary to prevent imminent harm to self or others;
      vii. Restraint, if not necessary to prevent imminent harm to self or others;
      viii. Sexual abuse according to A.R.S. § 13-1404; or
      ix. Sexual assault according to A.R.S. § 13-1406; and

2. A patient or the patient's representative:
   a. Is provided with the opportunity to participate in the development of the patient's treatment plan and in treatment decisions before the treatment is initiated, except in a medical emergency;
   b. Is provided with information about proposed treatments, alternatives to treatments, associated risks, and possible complications;
   c. Is allowed to control the patient's finances and have access to the patient's personal funds account according to the behavioral health specialized transitional facility's policies and procedures specified in R9-10-1302(C)(1)(j);
   d. Has an opportunity to review the medical record for the patient according to the behavioral health specialized transitional facility's policies and procedures; and
   e. Receives information about the behavioral health specialized transitional facility's policies and procedures for:
      i. Health care directives;
      ii. Filing complaints, including the telephone number of an individual at the behavioral health specialized transitional facility to contact about a complaint and the Department's telephone number; and
      iii. Petitioning a court for a patient's discharge or conditional release to a less restrictive alternative.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1309 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

**R9-10-1310. Behavioral Health Services**

**A.** A clinical director shall ensure that:
1. A treatment plan is developed and implemented for the patient:
   a. According to the behavioral health specialized transitional facility's policies and procedures;
   b. Based on the assessment conducted under R9-10-1306(C)(4) and on-going changes to the assessment of the patient's behavioral health issues, mental disorders, and physical health conditions, as applicable; and
   c. Including:
      i. The physical health services, behavioral health services, and ancillary services to be provided to the patient until completion of the treatment plan;
      ii. The type, frequency, and duration of counseling or other treatment ordered for the patient;
      iii. The name of each individual who ordered medication, counseling, or other treatment for the patient;
      iv. The signature of the patient or the patient's representative and dated signed, or documentation of the refusal to sign;
      v. The date when the patient's treatment plan will be reviewed;
      vi. If a discharge date has been determined, the treatment needed after discharge; and
      vii. The signature of the personnel member who developed the treatment plan and the date signed; and
2. A patient's treatment plan is reviewed and updated:
   a. According to the review date specified in the treatment plan,
   b. When a treatment goal is accomplished or changes,
   c. When additional information that affects the patient's assessment is identified, and
   d. When a patient has a significant change in condition or experiences an event that affects treatment.

**B.** A clinical director shall ensure that treatment is:
1. Offered to a patient according to the patient's treatment plan;
2. Except for a patient obtaining treatment under A.R.S. § 36-512, only provided after obtaining informed consent to the treatment from the patient; and
3. Documented in the patient's medical record as specified in R9-10-1312.

**C.** The clinical director shall ensure that restraint and seclusion are used, performed, and documented according to the behavioral health specialized transitional facility's policies and procedures.

**D.** A clinical director shall ensure that:
1. A patient receives the annual examination required by A.R.S. § 36-3708, and
2. A report of the patient's annual examination is prepared according to the behavioral health specialized transitional facility's policies and procedures.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1310 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

**R9-10-1311. Physical Health Services**

**A.** A medical director shall ensure that:
1. A patient's physical health is assessed during the physical examination specified in R9-10-1306(C)(1), and
2. Any physical health conditions identified through the assessment are addressed in the patient's treatment plan.

**B.** A medical director shall ensure that on-going assessment or treatment of a patient's physical health condition is:
1. Offered to a patient according to the patient's treatment plan;
2. Except for a patient obtaining treatment under A.R.S. § 36-512, only provided after obtaining informed consent to the assessment or treatment from the patient; and
3. Documented in the patient's medical record as specified in R9-10-1312.

**C.** An administrator shall ensure that, if a patient requires assessment or treatment not available at the behavioral health specialized transitional facility, the patient is provided with transportation to the location where assessment or treatment may be provided to the patient.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1311 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1312. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by an individual authorized by facility policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to facility policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or the electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
   c. As permitted by law;
6. A patient's medical record is available to the patient or patient's representative upon request at a time agreed upon by the patient or patient's representative and the administrator; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If a behavioral health specialized transitional facility maintains patient's medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and

2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:

1. A copy of the court order requiring the patient to be detained at or committed to the behavioral health specialized transitional facility;
2. The date the patient was detained at or committed to the behavioral health specialized transitional facility;
3. Patient information that includes:
   a. The patient's name;
   b. The patient's address;
   c. The patient's date of birth; and
   d. Any known allergies, including medication allergies;
4. Documentation of the patient's freedom from infectious tuberculosis as required in R9-10-1306(C)(2);
5. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
6. If applicable, the name and contact information of the patient's representative and:
   a. The document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative;
      i. Is a legal guardian, a copy of the court order establishing guardianship; or
      ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
7. Documentation of medical history and physical examination of the patient;
8. A copy of patient's health care directives, if applicable;
9. Orders;
10. The patient's assessment including updates;
11. The patient's treatment plan including updates;
12. Progress notes;
13. Documentation of transportation provided to the patient;
14. Documentation of behavioral health services and physical health services provided to the patient;
15. Documentation of patient's annual examination and report required by A.R.S. § 36-3708;
16. Documentation of the annual written notice of the patient of the patient's right to petition for:
   a. Conditional release to a less restrictive alternative as required by A.R.S. § 36-3709, or
   b. Discharged as required by A.R.S. § 36-3714;
17. A copy of any petition for discharge or conditional release to a less restrictive alternative filed by the patient and provided to the behavioral health specialized transitional facility and the outcome of the petition;
18. Documentation of the patient's, if applicable;
   a. Conditional release to a less restrictive alternative; or
   b. Discharge, including the disposition of the patient upon discharge;
19. If a patient has been discharged, a discharge summary that includes:
   a. A summary of the treatment provided to the patient;
   b. The patient's progress in meeting treatment goals, including treatment goals that were and were not achieved;
   c. The name, dosage, and frequency of each medication for the patient ordered at the time of the patient's discharge from the behavioral health specialized transitional facility;
   d. A description of the disposition of the patient's possessions, funds, or medications; and
   e. The date the patient was discharged from the behavioral health specialized transitional facility;
20. If applicable:
   a. Laboratory reports,
   b. Radiologic reports,
   c. Diagnostic reports,
   d. Documentation of restraint or seclusion,
   e. Patient follow-up instructions, and
   f. Consultation reports; and
21. Documentation of a medication administered to the patient that includes:
   a. The date and time of administration;
   b. The name, strength, dosage, and route of administration;
   c For a medication administered for pain:
      i. An assessment of the patient's pain before administering the medication, and
      ii. The effect of the medication administered;
   d. For a psychotropic medication:
      i. An assessment of the patient's behavior before administering the psychotropic medication, and

ii. The effect of the psychotropic medication administered;
e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication;
f. Any adverse reaction a patient has to the medication; and
g. If applicable, a patient's refusal to take medication ordered for the patient.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1312 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

**R9-10-1313. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:
1. Include:
   a. A process for providing information to a patient about medication prescribed for the patient, including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse response to a medication, or
      iii. A medication overdose;
   c. Procedures for documenting medication services and assistance in the self-administration of medication; and
   d. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**B.** A medical director shall ensure that:
1. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner;
   b. Specify the individuals who may:
      i. Order medication, and
      ii. Administer medication; and
   c. Ensure that medication is administered to a patient only as prescribed;
2. A patient's refusal to take prescribed medication is documented in the patient's medical record;
3. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
4. A medication administered to a patient:
   a. Is administered in compliance with an order, and
   b. Is documented in the patient's medical record; and
5. If pain medication is administered to a patient on a PRN basis, documentation in the patient's medical record includes:
   a. An identification of the patient's pain before administering the medication, and
   b. The effect of the pain medication administered.

**C.** If a behavioral health specialized transitional facility provides assistance in the self-administration of medication, a medical director shall ensure that:
1. A patient's medication is stored by the behavioral health specialized transitional facility;
2. The following assistance is provided to a patient:
   a. A reminder when it is time to take the medication;
   b. Opening the medication container for the patient;
   c. Observing the patient while the patient removes the medication from the container;
   d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
      i. The patient taking the medication is the individual stated on the medication container label,

ii. The dosage of the medication is the same as stated on the medication container label, and
iii. The medication is being taken by the patient at the time stated on the medication container label; or
e. Observing the patient while the patient takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
4. Training for a personnel member, other than a medical practitioner or nurse, in assistance in the self-administration of medication:
a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
b. Includes:
i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
iii. Process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a patient:
a. Is in compliance with an order, and
b. Is documented in the patient's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members; and
3. If pharmaceutical services are provided:
a. The pharmaceutical services are provided under the direction of a pharmacist;
b. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
c. A copy of the pharmacy license is provided to the Department upon request.

**E.** When medication is stored at a behavioral health specialized transitional facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
c. A medication recall and notification of patients who received recalled medication;
d. Storing, inventorying, and dispensing controlled substances; and
e. Documenting the maintenance of a medication requiring refrigeration.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the behavioral health specialized transitional facility's medical director.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1313 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1314. Food Services**

**A.** An administrator shall ensure that:
1. The behavioral health specialized transitional facility has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
2. A copy of the behavioral health specialized transitional facility's food establishment license is maintained;
3. If a behavioral health specialized transitional facility contracts with a food establishment, as defined in 9 A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health specialized transitional facility:

a. A copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health specialized transitional facility; and
b. The behavioral health specialized transitional facility is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;

4. A registered dietitian is employed full-time, part-time, or as a consultant; and
5. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to meet the nutritional needs of the patients.

**B.** A registered dietitian or director of food services shall ensure that:

1. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the behavioral health specialized transitional facility are served according to posted menus;
3. Meals for each day are planned using the applicable guidelines in http://www.health.gov/dietaryguidelines/2010.asp;
4. A patient is provided:
   a. A diet that meets the patient's nutritional needs as specified in the patient's assessment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(4)(d);
   c. The option to have a daily evening snack identified in subsection (B)(4)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. A patient group agrees; and
      ii. The patient is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
5. A patient requiring assistance to eat is provided with assistance that recognizes the patient's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
6. Water is available and accessible to a patient at all times, unless otherwise specified in the patient's treatment plan.

**C.** An administrator shall ensure that food is obtained, prepared, served, and stored as follows:

1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a patient such as cut, chopped, ground, pureed, or thickened;
4. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below; and
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
      i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
      ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
      iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
      v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
      vi. Leftovers are reheated to a temperature of at least 165° F;
5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
6. Frozen foods are stored at a temperature of 0° F or below; and
7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**Historical Note**

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1314 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1315. Emergency and Safety Standards**

**A.** A medical director shall ensure that policies and procedures for providing medical emergency treatment to a patient are established, documented, and implemented and include:
1. The medications, supplies, and equipment required on the premises for the medical emergency treatment provided by the behavioral health specialized transitional facility;
2. A system to ensure all medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
3. A requirement that a cart or container is available for medical emergency treatment that contains all of the medication, supplies, and equipment specified in the behavioral health specialized transitional facility's policies and procedures;
4. A method to verify and document that the contents of the cart or container in subsection (A)(3) are available for medical emergency treatment; and
5. A method for ensuring a patient may be transported to a hospital or other health care institution to receive treatment for a medical emergency that the behavioral health specialized transitional facility is not able or not authorized to provide.

**B.** An administrator shall ensure that medical emergency treatment is provided to a patient admitted to the behavioral health specialized transitional facility according to the behavioral health specialized transitional facility's policies and procedures.

**C.** An administrator shall ensure that the behavioral health specialized transitional facility has:
1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and a sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order; or
2. An alternative method to ensure a patient's safety, documented and approved by the local jurisdiction.

**D.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
   a. Procedures for protecting the health and safety of patients and other individuals at the behavioral health specialized transitional facility;
   b. When, how, and where patients will be relocated;
   c. How each patient's medical record will be available to personnel providing services to the patient during a disaster;
   d. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
   e. A plan for obtaining food and water for individuals present in the behavioral health specialized transitional facility or the behavioral health specialized transitional facility's relocation site during a disaster;
2. The disaster plan required in subsection (D)(1) is reviewed at least once every 12 months;
3. A disaster drill is performed on each shift at least once every 12 months;
4. Documentation of a disaster plan review required in subsection (D)(2) and a disaster drill required in subsection (D)(3) is created, is maintained for at least 12 months after the date of the disaster plan review or disaster drill, and includes:
   a. The date and time of the disaster plan review or disaster drill;
   b. The name of each personnel member, employee, or volunteer participating in the disaster plan review or disaster drill;
   c. A critique of the disaster plan review or disaster drill; and
   d. If applicable, recommendations for improvement;
5. An evacuation drill is conducted on each shift at least once every three months;
6. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for all employees and patients to evacuate the behavioral health specialized transitional facility;
   c. If applicable, an identification of patients needing assistance for evacuation;
   d. Any problems encountered in conducting the evacuation drill; and
   e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health specialized transitional facility.

**E.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

**R9-10-1316. Environmental Standards**

**A.** An administrator shall ensure that:
1. The premises and equipment are:
   a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
   b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Biohazardous medical wastes are identified, stored, and disposed of according to 18 A.A.C. 13, Article 14;
4. Equipment used at the behavioral health specialized transitional facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
6. Garbage and refuse are:
   a. Stored in covered containers, and
   b. Removed from the premises at least once a week;
7. Heating and cooling systems maintain the behavioral health specialized transitional facility at a temperature between 70° F and 84° F;
8. Common areas:
   a. Are lighted to assure the safety of patients, and
   b. Have lighting sufficient to allow personnel members to monitor patient activity;
9. Hot water temperatures are maintained between 95° F and 120° F in the areas of a behavioral health specialized transitional facility used by patients;
10. The supply of hot and cold water is sufficient to meet the personal hygiene needs of patients and the cleaning and sanitation requirements in this Article;
11. Soiled linen and soiled clothing stored by the behavioral health specialized transitional facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas; and
12. Pets and animals, except for service animals, are prohibited on the premises.

**B.** An administrator shall ensure that smoking or tobacco products are not permitted within or on the premises of the facility.

**C.** An administrator shall ensure that:
1. Poisonous or toxic materials stored by the behavioral health specialized transitional facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
2. Combustible or flammable liquids and hazardous materials stored by a behavioral health specialized transitional facility are stored in the original labeled containers or safety containers in an area inaccessible to patients; and
3. Poisonous, toxic, combustible, or flammable medical supplies in use for a patient are stored in a locked area according to the behavioral health specialized transitional facility's policies and procedures.

**D.** An administrator shall ensure that:
1. A patient's bedroom is provided with:
   a. An individual storage space, such as a dresser or chest;
   b. A bed that:
      i. Consists of at least a mattress and frame, and
      ii. Is at least 36 inches wide and 72 inches long; and
   c. A pillow and linens that include:
      i. A mattress pad;
      ii. A top sheet and a bottom sheet are large enough to tuck under the mattress;
      iii. A pillow case;
      iv. A waterproof mattress cover, if needed; and
      v. A blanket or bedspread sufficient to ensure the patient's warmth;
2. Clean linens and bath towels are provided to a patient as needed and at least once every seven calendar days; and
3. A patient's clothing may be cleaned according to policies and procedures.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-1317. Physical Plant Standards**

**A.** An administrator shall ensure that a behavioral health specialized transitional facility complies with the applicable physical plant health and safety codes and standards for secure residential facilities, incorporated by reference in R9-10-104.01, in effect on the date the behavioral health specialized transitional facility submitted architectural plans and specifications to the Department for approval according to R9-10-104.

**B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the behavioral health specialized transitional facility's scope of services, and
2. An individual accepted as a patient by the behavioral health specialized transitional facility.

**C.** An administrator shall ensure that:
1. A behavioral health specialized transitional facility has:
   a. An area in which a patient may meet with a visitor,
   b. Areas where patients may receive individual treatment,
   c. Areas where patients may receive group counseling or other group treatment,
   d. An area for community dining; and
   e. Sufficient space in one or more common areas for individual and group activities.

**D.** An administrator shall ensure that the behavioral health specialized transitional facility has:
1. A bathroom adjacent to a common area for use by patients and visitors that:
   a. Provides privacy to the user; and
   b. Contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue dispenser,
      iv. Dispensed soap for hand washing,
      v. Single use paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A means of ventilation;
2. An indoor common area that is not used as a sleeping area and that has:
   a. A working telephone that allows a patient to make a private telephone call;
   b. A distortion-free mirror;
   c. A current calendar and an accurate clock;
   d. A variety of books, current magazines and newspapers, and arts and crafts supplies appropriate to the age, educational, cultural, and recreational needs of patients; and
   e. A working television and access to a radio;
3. A dining room or dining area that:
   a. Is lighted and ventilated,
   b. Contains tables and seats, and
   c. Is not used as a sleeping area;
4. An outdoor area that:
   a. Is accessible to patients,
   b. Has sufficient space to accommodate the social and recreational needs of patients, and
   c. Has shaded and unshaded areas;
5. For every ten patients, at least one working toilet that flushes and has a seat and dispensed toilet tissue;
6. For every 12 patients, at least one sink with running water, dispensed soap for hand washing, and single use paper towels or a mechanical air hand dryer;
7. For every 12 patients, at least one working bathtub or shower with a slip resistant surface; and
8. For each patient, a private bedroom that:
   a. Contains at least 60 square feet of floor space, not including the closet;
   b. Has walls from floor to ceiling;
   c. Has a door that opens into a hallway or common area;
   d. Is constructed and furnished to provide unimpeded access to the door;
   e. Is not used as a passageway to another bedroom or a bathroom, unless the bathroom is for the exclusive use of a the patient occupying the bedroom; and
   f. Has sufficient lighting for a patient to read.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

## ARTICLE 14. SUBSTANCE ABUSE TRANSITIONAL FACILITIES

**R9-10-1401. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

"Emergency medical care technician" has the same meaning as in A.R.S. § 36-2201.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1402. Administration**

**A.** A governing authority shall:

1. Consist of one or more individuals accountable for the organization, operation, and administration of a substance abuse transitional facility;
2. Establish, in writing:
   a. A substance abuse transitional facility's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who meets the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1403;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
   a. Expected not to be present on a substance abuse transitional facility's premises for more than 30 calendar days, or
   b. Not present on a substance abuse transitional facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:

1. Is directly accountable to the governing authority for the daily operation of the substance abuse transitional facility and all services provided by or at the substance abuse transitional facility;
2. Has the authority and responsibility to manage the substance abuse transitional facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on a substance abuse transitional facility's premises and accountable for the substance abuse transitional facility when the administrator is not present on the substance abuse transitional facility's premises.

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a participant;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Cover cardiopulmonary resuscitation training, including:
      i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
      iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
      iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
   f. Include a method to identify a participant to ensure the participant receives physical health services and behavioral health services as ordered;
   g. Cover first aid training;
   h. Cover participant rights, including assisting a participant who does not speak English or who has a physical or other disability to become aware of participant rights;
   i. Cover specific steps for:
      i. A participant to file a complaint, and
      ii. The substance abuse transitional facility to respond to a participant's complaint;
   j. Cover medical records, including electronic medical records;
   k. Cover quality management, including incident reports and supporting documentation;
   l. Cover contracted services; and
   m. Cover when an individual may visit a participant in the substance abuse transitional facility;

2. Policies and procedures for services are established, documented, and implemented to protect the health and safety of a participant that:
   a. Cover participant screening, admission, assessment, transfer, discharge planning, and discharge;
   b. Include when general consent and informed consent are required;
   c. Cover the provision of behavioral health services and physical health services;
   d. Cover medication administration, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
   e. Cover infection control;
   f. Cover environmental services that affect participant care;
   g. Cover the process for receiving a fee from and refunding a fee to a participant or the participant's representative;
   h. Cover the security of a participant's possessions that are allowed on the premises;
   i. Cover smoking tobacco products on the premises;
   j. Cover how the facility will respond to a participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual; and
   k. Cover how often periodic monitoring occurs based on a participant's condition;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to employees; and
5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a substance abuse transitional facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the substance abuse transitional facility.

**D.** An administrator shall provide written notification to the Department of a participant's:
1. Death, if the participant's death is required to be reported according to A.R.S. § 11-593, within one working day after the participant's death; and
2. Self-injury, within two working days after the participant inflicts a self-injury that requires immediate intervention by an emergency medical services provider.

**E.** If abuse, neglect, or exploitation of a participant is alleged or suspected to have occurred before the participant was admitted or while the participant is not on the premises and not receiving services from a substance abuse transitional facility's employee or personnel member, an administrator shall immediately report the alleged or suspected abuse, neglect, or exploitation of the participant according to A.R.S. § 46-454.

**F.** If an administrator has a reasonable basis, according to A.R.S. § 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a participant is receiving services from a substance abuse transitional facility's employee or personnel member, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the participant according to A.R.S. § 46-454;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (F)(1); and
   c. The report in subsection (F)(2);
4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the participant and any change to the participant's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**G.** An administrator shall establish, document, and implement a process for responding to a participant's need for immediate and unscheduled behavioral health services or physical health services.

**H.** An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, an employee, a participant, or a participant's representative:
1. The participant rights listed in R9-10-1409,
2. The facility's current license,
3. The location at which inspection reports are available for review or can be made available for review, and

4. The days and times when a participant may accept visitors and make telephone calls.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1402 repealed; new Section R9-10-1402 renumbered from Section R9-10-1403 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1403. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to participants;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to participant care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to participant care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to participant care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to participant care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1403 renumbered to R9-10-1402; new Section R9-10-1403 renumbered from R9-10-1404 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1404. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1404 renumbered to R9-10-1403; new Section R9-10-1404 renumbered from R9-10-1405 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1405. Personnel**

**A.** An administrator shall ensure that:

1. A personnel member is:
   a. At least 21 years old, or
   b. If providing behavioral health services, at least 18 years old;
2. An employee is at least 18 years old;
3. A student is at least 18 years old; and
4. A volunteer is at least 21 years old.

**B.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of participants receiving behavioral health services or physical health services from the personnel member according to the established job description;
   b. Include:
      i. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;

ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description, and
iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides behavioral health services or physical health services, and
   b. According to policies and procedures;
3. An emergency medical care technician complies with the requirements in 9 A.A.C. 25 for certification and medical direction;
4. A substance abuse transitional facility has sufficient personnel members with the qualifications, education, experience, skills, and knowledge necessary to:
   a. Provide the behavioral health services and physical health services in the substance abuse transitional facility's scope of services,
   b. Meet the needs of a participant, and
   c. Ensure the health and safety of a participant;
5. A written plan is developed and implemented to provide orientation specific to the duties of a personnel member;
6. A personnel member's orientation is documented, to include:
   a. The personnel member's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
7. In addition to the training required in subsections (B)(1) and (B)(5), a written plan is developed and implemented to provide a personnel member with in-service education specific to the duties of the personnel member;
8. A personnel member's skills and knowledge are verified and documented:
   a. Before providing services related to participant care, and
   b. At least once every 12 months after the date the personnel member begins providing services related to participant care; and
9. An individual's in-service education and, if applicable, training in how to respond to a participant's sudden, intense, or out-of-control behavior is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training.

**C.** An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as a baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor receives direct supervision as defined in A.A.C. R4-6-101.

**D.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have direct interaction with a participant for more than eight hours in a week, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the substance abuse transitional facility, and
2. As specified in R9-10-113.

**E.** An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.

**F.** An administrator shall ensure that a personnel record is maintained for a personnel member, employee, volunteer, or student that contains:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. The individual's completion of the training required in subsection (B)(8), if applicable;
   f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   g. Cardiopulmonary resuscitation training, if required for the individual according to subsection (H) or policies and procedures;
   h. First aid training, if required for the individual according to subsection (H) or policies and procedures; and
   i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (D).

**G.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout an individual's period of providing services at or for a substance abuse transitional facility, and

b. For at least 24 months after the last date the individual provided services at or for a substance abuse transitional facility; and

2. For a personnel member who has not provided physical health services or behavioral health services at or for the substance abuse transitional facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**H.** An administrator shall ensure at least one personnel member who is present at the substance abuse transitional facility during hours of facility operation has first-aid and cardiopulmonary resuscitation training certification specific to the populations served by the facility.

**I.** An administrator shall ensure that:

1. At least one personnel member is present and awake at a substance abuse transitional facility at all times when a participant is on the premises;
2. In addition to the personnel member in subsection (I)(1), at least one personnel member is on-call and available to come to the substance abuse transitional facility if needed;
3. A substance abuse transitional facility has sufficient personnel members to provide general participant supervision and treatment and sufficient personnel members or employees to provide ancillary services to meet the scheduled and unscheduled needs of each participant;
4. There is a daily staffing schedule that:
   a. Indicates the date, scheduled work hours, and name of each individual assigned to work, including on-call individuals;
   b. Includes documentation of the employees who work each day and the hours worked by each employee; and
   c. Is maintained for at least 12 months after the last date on the documentation;
5. A behavioral health professional is present on the substance abuse transitional facility's premises or on-call; and
6. A registered nurse is present on the substance abuse transitional facility's premises or on-call.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1405 renumbered to R9-10-1404; new Section R9-10-1405 renumbered from R9-10-1406 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1406. Admission; Assessment**

An administrator shall ensure that:

1. A participant is admitted based upon the participant's presenting behavioral health issue and treatment needs and the substance abuse transitional facility's ability and authority to provide behavioral health services or physical health services consistent with the participant's needs;
2. General consent is obtained from a participant or the participant's representative before or at the time of admission ;
3. The general consent obtained in subsection (2) is documented in the participant's medical record;
4. An assessment of a participant is completed or updated by an emergency medical care technician or a registered nurse;
5. If an assessment is completed or updated by an emergency medical care technician, a registered nurse reviews the assessment within 24 hours after the completion of the assessment to ensure that the assessment identifies the behavioral health services and physical health services needed by the participant;
6. If an assessment that complies with the requirements in this Section is received from a behavioral health provider other than the substance abuse transitional facility or the substance abuse transitional facility has a medical record for the participant that contains an assessment that was completed within 12 months before the date of the participant's current admission:
   a. The participant's assessment information is reviewed and updated if additional information that affects the participant's assessment is identified, and
   b. The review and update of the participant's assessment information is documented in the participant's medical record within 48 hours after the review is completed;
7. An assessment:
   a. Documents a participant's:
      i. Presenting issue;
      ii. Substance abuse history;
      iii. Co-occurring disorder;
      iv. Medical condition and history;
      v. Behavioral health treatment history;
      vi. Symptoms reported by the participant; and
      vii. Referrals needed by the participant, if any;
   b. Includes:
      i. Recommendations for further assessment or examination of the participant's needs,
      ii. The behavioral health services and physical health services that will be provided to the participant, and
      iii. The signature and date signed of the personnel member conducting the assessment; and
   c. Is documented in participant's medical record;

8. A participant is referred to a medical practitioner if a determination is made that the participant requires immediate physical health services or the participant's behavioral health issue may be related to the participant's medical condition;
9. If a participant requires behavioral health services that the substance abuse transitional facility is not authorized or not able to provide, a personnel member arranges for the participant to be provided transportation to transfer to another health care institution where the behavioral health services can be provided;
10. A request for participation in a participant's assessment is made to the participant or the participant's representative;
11. An opportunity for participation in the participant's assessment is provided to the participant or the participant's representative;
12. Documentation of the request in subsection (10) and the opportunity in subsection (11) is in the participant's medical record; and
13. A participant's assessment information is:
    a. Documented in the medical record within 48 hours after completing the assessment, and
    b. Reviewed and updated when additional information that affects the participant's assessment is identified.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1406 renumbered to R9-10-1405; new Section R9-10-1406 renumbered from R9-10-1407 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1407. Discharge**

**A.** An administrator shall ensure that:
1. If a participant is not being transferred to another health care institution, before discharging the participant from a substance abuse transitional facility, a personnel member:
    a. Identifies the specific needs of the participant after discharge necessary to assist the participant to address the participant's substance abuse issues;
    b. Identifies any resources, including family members, community social services, peer support services, and Regional Behavioral Health Agency staff, that may be available to assist the participant; and
    c. Documents the information in subsection (A)(1)(a) and the resources in subsection (A)(1)(b) in the participant's medical record; and
2. When an individual is discharged, a personnel member:
    a. Provides the participant with discharge information that includes:
        i. The identified specific needs of the participant after discharge, and
        ii. Resources that may be available for the participant; and
    b. Contacts any resources identified as required in subsection (A)(1)(b).

**B.** An administrator shall ensure that there is a documented discharge order by a medical practitioner before a participant is discharged unless the participant leaves the facility against a medical practitioner's advice.

**C.** An administrator shall ensure that, at the time of discharge, a participant receives a referral for behavioral health services that the participant may need after discharge, if applicable.

**D.** An administrator shall ensure that a discharge summary:
1. Is entered into the participant's medical record within 10 working days after a participant's discharge; and
2. Includes the following information completed by an individual authorized by policies and procedures:
    a. The participant's presenting issue and other behavioral health and physical health issues identified in the participant's assessment;
    b. A summary of the behavioral health services and physical health services provided to the participant;
    c. The name, dosage, and frequency of each medication for the participant ordered at the time of the participant's discharge by a medical practitioner at the facility; and
    d. A description of the disposition of the participant's possessions, funds, or medications brought to the facility by the participant.

**E.** An administrator shall ensure that a participant who is dependent upon a prescribed medication is offered a written referral to detoxification services or opioid treatment before the participant is discharged.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1407 renumbered to R9-10-1406; new Section R9-10-1407 renumbered from R9-10-1408 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1408. Transfer**

Except for a transfer of a participant due to an emergency, an administrator shall ensure that:
1. A personnel member coordinates the transfer and the services provided to the participant;

2. According to policies and procedures:
   a. An evaluation of the participant is conducted before the transfer;
   b. Information in the participant's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the participant or the participant's representative; and
3. Documentation in the participant's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the participant during a transfer.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1408 renumbered to R9-10-1407; new Section R9-10-1408 renumbered from R9-10-1409 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1409. Participant Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the participant rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a participant or the participant's representative receives a written copy of the requirements in subsection (B) and the participant rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant that include:
   a. How and when a participant or the participant's representative is informed of participant rights in subsection (C), and
   b. Where participant rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A participant is treated with dignity, respect, and consideration;
2. A participant is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity;
   k. Misappropriation of personal and private property by the substance abuse transitional facility's personnel members, employees, volunteers, or students; or
   l. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the participant's treatment needs, except as established in a fee agreement signed by the participant or the participant's representative; and
3. A participant or the participant's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication, associated risks, and possible complications;
   d. Is informed of the participant complaint process; and
   e. Except as otherwise permitted by law, provides written consent to the release of information in the participant's:
      i. Medical record, or
      ii. Financial records.

**C.** A participant has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that:
   a. Supports and respects the participant's individuality, choices, strengths, and abilities;
   b. Supports the participant's personal liberty and only restricts the participant's personal liberty according to a court order, by the participant's or the participant's representative's general consent, or as permitted in this Chapter; and
   c. Is provided in the least restrictive environment that meets the participant's treatment needs;

3. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
   a. A participant may be photographed when admitted to a substance abuse transitional facility for identification and administrative purposes;
   b. For a participant receiving treatment according to A.R.S. Title 36, Chapter 37; or
   c. For video recordings used for security purposes that are maintained only on a temporary basis;
4. To review, upon written request, the participant's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the substance abuse transitional facility is not authorized or not able to provide behavioral health services or physical health services needed by the participant;
6. To participate or have the participant's representative participate in the development of or decisions concerning treatment;
7. To receive assistance from a family member, the participant's representative, or other individual in understanding, protecting, or exercising the participant's rights;
8. To be provided locked storage space for the participant's belongings while the participant receives services; and
9. To be informed of the requirements necessary for the participant's discharge.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1409 renumbered to R9-10-1408; new Section R9-10-1409 renumbered from R9-10-1410 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1410. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each participant according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a participant's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the participant's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A participant's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the participant's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the participant or the participant's representative; or
   c. As permitted by law; and
6. A participant's medical record is protected from loss, damage, or unauthorized use.

**B.** If a substance abuse transitional agency maintains participants' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a participant's medical record contains:
1. Participant information that includes:
   a. The participant's name;
   b. The participant's address;
   c. The participant's date of birth; and
   d. Any known allergies, including medication allergies;
2. A participant's presenting behavioral health issue;
3. Documentation of general consent and, if applicable, informed consent for treatment by the participant or the participant's representative, except in an emergency;
4. If applicable, the name and contact information of the participant's representative and:
   a. The document signed by the participant consenting for the participant's representative to act on the participant's behalf; or
   b. If the participant's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;

5. Documentation of medical history and results of a physical examination;
6. The date of admission and, if applicable, date of discharge;
7. Orders;
8. Assessment;
9. Progress notes;
10. Documentation of substance abuse transitional agency services provided to the participant;
11. If applicable, documentation of any actions taken to control the participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual;
12. The disposition of the participant upon discharge;
13. The discharge plan;
14. A discharge summary, if applicable; and
15. Documentation of a medication administered to a participant that includes:
    a. The date and time of administration;
    b. The name, strength, dosage, and route of administration;
    c. For a medication administered for pain:
        i. An evaluation of the participant's pain before administering the medication, and
        ii. The effect of the medication administered;
    d. For a psychotropic medication:
        i. An evaluation of the participant's behavior before administering the psychotropic medication, and
        ii. The effect of the psychotropic medication administered;
    e. The signature of the individual administering the medication; and
    f. Any adverse reaction a participant has to the medication.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1410 renumbered to R9-10-1409; new Section R9-10-1410 renumbered from R9-10-1411 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1411. Behavioral Health Services**

**A.** An administrator shall ensure that counseling is:
1. Offered as described in the substance abuse transitional facility's scope of services,
2. Provided according to the frequency and number of hours identified in the participant's assessment, and
3. Provided by a behavioral health professional.

**B.** An administrator shall ensure that:
1. A behavioral health professional providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
2. Each counseling session is documented in a participant's medical record to include:
    a. The date of the counseling session;
    b. The amount of time spent in the counseling session;
    c. Whether the counseling was individual counseling, family counseling, or group counseling;
    d. The treatment goals addressed in the counseling session; and
    e. The signature of the personnel member who provided the counseling and the date signed.

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1411 renumbered to R9-10-1410; new Section R9-10-1411 renumbered from R9-10-1412 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1412. Medication Services**

**A.** If a facility provides medication administration or assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication services:
1. Include:
    a. A process for providing information to a participant about medication prescribed for the participant including:
        i. The prescribed medication's anticipated results,
        ii. The prescribed medication's potential adverse reactions,
        iii. The prescribed medication's potential side effects, and
        iv. Potential adverse reactions that could result from not taking the medication as prescribed;
    b. Procedures for preventing, responding to, and reporting:
        i. A medication error,

ii. An adverse reaction to a medication, or
iii. A medication overdose;
c. Procedures to ensure that a participant's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the participant's needs;
d. Procedures for documenting medication administration and assistance in the self-administration of medication;
e. Procedures for assisting a participant in obtaining medication; and
f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. Specify a process for review through the quality management program of:
a. A medication administration error, and
b. An adverse reaction to a medication.

**B.** If a substance abuse transitional facility provides medication administration, an administrator shall ensure that:
1. Policies and procedures for medication administration:
a. Are reviewed and approved by a medical practitioner;
b. Specify the individuals who may:
i. Order medication, and
ii. Administer medication;
c. Ensure that medication is administered to a participant only as prescribed;
d. Cover the documentation of a participant's refusal to take prescribed medication in the participant's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a participant:
a. Is administered in compliance with an order, and
b. Is documented in the participant's medical record.

**C.** If a substance abuse transitional facility provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A participant's medication is stored by the substance abuse transitional facility;
2. The following assistance is provided to a participant:
a. A reminder when it is time to take the medication;
b. Opening the medication container for the participant;
c. Observing the participant while the participant removes the medication from the container;
d. Verifying that the medication is taken as ordered by the participant's medical practitioner by confirming that:
i. The participant taking the medication is the individual stated on the medication container label,
ii. The participant is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
iii. The participant is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
e. Observing the participant while the participant takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse;
b. Includes:
i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a participant:
a. Is in compliance with an order, and
b. Is documented in the participant's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members, and
2. A current toxicology reference guide is available for use by personnel members.

**E.** When medication is stored at the substance abuse transitional facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;

2. Medication is stored according to the instructions of the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of participants who received recalled medication;
   d. Storing, inventorying, and dispensing controlled substances; and
   e. Documenting the maintenance of a medication requiring refrigeration.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a participant's adverse reaction to a medication to the medical practitioner who ordered the medication and the registered nurse required in R9-10-1405(I)(6).

**Historical Note**

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1412 renumbered to R9-10-1411; new Section R9-10-1412 renumbered from R9-10-1413 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1413. Food Services**

**A.** An administrator shall ensure that:
1. If a substance abuse transitional facility has a licensed capacity of more than 10 participants:
   a. Food services are provided in compliance with 9 A.A.C. 8, Article 1; and
   b. A copy of the substance abuse transitional facility's food establishment license or permit required according to subsection (A)(1) is maintained;
2. If a substance abuse transitional facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the facility:
   a. A copy of the contracted food establishment's license or permit is maintained by the substance abuse transitional facility; and
   b. The substance abuse transitional facility is able to store, refrigerate, and reheat food to meet the dietary needs of a participant;
3. A registered dietitian is employed full-time, part-time, or as a consultant; and
4. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to meet the nutritional needs of the participants.

**B.** A registered dietitian or director of food services shall ensure that:
1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a participant such as cut, chopped, ground, pureed, or thickened;
2. A food menu is:
   a. Prepared at least one week in advance,
   b. Conspicuously posted, and
   c. Maintained for at least 60 calendar days after the last day included in the food menu;
3. If there is a change to a posted food menu, the change is noted on the posted menu no later than the morning of the day the change occurs;
4. Meals and snacks provided by the substance abuse transitional facility are served according to posted menus;
5. Meals and snacks for each day are planned using the applicable guidelines in http://www.health.gov/dietaryguidelines/2010.asp;
6. A participant is provided:
   a. A diet that meets the participant's nutritional needs as specified in the participant's assessment;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(6)(d);
   c. The option to have a daily evening snack identified in subsection (B)(6)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. The participant agrees; and
      ii. The participant is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
7. A participant requiring assistance to eat is provided with assistance that recognizes the participant's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
8. Water is available and accessible to participants at all times, unless otherwise stated in a participant's assessment.

**C.** An administrator shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Potentially hazardous food is maintained as follows:

a. Foods requiring refrigeration are maintained at 41° F or below; and
b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
i. Ground beef and any food containing ground beef are cooked to heat all parts of the food to at least 155° F;
ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
v. If the facility serves a population that is not a highly susceptible population, rare roast beef may be served cooked to an internal temperature of at least 145° F for at least three minutes and a whole muscle intact beef steak may be served cooked on both top and bottom to a surface temperature of at least 145° F; and
vi. Leftovers are reheated to a temperature of at least 165° F;
4. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
5. Frozen foods are stored at a temperature of 0° F or below; and
6. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1413 renumbered to R9-10-1412; new Section R9-10-1413 renumbered from R9-10-1414 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1414. Emergency and Safety Standards**

**A.** An administrator shall ensure that:
1. An evacuation drill for employees and participants on the premises is conducted at least once every six months on each shift;
2. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
a. The date and time of the drill;
b. The amount of time taken for all employees and participants to evacuate the substance abuse transitional facility;
c. Any problems encountered in conducting the drill; and
d. Recommendations for improvement, if applicable;
3. An evacuation path is conspicuously posted on each hallway of each floor of the facility;
4. A disaster plan is developed, documented, maintained in a location accessible to personnel members, and, if necessary, implemented that includes:
a. When, how, and where participants will be relocated;
b. How a participant's medical record will be available to individuals providing services to the participant during a disaster;
c. A plan to ensure a participant's medication will be available to administer to the participant during a disaster; and
d. A plan for obtaining food and water for individuals present in the substance abuse transitional facility or the substance abuse transitional facility's relocation site during a disaster;
5. The disaster plan required in subsection (A)(4) is reviewed at least once every 12 months;
6. Documentation of a disaster plan review required in subsection (A)(5) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
a. The date and time of the disaster plan review;
b. The name of each employee or volunteer participating in the disaster plan review;
c. A critique of the disaster plan review; and
d. If applicable, recommendations for improvement; and
7. A disaster drill for employees is conducted on each shift at least once every three months and documented.

**B.** An administrator shall ensure that:
1. A fire inspection is conducted by a local fire department or the State Fire Marshal before licensing and according to the time-frame established by the local fire department or the State Fire Marshal,
2. Any repairs or corrections stated on the fire inspection report are made, and
3. Documentation of a current fire inspection is maintained.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1414 renumbered to R9-10-1413; new Section R9-10-1414 renumbered from R9-10-1415 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1415. Environmental Standards**

**A.** An administrator shall ensure that:

1. The premises and equipment are sufficient to accommodate the activities, treatment, and ancillary services stated in the substance abuse transitional facility's scope of services;
2. The premises and equipment are:
   a. Maintained in a condition that allows the premises and equipment to be used for the original purpose of the premises and equipment,
   b. Clean, and
   c. Free from a condition or situation that may cause a participant or other individual to suffer physical injury or illness;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. Biohazardous waste and hazardous waste are identified, stored, used, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
5. Equipment used at the substance abuse transitional facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
6. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
7. Garbage and refuse are:
   a. Stored in plastic bags in covered containers, and
   b. Removed from the premises at least once a week;
8. Heating and cooling systems maintain the facility at a temperature between 70° F and 84° F at all times;
9. A space heater is not used;
10. Common areas:
    a. Are lighted to assure the safety of participants, and
    b. Have lighting sufficient to allow personnel members to monitor participant activity;
11. Hot water temperatures are maintained between 95° F and 120° F in the areas of the substance abuse transitional facility used by participants;
12. The supply of hot and cold water is sufficient to meet the personal hygiene needs of participants and the cleaning and sanitation requirements in this Article;
13. Soiled linen and soiled clothing stored by the substance abuse transitional facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
14. Oxygen containers are secured in an upright position;
15. Poisonous or toxic materials stored by the substance abuse transitional facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to participants;
16. Combustible or flammable liquids and hazardous materials stored by the substance abuse transitional facility are stored in the original labeled containers or safety containers in a locked area inaccessible to participants;
17. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
    a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
    b. If necessary, corrective action is taken to ensure the water is safe to drink; and
    c. Documentation of testing is retained for at least 12 months after the date of the test; and
18. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

**B.** An administrator shall ensure that:

1. Smoking tobacco products is not permitted within a substance abuse transitional facility; and
2. Smoking tobacco products may be permitted on the premises outside a substance abuse transitional facility if:
   a. Signs designating smoking areas are conspicuously posted, and
   b. Smoking is prohibited in areas where combustible materials are stored or in use.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1415 renumbered to R9-10-1414; new Section R9-10-1415 renumbered from R9-10-1416 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-1416. Physical Plant Standards**

**A.** An administrator shall ensure that a substance abuse transitional facility has:

1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and a sprinkler system installed according to the National

Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order; or

2. An alternative method to ensure participant safety that is documented and approved by the local jurisdiction.

**B.** An administrator shall ensure that:

1. If a participant has a mobility, sensory, or other physical impairment, modifications are made to the premises to ensure that the premises are accessible to and usable by the participant; and
2. A substance abuse transitional facility has:
   a. A room that provides privacy for a participant to receive treatment or visitors; and
   b. A common area and a dining area that:
      i. Are not converted, partitioned, or otherwise used as a sleeping area; and
      ii. Contain furniture and materials to accommodate the recreational and socialization needs of the participants and other individuals in the facility.

**C.** An administrator shall ensure that:

1. For every six participants, there is at least one working toilet that flushes and one sink with running water;
2. For every eight participants, there is at least one working bathtub or shower;
3. A participant bathroom provides privacy when in use and contains:
   a. A shatter-proof mirror;
   b. Toilet tissue for each toilet;
   c. Soap accessible from each sink;
   d. Paper towels in a dispenser or a mechanical air hand dryer for a bathroom that is used by more than one participant;
   e. A window that opens or another means of ventilation; and
   f. Nonporous surfaces for shower enclosures, clean usable shower curtains, and slip-resistant surfaces in tubs and showers;
4. Each participant is provided a bedroom for sleeping; and
5. A participant bedroom complies with the following:
   a. Is not used as a common area;
   b. Except as provided in subsection (D):
      i. Contains a door that opens into a hallway, common area, or outdoors; and
      ii. In addition to the door in subsection (C)(5)(b)(i), contains another means of egress;
   c. Is constructed and furnished to provide unimpeded access to the door;
   d. Has window or door covers that provide participant privacy;
   e. Except as provided in subsection (D), is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of an individual occupying the bedroom;
   f. Has floor to ceiling walls;
   g. Is a:
      i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
      ii. Shared bedroom that, except as provided in subsection (D):
         (1) Is shared by no more than eight participants;
         (2) Contains at least 60 square feet of floor space, not including a closet, for each individual occupying the bedroom; and
         (3) Provides at least three feet of floor space between beds or bunk beds;
   h. Except as provided in subsection (D), contains for each participant occupying the bedroom:
      i. A bed that is at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and linens; and
      ii. Individual storage space for personnel effects and clothing such as a dresser or chest; and
   i. Has sufficient lighting for participant occupying the bedroom to read.

**D.** An administrator of a substance abuse transitional facility that uses a building that was licensed as a rural substance abuse transitional center before October 1, 2013 shall ensure that:

1. A bedroom has a door that allows egress from the bedroom,
2. A shared bedroom contains enough space to allow each participant occupying the bedroom to freely move about the bedroom,
3. A bed is of a sufficient size to accommodate a participant using the bed and provide space for all parts of the participant's body on the bed's mattress, and
4. A participant is provided storage space on a substance abuse transitional facility's premises that is accessible to the participant.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1416 renumbered to R9-10-1415; new Section R9-10-1416 renumbered from R9-10-1417 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

**R9-10-1417. Renumbered**

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1417 renumbered to R9-10-1416 by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

## ARTICLE 15. ABORTION CLINICS

**R9-10-1501. Definitions**

In addition to the definitions in A.R.S. §§ 36-401, 36-449.01, 36-449.03, 36-2151, 36-2158, and 36-2301.01 and R9-10-101, the following definitions apply in this Article, unless otherwise specified:

1. "Admitting privileges" means permission extended by a hospital to a physician to allow admission of an individual as an inpatient, as defined in R9-10-201:
   a. By the patient's own physician, or
   b. Through a written agreement between the patient's physician and another physician that states that the other physician has permission to personally admit the patient to a hospital in this state and agrees to do so.
2. "Course" means training or education, including hands-on practice under the supervision of a physician.
3. "Employee" means an individual who receives compensation from a licensee, but does not provide medical services, nursing services, or health-related services.
4. "First trimester" means 1 through 14 weeks as measured from the first day of the last menstrual period or 1 through 12 weeks as measured from the date of fertilization.
5. "Incident" means an abortion-related patient death or serious injury to a patient or fetus delivered alive.
6. "Local" means under the jurisdiction of a city or county in Arizona.
7. "Medical director" means a physician who is responsible for the direction of the medical services, nursing services, and health-related services provided to patients at an abortion clinic.
8. "Medical evaluation" means obtaining a patient's medical history, performing a physical examination of a patient's body, and conducting laboratory tests as provided in R9-10-1509.
9. "Monitor" means to observe and document, continuously or intermittently, the values of certain physiologic variables on a patient such as pulse, blood pressure, oxygen saturation, respiration, and blood loss.
10. "Neonatal resuscitation" means procedures to assist in maintaining the life of a fetus delivered alive, as described in A.R.S. § 36-2301(D)(3).
11. "Patient" means a female receiving medical services, nursing services, or health-related services related to an abortion.
12. "Patient care staff member" means a physician, registered nurse practitioner, nurse, physician assistant, or surgical assistant who provides medical services, nursing services, or health-related services to a patient.
13. "Patient transfer" means relocating a patient requiring medical services from an abortion clinic to another health care institution.
14. "Personally identifiable patient information" means:
    a. The name, address, telephone number, e-mail address, Social Security number, and birth date of:
       i. The patient,
       ii. The patient's representative,
       iii. The patient's emergency contact,
       iv. The patient's children,
       v. The patient's spouse,
       vi. The patient's sexual partner, and
       vii. Any other individual identified in the patient's medical record other than patient care staff;
    b. The patient's place of employment;
    c. The patient's referring physician;
    d. The patient's insurance carrier or account;
    e. Any "individually identifiable health information" as proscribed in 45 CFR 164-514; and
    f. Any other information in the patient's medical record that could reasonably lead to the identification of the patient.
15. "Personnel" means patient care staff members, employees, and volunteers.
16. "Serious injury" means a life-threatening physical condition related to an abortion procedure.
17. "Surgical assistant" means an individual who is not licensed as a physician, physician assistant, registered nurse practitioner, or nurse who performs duties as directed by a physician, physician assistant, registered nurse practitioner, or nurse.
18. "Volunteer" means an individual who, without compensation, performs duties as directed by a patient care staff member at an abortion clinic.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State

October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1502. Application Requirements and Documentation Submission**

**A.** An applicant shall submit an application for licensure that meets the requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1.

**B.** A licensee shall submit to the Department the documentation required according to A.R.S. § 36-449.02(B) with the applicable fees required in R9-10-106(C).

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**Exhibit A. Repealed**

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

**R9-10-1503. Administration**

**A.** A licensee is responsible for the organization and management of an abortion clinic.

**B.** A licensee shall:

1. Adopt policies and procedures for the administration and operation of an abortion clinic;
2. Designate a medical director who:
   a. Is licensed according to A.R.S. Title 32, Chapter 13, 17, or 29; and
   b. May be the same individual as the licensee;
3. Ensure the following documents are conspicuously posted on the premises:
   a. Current abortion clinic license issued by the Department,
   b. Current telephone number and address of the unit in the Department responsible for licensing the abortion clinic,
   c. Evacuation map, and
   d. Signs that comply with A.R.S. § 36-2153(H); and
4. Except as specified in R9-10-1512(D)(4), ensure that documentation required by this Article is provided to the Department within two hours after a Department request.

**C.** A medical director shall ensure written policies and procedures are established, documented, and implemented to protect the health and safety of a patient including:

1. Personnel qualifications, duties, and responsibilities;
2. Individuals qualified to provide counseling in the abortion clinic and the amount and type of training required for an individual to provide counseling;
3. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age:
   a. Individuals qualified in neonatal resuscitation and the amount and type of training required for an individual to provide neonatal resuscitation, and
   b. Designation of an individual to arrange the transfer to a hospital of a fetus delivered alive;
4. Verification of the competency of the physician performing an abortion according to R9-10-1506;
5. The storage, administration, accessibility, disposal, and documentation of a medication or controlled substance;
6. Accessibility and security of medical records;
7. Abortion procedures including:
   a. Recovery and follow-up care;
   b. The minimum length of time a patient remains in the recovery room or area based on:

i. The type of abortion performed,
ii. The estimated gestational age of the fetus,
iii. The type and amount of medication administered, and
iv. The physiologic signs including vital signs and blood loss; and

c. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, the requirements in A.R.S. § 36-2301(D);

8. Infection control including methods of sterilizing equipment and supplies;
9. Medical emergencies; and
10. Patient discharge and patient transfer.

**D.** For an abortion clinic that is not in substantial compliance or that is in substantial compliance but refuses to carry out a plan of correction acceptable to the Department, the Department may take enforcement action as specified in R9-10-111.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 2078, effective July 24, 2014 (Supp. 14-3). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1504. Quality Management**

A medical director shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the licensee;
2. A documented report is submitted to the licensee that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any changes made or actions taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the licensee.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1504 renumbered to R9-10-1505; new Section R9-10-1504 made by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1505. Incident Reporting**

**A.** A licensee shall ensure that the Department is notified of an incident as follows:

1. For the death of a patient, verbal notification the next working day;
2. For a fetus delivered alive, verbal notification the next working day; and
3. For a serious injury of a patient or viable fetus, written notification within 10 calendar days after the date of the serious injury.

**B.** A medical director shall conduct an investigation of an incident and document an incident report that includes:

1. The date and time of the incident;
2. The name of the patient;
3. A description of the incident, including, if applicable, information required in A.R.S. § 36-2161(A)(15);
4. Names of individuals who observed the incident;

5. Action taken by patient care staff members and employees during the incident and immediately following the incident; and
6. Action taken by the patient care staff members and employees to prevent the incident from occurring in the future.

**C.** A medical director shall ensure that the incident report is:

1. Submitted to the Department and, if the incident involved a licensed individual, the applicable professional licensing board within 10 calendar days after the date of the notification in subsection (A); and
2. Maintained on the premises for at least two years after the date of the incident.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1505 renumbered to R9-10-1506; new Section R9-10-1505 renumbered from R9-10-1504 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4). Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

**R9-10-1506. Personnel Qualifications and Records**

A licensee shall ensure that:

1. A physician who performs an abortion demonstrates to the medical director that the physician is competent to perform an abortion by:
   a. The submission of documentation of education and experience, and
   b. Observation by or interaction with the medical director;
2. Surgical assistants and volunteers who provide counseling and patient advocacy receive training in these specific responsibilities and any other responsibilities assigned and that documentation of the training received is maintained in the individual's personnel file;
3. An individual who performs an ultrasound provides documentation that the individual is:
   a. A physician;
   b. A physician assistant, registered nurse practitioner, or nurse who completed a course in performing ultrasounds under the supervision of a physician; or
   c. An individual who:
      i. Completed a course in performing ultrasounds under the supervision of a physician, and
      ii. Is not otherwise precluded by law from performing an ultrasound;
4. An individual has completed a course for the type of ultrasound the individual performs;
5. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, an individual who is available to perform neonatal resuscitation provides documentation that the individual:
   a. Is a:
      i. Physician,
      ii. Physician assistant,
      iii. Registered nurse practitioner, or
      iv. Nurse; and
   b. Has completed a course in performing neonatal resuscitation that is consistent with training provided by the American Academy of Pediatrics Neonatal Resuscitation Program and includes:
      i. Instruction in the use of resuscitation devices for positive-pressure ventilation, tracheal intubation, medications that may be necessary for neonatal resuscitation and their administration, and resuscitation of pre-term newborns; and
      ii. Assessment of the individual's skill in applying the information provided through the instruction in subsection (5)(b)(i);
6. A personnel file for each patient care staff member and each volunteer is maintained either electronically or in writing and includes:
   a. The individual's name and position title;
   b. The first and, if applicable, the last date of employment or volunteer service;
   c. Verification of qualifications, training, or licensure, as applicable;
   d. Documentation of cardiopulmonary resuscitation certification, as applicable;
   e. Documentation of verification of competency, as required in subsection (1), and signed and dated by the medical director;
   f. Documentation of training for surgical assistants and volunteers;
   g. Documentation of completion of a course as required in subsection (3), for an individual performing ultrasounds; and
   h. Documentation of competency to perform neonatal resuscitation, as required in subsection (5), if applicable; and
7. Personnel files are maintained on the premises for at least two years after the ending date of employment or volunteer service.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1506 renumbered to R9-10-1507; new Section R9-10-1506 renumbered from R9-10-1505 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1507. Staffing Requirements**

**A.** A licensee shall ensure that there is a sufficient number of patient care staff members and employees to:
1. Meet the requirements of this Article,
2. Ensure the health and safety of a patient, and
3. Meet the needs of a patient based on the patient's medical evaluation.

**B.** A licensee shall ensure that:
1. A patient care staff member other than a surgical assistant, who is current in cardiopulmonary resuscitation certification, is on the premises until all patients are discharged;
2. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B), remains on the premises of the abortion clinic until all patients who received a medication abortion are stable and ready to leave;
3. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B) and that is within 30 miles of the abortion clinic by road, as defined in A.R.S. § 17-451, remains on the abortion clinic's premises until all patients who received a surgical abortion are stable and discharged from the recovery room;
4. A patient care staff member is on the premises to comply with R9-10-1509(H); and
5. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, a patient care staff member qualified according to policies and procedures to perform neonatal resuscitation is available for the abortion procedure.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1507 renumbered to R9-10-1508; new Section R9-10-1507 renumbered from R9-10-1506 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1508. Patient Rights**

A licensee shall ensure that a patient is afforded the following rights, and is informed of these rights:
1. To refuse treatment, or withdraw consent for treatment;
2. To have medical records kept confidential; and
3. To be informed of:
   a. Billing procedures and financial liability before abortion services are provided;
   b. Proposed medical or surgical procedures, associated risks, possible complications, and alternatives;
   c. Counseling services that are provided on the premises;
   d. The right to review the ultrasound results with a physician, a physician assistant, a registered nurse practitioner, or a registered nurse before the abortion procedure; and
   e. The right to receive a print of the ultrasound image.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State

October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1508 renumbered to R9-10-1509; new Section R9-10-1508 renumbered from R9-10-1507 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1509. Abortion Procedures**

**A.** A medical director shall ensure that a medical evaluation of a patient is conducted before the patient's abortion is performed that includes:
1. A medical history including:
   a. Allergies to medications, antiseptic solutions, or latex;
   b. Obstetrical and gynecological history;
   c. Past surgeries;
   d. Medication the patient is currently taking; and
   e. Other medical conditions;
2. A physical examination, performed by a physician that includes a bimanual examination to estimate uterine size and palpation of adnexa;
3. The following laboratory tests:
   a. A urine or blood test to determine pregnancy;
   b. Rh typing, unless the patient provides written documentation of blood type acceptable to the physician;
   c. Anemia screening; and
   d. Other laboratory tests recommended by the physician or medical director on the basis of the physical examination; and
4. An ultrasound imaging study of the fetus, performed as required in A.R.S. §§ 36-2156 and 36-2301.02(A).

**B.** If the medical evaluation indicates a patient is Rh negative, a medical director shall ensure that:
1. The patient receives information from a physician on this condition;
2. The patient is offered RhO(d) immune globulin within 72 hours after the abortion procedure;
3. If a patient refuses RhO(d) immune globulin, the patient signs and dates a form acknowledging the patient's condition and refusing the RhO(d) immune globulin;
4. The form in subsection (B)(3) is maintained in the patient's medical record; and
5. If a patient refuses RhO(d) immune globulin or if a patient refuses to sign and date an acknowledgment and refusal form, the physician documents the patient's refusal in the patient's medical record.

**C.** A physician shall estimate the gestational age of the fetus, based on one of the following criteria, and record the estimated gestational age in the patient's medical record:
1. Ultrasound measurements of the biparietal diameter, length of femur, abdominal circumference, visible pregnancy sac, or crown-rump length or a combination of these; or
2. The date of the last menstrual period or the date of fertilization and a bimanual examination of the patient.

**D.** A medical director shall ensure that:
1. The ultrasound of a patient required in subsection (A)(4) is performed by an individual who meets the requirements in R9-10-1506(3);
2. An ultrasound estimate of gestational age of a fetus is performed using methods and tables or charts in a publication distributed nationally that contains peer-reviewed medical information, such as medical information derived from a publication describing research in obstetrics and gynecology or in diagnostic imaging;
3. An original patient ultrasound image is:
   a. Interpreted by a physician, and
   b. Maintained in the patient's medical record in either electronic or paper form; and
4. If requested by the patient, the ultrasound image is reviewed with the patient by a physician, physician assistant, registered nurse practitioner, or registered nurse.

**E.** A medical director shall ensure that before an abortion is performed on a patient:
1. Written consent, that meets the requirements in A.R.S. § 36-2152 or 36-2153, as applicable, and A.R.S. § 36-2158 is signed and dated by the patient or the patient's representative;
2. Information is provided to the patient on the abortion procedure, including alternatives, risks, and potential complications;
3. Information specified in A.R.S. § 36-2161(A)(12) is requested from the patient; and
4. If applicable, information required in A.R.S. § 36-2161(C) is provided to the patient.

**F.** A medical director shall ensure that an abortion is performed according to the abortion clinic's policies and procedures and this Article.

**G.** A medical director shall ensure that:

1. A patient care staff member monitors a patient's vital signs throughout an abortion procedure to ensure the patient's health and safety;
2. Intravenous access is established and maintained on a patient undergoing an abortion after the first trimester unless the physician determines that establishing intravenous access is not appropriate for the particular patient and documents that fact in the patient's medical record;
3. If an abortion procedure is performed at or after 20 weeks gestational age, a patient care staff member qualified in neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure takes place before the delivery of the fetus; and
4. If a fetus is delivered alive:
   a. Resuscitative measures, including the following, are used to support life:
      i. Warming and drying of the fetus,
      ii. Clearing secretions from and positioning the airway of the fetus,
      iii. Administering oxygen as needed to the fetus, and
      iv. Assessing and monitoring the cardiopulmonary status of the fetus;
   b. A determination is made of whether the fetus is a viable fetus;
   c. A viable fetus is provided treatment to support life;
   d. A viable fetus is transferred as required in R9-10-1510; and
   e. Resuscitative measures and the transfer, as applicable, are documented.

**H.** To ensure a patient's health and safety, a medical director shall ensure that following the abortion procedure:
1. A patient's vital signs and bleeding are monitored by:
   a. A physician;
   b. A physician assistant;
   c. A registered nurse practitioner;
   d. A nurse; or
   e. If a physician is able to provide direct supervision, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, to a medical assistant, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, a medical assistant under the direct supervision of the physician; and
2. A patient remains in the recovery room or recovery area until a physician, physician assistant, registered nurse practitioner, or nurse examines the patient and determines that the patient's medical condition is stable and the patient is ready to leave the recovery room or recovery area.

**I.** A medical director shall ensure that follow-up care:
1. For a surgical abortion is offered to a patient that includes:
   a. With a patient's consent, a telephone call made to the patient to assess the patient's recovery:
      i. By a patient care staff member other than a surgical assistant; and
      ii. Within 24 hours after the patient's discharge following a surgical abortion; and
   b. A follow-up visit scheduled, if requested, no more than 21 calendar days after the abortion that includes:
      i. A physical examination,
      ii. A review of all laboratory tests as required in subsection (A)(3), and
      iii. A urine pregnancy test;
2. For a medication abortion includes a follow-up visit, scheduled between seven and 21 calendar days after the initial dose of a substance used to induce an abortion, that includes:
   a. A urine pregnancy test, and
   b. An assessment of the degree of bleeding; and
3. Is documented in the patient's medical record, including:
   a. A patient's acceptance or refusal of a follow-up visit following a surgical abortion;
   b. If applicable, the results of the follow-up visit; and
   c. If applicable, whether the patient consented to a telephone call and, if so, whether the patient care staff member making the telephone call to the patient:
      i. Spoke with the patient about the patient's recovery, or
      ii. Was unable to speak with the patient.

**J.** If a continuing pregnancy is suspected as a result of the follow-up visit in subsection (I)(1)(b) or (I)(2), a physician who performs abortions shall be consulted.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1509 re-

numbered to R9-10-1510; new Section R9-10-1509 renumbered from R9-10-1508 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4). Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

**R9-10-1510. Patient Transfer and Discharge**

**A.** A medical director shall ensure that:
1. For a patient:
   a. A patient is transferred to a hospital for an emergency involving the patient;
   b. A patient transfer is documented in the patient's medical record; and
   c. Documentation of a medical evaluation, treatment provided, and laboratory and diagnostic information is transferred with a patient; and
2. For a viable fetus:
   a. A viable fetus requiring emergency care is transferred to a hospital,
   b. The transfer of a viable fetus is documented in the viable fetus's medical record, and
   c. Documentation of an assessment of cardiopulmonary function and treatment provided to a viable fetus is transferred with the viable fetus.

**B.** A medical director shall ensure that before a patient is discharged:
1. A physician signs the patient's discharge order; and
2. A patient receives follow-up instructions at discharge that include:
   a. Signs of possible complications,
   b. When to access medical services in response to complications,
   c. A telephone number of an individual or entity to contact for medical emergencies,
   d. Information and precautions for resuming vaginal intercourse after the abortion, and
   e. Information specific to the patient's abortion or condition.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1510 renumbered to R9-10-1511; new Section R9-10-1510 renumbered from R9-10-1509 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1511. Medications and Controlled Substances**

A medical director shall ensure that:
1. The abortion clinic complies with the requirements for medications and controlled substances in A.R.S. Title 32, Chapter 18, and A.R.S. Title 36, Chapter 27;
2. A medication is administered in compliance with an order from a physician, physician assistant, registered nurse practitioner, or as otherwise provided by law;
3. A medication is administered to a patient or to a viable fetus by a physician or as otherwise provided by law;
4. Medications and controlled substances are maintained in a locked area on the premises;
5. Only personnel designated by policies and procedures have access to the locked area containing medications and controlled substances;
6. Expired, mislabeled, or unusable medications and controlled substances are disposed of according to policies and procedures;
7. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is immediately reported to the medical director and licensee, and recorded in the patient's medical record;
8. Medication information for a patient is maintained in the patient's medical record and contains:
   a. The patient's name, age, and weight;
   b. The medications the patient is currently taking;
   c. Allergies or sensitivities to medications, antiseptic solutions, or latex; and
   d. If medication is administered to the patient:
      i. The date and time of administration;
      ii. The name, strength, dosage form, amount of medication, and route of administration; and
      iii. The identification and signature of the individual administering the medication; and
9. If administered to a fetus delivered alive, the following are documented in the fetus's medical record:
   a. The date and time of oxygen administration;

b. The amount and flow rate of the oxygen;
c. The identification and signature of the individual administering the oxygen; and
d. For a viable fetus:
   i. The date and time of medication administration;
   ii. The name, strength, dosage form, amount of medication, and route of administration; and
   iii. The identification and signature of the individual administering the medication.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 2078, effective July 24, 2014 (Supp. 14-3). Section R9-10-1511 renumbered to R9-10-1512; new Section R9-10-1511 renumbered from R9-10-1510 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1512. Medical Records**

**A.** A licensee shall ensure that a medical record is established and maintained for a patient that contains:
1. Patient identification including:
   a. The patient's name, address, and date of birth;
   b. The designated patient's representative, if applicable; and
   c. The name and telephone number of an individual to contact in an emergency;
2. The patient's medical history required in R9-10-1509(A)(1);
3. The patient's physical examination required in R9-10-1509(A)(2);
4. The laboratory test results required in R9-10-1509(A)(3);
5. The ultrasound results, including the original print, required in R9-10-1509(A)(4);
6. The physician's estimated gestational age of the fetus required in R9-10-1509(C);
7. Each consent form signed by the patient or the patient's representative;
8. Orders issued by a physician, physician assistant, or registered nurse practitioner;
9. A record of medical services, nursing services, and health-related services provided to the patient;
10. The patient's medication information;
11. Documentation related to follow-up care specified in R9-10-1509(I); and
12. If the abortion procedure was performed at or after 20 weeks gestational age and the fetus was not delivered alive, documentation from the physician and other patient care staff member present certifying that the fetus was not delivered alive.

**B.** A licensee shall ensure that a medical record is established and maintained for a fetus delivered alive that contains:
1. An identification of the fetus, including:
   a. The name of the patient from whom the fetus was delivered alive, and
   b. The date the fetus was delivered alive;
2. Orders issued by a physician, physician assistant, or registered nurse practitioner;
3. A record of medical services, nursing services, and health-related services provided to the fetus delivered alive;
4. If applicable, information about medication administered to the fetus delivered alive; and
5. If the abortion procedure was performed at or after 20 weeks gestational age:
   a. Documentation of the requirements in R9-10-1509(G)(4); and
   b. If the fetus had a lethal fetal condition, the results of the confirmation of the lethal fetal condition.

**C.** A licensee shall ensure that:
1. A medical record is accessible only to the Department or personnel authorized by policies and procedures;
2. Medical record information is confidential and released only with the written informed consent of a patient or the patient's representative or as otherwise permitted by law;
3. A medical record is protected from loss, damage, or unauthorized use and is maintained and accessible for at least seven years after the date of an adult patient's discharge or if the patient is a child, either for at least three years after the child's 18th birthday or for at least seven years after the patient's discharge, whichever date occurs last;
4. A medical record is maintained at the abortion clinic for at least six months after the date of the patient's discharge; and
5. Vital records and vital statistics are retained according to A.R.S. § 36-343.

**D.** If the Department requests patient medical records for review, the licensee:
1. Is not required to produce any patient medical records created or prepared by a referring physician's office;
2. May provide patient medical records to the Department either in paper or in an electronic format that is acceptable to the Department;

3. Shall provide the Department with the following patient medical records related to medical services associated with an abortion, including any follow-up visits to the abortion clinic in connection with the abortion:
   a. The patient's medical history required in R9-10-1509(A)(1);
   b. The patient's physical examination required in R9-10-1509(A)(2);
   c. The laboratory test results required in R9-10-1509(A)(3);
   d. The physician's estimate of gestational age of the fetus required in R9-10-1509(C);
   e. The ultrasound results required in R9-10-1509(D)(2);
   f. Each consent form signed by the patient or the patient's representative;
   g. Orders issued by a physician, physician assistant, or registered nurse practitioner;
   h. A record of medical services, nursing services, and health-related services provided to the patient; and
   i. The patient's medication information;
4. If the Department's request is in connection with a licensing or compliance inspection:
   a. Is not required to produce any patient medical records associated with an abortion that occurred before the licensing inspection or a previous compliance inspection of the abortion clinic; and
   b. Shall:
      i. Redact only personally identifiable patient information from the patient medical records before the licensee discloses the patient medical records to the Department;
      ii. Upon request by the Department, code the requested patient medical records by a means that allows the Department to track all patient medical records related to a specific patient without the personally identifiable patient information; and
      iii. Unless the Department and the licensee agree otherwise, provide redacted copies of patient medical records to the Department:
         (1) For one to ten patients, within two working days after the request, and
         (2) For every additional five patients, within an additional two working days; and
5. If the Department's request is in connection with a complaint investigation, shall:
   a. Not redact patient information from the patient medical records before the licensee discloses the patient medical records to the Department; and
   b. Ensure the patient medical records include:
      i. The patient's name, address, and date of birth;
      ii. The patient's representative, if applicable; and
      iii. The name and telephone number of an individual to contact in an emergency.

**E.** A medical director shall ensure that only personnel authorized by policies and procedures, records or signs an entry in a medical record and:
1. An entry in a medical record is dated and legible;
2. An entry is authenticated by:
   a. A signature; or
   b. An individual's initials if the individual's signature already appears in the medical record;
3. An entry is not changed after it has been recorded, but additional information related to an entry may be recorded in the medical record;
4. When a verbal or telephone order is entered in the medical record, the entry is authenticated within 21 calendar days by the individual who issued the order;
5. If a rubber-stamp signature or an electronic signature is used:
   a. An individual's rubber stamp or electronic signature is not used by another individual;
   b. The individual who uses a rubber stamp or electronic signature signs a statement that the individual is responsible for the use of the rubber stamp or the electronic signature; and
   c. The signed statement is included in the individual's personnel record; and
6. If an abortion clinic maintains medical records electronically, the medical director shall ensure the date and time of an entry is recorded by the computer's internal clock.

**F.** As required by A.R.S. § 36-449.03(J), the Department shall not release any personally identifiable patient or physician information.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1512 renumbered to R9-10-1513; new Section R9-10-1512 renumbered from R9-10-1511 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1513. Environmental and Safety Standards**

A licensee shall ensure that:

1. The premises:
   a. Provide lighting and ventilation to ensure the health and safety of a patient,
   b. Are maintained in a clean condition,
   c. Are free from a condition or situation that may cause a patient to suffer physical injury,
   d. Are maintained free from insects and vermin, and
   e. Are smoke-free;
2. A warning notice is placed at the entrance to a room or area where oxygen is in use;
3. Soiled linen and clothing are kept:
   a. In a covered container, and
   b. Separate from clean linen and clothing;
4. Personnel wash hands after each direct patient contact and after handling soiled linen, soiled clothing, or biohazardous medical waste;
5. A written emergency plan is established, documented, and implemented that includes procedures for protecting the health and safety of patients and other individuals in a fire, natural disaster, loss of electrical power, or threat or incidence of violence;
6. An evacuation drill is conducted at least once every six months that includes all personnel on the premises on the day of the evacuation drill; and
7. Documentation of the evacuation drill is maintained on the premises for at least one year after the date of the evacuation drill and includes:
   a. The date and time of the evacuation drill, and
   b. The names of personnel participating in the evacuation drill.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1513 renumbered to R9-10-1514; new Section R9-10-1513 renumbered from R9-10-1512 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1514. Equipment Standards**

A licensee shall ensure that:

1. Equipment and supplies are maintained in a:
   a. Clean condition, and
   b. Quantity sufficient to meet the needs of patients present in the abortion clinic;
2. Equipment to monitor vital signs is in each room in which an abortion is performed;
3. A surgical or gynecologic examination table is used for an abortion;
4. The following equipment and supplies are available in the abortion clinic:
   a. Equipment to measure blood pressure;
   b. A stethoscope;
   c. A scale for weighing a patient;
   d. Supplies for obtaining specimens and cultures and for laboratory tests; and
   e. Equipment and supplies for use in a medical emergency including:
      i. Ventilatory assistance equipment,
      ii. Oxygen source,
      iii. Suction apparatus, and
      iv. Intravenous fluid equipment and supplies; and
   f. Ultrasound equipment;
5. In addition to the requirements in subsection (4), the following equipment is available for an abortion procedure performed after the first trimester:
   a. Drugs to support cardiopulmonary function of a patient, and
   b. Equipment to monitor the cardiopulmonary status of a patient;
6. In addition to the requirements in subsections (4) and (5), if the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, the following equipment is available for the abortion procedure:
   a. Equipment to provide warmth and drying of a fetus delivered alive,
   b. Equipment necessary to clear secretions from and position the airway of a fetus delivered alive,
   c. Equipment necessary to administer oxygen to a fetus delivered alive,

d. Equipment to assess and monitor the cardiopulmonary status of a fetus delivered alive, and
e. Drugs to support cardiopulmonary function in a viable fetus;
7. Equipment and supplies are clean and, if applicable, sterile before each use;
8. Equipment required in this Section is maintained in working order, tested and calibrated at least once every 12 months or according to the manufacturer's recommendations, and used according to the manufacturer's recommendations; and
9. Documentation of each equipment test, calibration, and repair is maintained on the premises for at least 12 months after the date of the testing, calibration, or repair and provided to the Department for review within two hours after the Department requests the documentation.

**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1514 renumbered to R9-10-1515; new Section R9-10-1514 renumbered from R9-10-1513 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

**R9-10-1515. Physical Plant Standards**

**A.** A licensee shall ensure that an abortion clinic complies with all local building codes, ordinances, fire codes, and zoning requirements. If there are no local building codes, ordinances, fire codes, or zoning requirements, the abortion clinic shall comply with the applicable codes and standards incorporated by reference in A.A.C. R9-1-412 that were in effect on the date the abortion clinic's architectural plans and specifications were submitted to the Department for approval.

**B.** A licensee shall ensure that an abortion clinic provides areas or rooms:
1. That provide privacy for:
   a. A patient's interview, medical evaluation, and counseling;
   b. A patient to dress; and
   c. Performing an abortion procedure;
2. For personnel to dress;
3. With a sink and a flushable toilet in working order;
4. For cleaning and sterilizing equipment and supplies;
5. For storing medical records;
6. For storing equipment and supplies;
7. For hand washing before the abortion procedure; and
8. For a patient recovering after an abortion.

**C.** A licensee shall ensure that an abortion clinic has an emergency exit to accommodate a stretcher or gurney.

## ARTICLE 17. UNCLASSIFIED HEALTH CARE INSTITUTIONS

**R9-10-1701. Definitions**

Definitions in A.R.S. § 36-401 and R9-10-101 apply in this Article unless otherwise specified.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-1702. Administration**

**A.** A governing authority for a health care institution not otherwise classified or subclassified in A.R.S. Title 36, Chapter 4 or 9 A.A.C. 10 shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of the health care institution;
2. Establish, in writing:
   a. A health care institution's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1703;
5. Review and evaluate the effectiveness of the quality management program in R9-10-1703 at least once every 12 months;

6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
   a. Expected not to be present on a health care institution's premises for more than 30 calendar days, or
   b. Not present on a health care institution's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425 when there is a change in an administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:
1. Is directly accountable to the governing authority of a health care institution for the daily operation of the health care institution and all services provided by or at the health care institution;
2. Has the authority and responsibility to manage the health care institution; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the health care institution's premises and accountable for the health care institution when the administrator is not present on the health care institution's premises.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a patient;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Cover cardiopulmonary resuscitation training, including:
      i. The method and content of cardiopulmonary resuscitation training,
      ii. The qualifications for an individual providing cardiopulmonary resuscitation training,
      iii. The time-frame for renewal of cardiopulmonary resuscitation training, and
      iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
   f. Include a method to identify a patient to ensure the patient receives services as ordered;
   g. Cover first aid training;
   h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
   i. Cover specific steps for:
      i. A patient to file a complaint, and
      ii. The health care institution to respond to and resolve a patient complaint;
   j. Cover medical records, including electronic medical records;
   k. Cover a quality management program, including incident report and supporting documentation;
   l. Cover contracted services;
   m. Cover health care directives; and
   n. Cover when an individual may visit a patient in a health care institution;
2. Policies and procedures for health care institution services are established, documented, and implemented to protect the health and safety of a patient that:
   a. Cover patient screening, admission, assessment, treatment plan, transport, transfer, and discharge, if applicable;
   b. Cover patient outings, if applicable;
   c. Include when general consent and informed consent are required;
   d. Cover the provision of services listed in the health care institution's scope of services;
   e. Cover administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances, if applicable;
   f. Cover infection control;
   g. Cover telemedicine, if applicable;
   h. Cover environmental services that affect patient care;
   i. Cover smoking and the use of tobacco products on the health care institution's premises;
   j. Cover how the health care institution will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
   k. Cover how incidents are reported and investigated; and
   l. Designate which employees or personnel members are required to have current certification in cardiopulmonary resuscitation and first aid training;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after the Department's request; and

b. When documentation or information is required by this Chapter to be submitted on behalf of a health care institution, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the health care institution.

**D.** If applicable, an administrator shall designate a clinical director who:
1. Provides direction for behavioral health services provided at the health care institution, and
2. Is a behavioral health professional.

**E.** An administrator shall provide written notification to the Department of a patient's:
1. Death, if the patient's death is required to be reported according to A.R.S. § 11-593, within one working day after the patient's death; and
2. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical services provider.

**F.** If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from a health care institution's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:
1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
2. For a patient under 18 years of age, according to A.R.S. § 13-3620.

**G.** If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while the patient is receiving unclassified healthcare services, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the patient:
   a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
   b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (G)(1); and
   c. The report in subsection (G)(2);
4. Maintain the documentation in subsection (G)(3) for at least 12 months after the date of the report in subsection (G)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in (G)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The action taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (G)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**H.** An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, an employee, a patient, or a patient's representative:
1. The health care institution's current license,
2. The evacuation plan listed in R9-10-1711, and
3. The location at which inspection reports required in R9-10-1711(B) are available for review or can be made available for review.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Subsection reference for inspection reports corrected at R9-10-1702(H)(3), file number R20-03 at the request of the Department (Supp. 19-3).

**R9-10-1703. Quality Management**

An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:

a. An identification of each concern about the delivery of services related to patient care, and
b. Any changes made or actions taken as a result of the identification of a concern about the delivery of services related to patient care; and

3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1704. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article,
2. Documented of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1705. Personnel**

**A.** An administrator shall ensure that:

1. A personnel member is:
   a. At least 21 years old, or
   b. If providing behavioral health services, at least 18 years old;
2. An employee is at least 18 years old;
3. A student is at least 18 years old; and
4. A volunteer is at least 21 years old.

**B.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of participants receiving behavioral health services or physical health services from the personnel member according to the established job description;
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures;
3. Sufficient personnel members are present on a health care institution's premises with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the health care institution's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient.

**C.** An administrator shall ensure that:

1. A plan to provide orientation specific to the duties of a personnel member, employee, volunteer, and student is developed, documented, and implemented;
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;

4. A plan to provide in-service education specific to the duties of a personnel member is developed;
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training; and
6. A work schedule of each personnel member is developed and maintained at the health care institution for at least 12 months after the date of the work schedule.

**D.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the unclassified healthcare institution, and
   b. As specified in R9-10-113.

**E.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. If the health care institution provides serves to children, the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03;
   f. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-1702(C)(2)(l);
   g. First aid training, if required for the individual according to this Article or policies and procedures; and
   h. Evidence of freedom from infectious tuberculosis, if the individual is required to provide evidence of freedom according to subsection (D).

**F.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout an individual's period of providing services in or for the health care institution, and
   b. For at least 24 months after the last date the individual provided services in or for the health care institution; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the health care institution during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**G.** An administrator shall ensure that at least one personnel member who is present at the health care institution during the hours of the health care institution operation has first-aid training and cardiopulmonary resuscitation certification specific to the populations served by the health care institution.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1706. Transport; Transfer**

**A.** Except as provided in subsection (B), an administrator shall ensure that:
1. A personnel member coordinates the transport and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before and after the transport,
   b. Information in the patient's medical record is provided to a receiving health care institution, and
   c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transport;
   c. The mode of transportation; and
   d. If applicable, the personnel member accompanying the patient during a transport.

**B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a patient by the patient or the patient's representative,
3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative, or

4. A transport to another licensed health care institution in an emergency.

**C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
   a. An evaluation of the patient is conducted before the transfer;
   b. Information in the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the patient during a transfer.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1707. Patient Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
   b. Where patient rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by the unclassified health care institution's personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
   a. Is informed of the patient complaint process;
   b. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a health care institution for identification and administrative purposes; and
   c. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records.

**C.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive services that support and respect the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the provider is not authorized or not able to provide physical health services or behavioral health services needed by the patient; and
6. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1708. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the entry illegible;
3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
   c. As permitted by law;
6. Policies and procedures include the maximum time-frame to retrieve a patient's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If a health care institution maintains a patient's medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
   a. The patient's name;
   b. The patient's address;
   c. The patient's date of birth; and
   d. Any known allergies, including medication allergies;
2. The name of the admitting medical practitioner or behavioral health professional;
3. The date of admission and, if applicable, the date of discharge;
4. An admitting diagnosis;
5. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative:
      i. Is a legal guardian, a copy of the court order establishing guardianship; or
      ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
6. If applicable, documented general consent and informed consent by the patient or the patient's representative;
7. Documentation of medical history and results of a physical examination;
8. A copy of the patient's health care directive, if applicable;
9. Orders;
10. Assessment;
11. Treatment plans;
12. Interval note;
13. Progress notes;
14. Documentation of health care institution services provided to the patient;
15. Disposition of the patient after discharge;
16. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;

17. Discharge plan;
18. A discharge summary, if applicable;
19. If applicable:
    a. Laboratory reports,
    b. Radiologic reports,
    c. Diagnostic reports, and
    d. Consultation reports; and
20. Documentation of a medication administered to the patient that includes:
    a. The date and time of administration;
    b. The name, strength, dosage, and route of administration;
    c. For a medication administered for pain, when initially administered or PRN:
        i. An assessment of the patient's pain before administering the medication, and
        ii. The effect of the medication administered;
    d. For a psychotropic medication, when initially administered or PRN:
        i. An assessment of the patient's behavior before administering the psychotropic medication, and
        ii. The effect of the psychotropic medication administered;
    e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and
    f. Any adverse reaction a patient has to the medication.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1709. Medication Services**

**A.** An administrator shall ensure that:
1. Policies and procedures for medication services include:
    a. A process for providing information to a patient about medication prescribed for the patient including:
        i. The prescribed medication's anticipated results,
        ii. The prescribed medication's potential adverse reactions,
        iii. The prescribed medication's potential side effects, and
        iv. Potential adverse reactions that could result from not taking the medication as prescribed;
    b. Procedures for preventing, responding to, and reporting a medication error;
    c. Procedures for responding to and reporting an unexpected reaction to a medication;
    d. Procedures to ensure that a patient's medication regimen and method of administration is reviewed by a medical practitioner and to ensure the medication regimen meets the patient's needs;
    e. Procedures for:
        i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
        ii. Monitoring a patient who self-administers medication;
    f. Procedures for assisting a patient in obtaining medication; and
    g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. A process is specified for review through the quality management program of:
    a. A medication administration error, and
    b. An adverse reaction to a medication.

**B.** If a health care institution provides medication administration, an administrator shall ensure that:
1. Medication is stored by the health care institution;
2. Policies and procedures for medication administration:
    a. Are reviewed and approved by a medical practitioner;
    b. Specify the individuals who may:
        i. Order medication, and
        ii. Administer medication;
    c. Ensure that medication is administered to a patient only as prescribed; and
    d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
3. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
4. A medication administered to a patient:
    a. Is administered in compliance with an order, and
    b. Is documented in the patient's medical record.

**C.** If a health care institution provides assistance in the self-administration of medication, an administrator shall ensure that:

1. A patient's medication is stored by the health care institution;
2. The following assistance is provided to a patient:
   a. A reminder when it is time to take the medication;
   b. Opening the medication container for the patient;
   c. Observing the patient while the patient removes the medication from the container;
   d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
      i. The patient taking the medication is the individual stated on the medication container label,
      ii. The patient is taking the dosage of the medication as stated on the medication container label, and
      iii. The patient is taking the medication at the time stated on the medication container label; or
   e. Observing the patient while the patient takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
   a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
   b. Includes:
      i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
      ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
      iii. Process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a patient:
   a. Is in compliance with an order, and
   b. Is documented in the patient's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members; and
3. If pharmaceutical services are provided on the premises:
   a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
      i. Develop a drug formulary,
      ii. Update the drug formulary at least once every 12 months,
      iii. Develop medication usage and medication substitution policies and procedures, and
      iv. Specify which medications and medication classifications are required to be automatically stopped after a specific time period unless the ordering medical practitioner specifically orders otherwise;
   b. The pharmaceutical services are provided under the direction of a pharmacist;
   c. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
   d. A copy of the pharmacy license is provided to the Department upon request.

**E.** When medication is stored at a health care institution, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of patients who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the health care institution's clinical director.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1710. Food Services**

If food services are provided, an administrator shall ensure:

1. Food is obtained, handled, and stored to prevent contamination, spoilage, or a threat to the health of a patient;
2. Three nutritionally balanced meals are served each day;
3. Nutritious snacks are available between meals;
4. Food served meets any special dietary needs of a patient as prescribed by the patient's physician or dietitian; and
5. Chemicals and detergents are not stored with food.

**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-1711. Emergency and Safety Standards**

**A.** An administrator shall ensure that:

1. A first aid kit is available at a health care institution;
2. If a firearm or ammunition for a firearm are stored at a health care institution:
   a. The firearm is stored separate from the ammunition for the firearm; and
   b. The firearm and the ammunition for the firearm are:
      i. Stored in a locked closet, cabinet, or container; and
      ii. Inaccessible to a patient;
3. If applicable, there is a smoke detector installed in:
   a. A bedroom used by a patient,
   b. A hallway in a health care institution, and
   c. A health care institution's kitchen;
4. A smoke detector required in subsection (A)(3):
   a. Is maintained in operable condition; and
   b. Is battery operated or, if hard-wired into the electrical system of a health care institution, has a back-up battery;
5. A health care institution has a portable fire extinguisher that is labeled 1A-10-BC by the Underwriters Laboratory and is available to a personnel member;
6. A portable fire extinguisher required in subsection (A)(5) is:
   a. If a disposable fire extinguisher, replaced when the fire extinguisher's indicator reaches the red zone; or
   b. Serviced at least once every 12 months and has a tag attached to the fire extinguisher that includes the date of service;
7. A written evacuation plan is maintained and available for use by personnel members and any patient in a health care institution;
8. An evacuation drill is conducted at least once every six months; and
9. A record of an evacuation drill required in subsection (A)(8) is maintained for at least 12 months after the date of the evacuation drill.

**B.** An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Section repealed; new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

**R9-10-1712. Physical Plant, Environmental Services, and Equipment Standards**

**A.** If applicable, an administrator shall ensure that a health care institution:

1. Is in a building that:
   a. Has a certificate of occupancy from the local jurisdiction; and
   b. Is free of any plumbing, electrical, ventilation, mechanical, or structural hazard that may jeopardize the health or safety of a patient;
2. Has a living room accessible at all times to a patient;
3. Has a dining area furnished for group meals that is accessible to the provider, patients, and any other individuals present in the health care institution;
4. Has:
   a. At least one bathroom for each six individuals residing in the health care institution, including patients; and
   b. A bathroom accessible for use by a patient that contains:
      i. A working sink with running water, and
      ii. A working toilet that flushes and has a seat; and
5. Has equipment and supplies to maintain a patient's personal hygiene that are accessible to the patient.

**B.** An administrator shall ensure that:
1. A health care institution's premises are:
   a. Sufficient to provide the health care institution's scope of services;
   b. Cleaned and disinfected according to the health care institution's policies and procedures to prevent, minimize, and control illness and infection;
   c. Clean and free from accumulations of dirt, garbage, and rubbish; and
   d. Free from a condition or situation that may cause an individual to suffer physical injury;
2. If a health care institution collects urine or stool specimens from a patient, the health care institution has at least one bathroom that:
   a. Contains:
      i. A working sink with running water,
      ii. A working toilet that flushes and has a seat,
      iii. Toilet tissue,
      iv. Soap for hand washing,
      v. Paper towels or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A means of ventilation; and
   b. Is for the exclusive use of the health care institution;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. If pets or animals are allowed in the health care institution, pets or animals are:
   a. Controlled to prevent endangering the patients and to maintain sanitation;
   b. Licensed consistent with local ordinances; and
   c. For a dog or a cat, vaccinated against rabies;
5. A smoke-free environment is maintained on the premises;
6. A refrigerator used to store a medication is:
   a. Maintained in working order, and
   b. Only used to store medications;
7. Equipment at the health care institution is:
   a. Sufficient to provide the health care institution's scope of service;
   b. Maintained in working condition;
   c. Used according to the manufacturer's recommendations; and
   d. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures;
8. Documentation of an equipment test, calibration, and repair is maintained for at least 12 months after the date of testing, calibration, or repair; and
9. Combustible or flammable liquids and hazardous materials stored by the health care institution are stored in the original labeled containers or safety containers in a storage area that is locked and inaccessible to patients.

**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

**R9-10-1713. Repealed**

**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

**R9-10-1714. Reserved**

**R9-10-1715. Repealed**

**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1716. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1717. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1718. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1719. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1720. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1721. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1722. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1723. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1724. Reserved**

**R9-10-1725. Reserved**

**R9-10-1726. Reserved**

**R9-10-1727. Reserved**

**R9-10-1728. Reserved**

**R9-10-1729. Reserved**

**R9-10-1730. Reserved**

**R9-10-1731. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1732. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

**R9-10-1733. Repealed**

**Historical Note**
Adopted effective July 24, 1978 (Supp. 78-4). Corrections: R9-10-1733(B)(2), correction in spelling, “architectural”; R9-10-1733(C)(1)(d), 100 square feet, corrected to read “1000” square feet, as certified effective July 24, 1978 (Supp. 87-2).

Repealed effective July 6, 1994 (Supp. 94-3).

## ARTICLE 19. COUNSELING FACILITIES

**0R9-10-1902. Supplemental Application Requirements**

In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for a license as a counseling facility shall submit, in a format provided by the Department:

1. The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation;
2. If applicable, a request to provide one of more of the following:
   a. DUI screening,
   b. DUI education,
   c. DUI treatment, or
   d. Misdemeanor domestic violence offender treatment;
3. Whether the counseling facility has an affiliated outpatient treatment center;
4. If the counseling facility has an affiliated outpatient treatment center:
   a. The affiliated outpatient treatment center's name; and
   b. Either:
      i. The license number assigned to the affiliated outpatient treatment center by the Department; or
      ii. If the affiliated outpatient treatment center is not currently licensed, the:
         (1) Street address of the affiliated outpatient treatment center, and
         (2) Date the affiliated outpatient treatment center submitted to the Department an application for a health care institution license;
5. Whether the counseling facility is sharing administrative support with an affiliated counseling facility; and
6. If the counseling facility is sharing administrative support with an affiliated counseling facility, for each affiliated counseling facility sharing administrative support with the counseling facility:
   a. The affiliated counseling facility's name; and
   b. Either:
      i. The license number assigned to the affiliated counseling facility by the Department; or
      ii. If the affiliated counseling facility is not currently licensed, the:
         (1) Street address of the affiliated counseling facility, and
         (2) Date the affiliated counseling facility submitted to the Department an application for a health care institution license.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

**R9-10-1903. Administration**

**A.** A governing authority shall:

1. Consist of one of more individuals accountable for the organization, operation, and administration of a counseling facility;
2. Establish, in writing:
   a. A counseling facility's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1904;
5. Review and evaluate the effectiveness of the quality management program in R9-10-1904 at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
   a. Expected not to be present on the premises for more than 30 calendar days, or
   b. Not present on the premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in an administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:

1. Is directly accountable to the governing authority for the daily operation of the counseling facility and all services provided by or at the counseling facility;
2. Has the authority and responsibility to manage the counseling facility; and

3. Except as provided in subsection (A)(6), designates in writing, an individual who is present on the counseling facility's premises and accountable for the counseling facility when the administrator is not available.

**C.** An administrator or the administrator of the counseling facility's affiliated outpatient treatment center shall establish policies and procedures to protect the health and safety of a patient that:
1. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience, for personnel members, employees, volunteers, and students;
2. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
3. Include how a personnel member may submit a complaint relating to services provided to a patient;
4. Cover the requirements in Title 36, Chapter 4, Article 11;
5. Cover patient screening, admission, assessment, discharge planning, and discharge;
6. Cover medical records;
7. Cover the provision of counseling and any services listed in the counseling facility's scope of services;
8. Include when general consent and informed consent are required;
9. Cover telemedicine, if applicable;
10. Cover specific steps for:
    a. A patient or a patient's representative to file a complaint, and
    b. A counseling facility to respond to a complaint; and
11. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual.

**D.** An administrator shall ensure that:
1. Policies and procedures established according to subsection (C) are documented and implemented;
2. Counseling facility policies and procedures are:
    a. Reviewed at least once every three years and updated as needed, and
    b. Available to personnel members and employees;
3. Unless otherwise stated:
    a. Documentation required by this Article is maintained and provided to the Department within two hours after a Department request; and
    b. When documentation or information is required by this Chapter to be submitted on behalf of a counseling facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the counseling facility;
4. The following are conspicuously posted:
    a. The current license for the counseling facility issued by the Department;
    b. The name, address, and telephone number of the Department;
    c. A notice that a patient may file a complaint with the Department about the counseling facility;
    d. A list of patient rights;
    e. A map for evacuating the facility; and
    f. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(H), with patient information redacted, are available;
5. Patient follow-up instructions are:
    a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the counseling facility unless the patient leaves against a personnel member's advice; and
    b. Documented in the patient's medical record; and
6. Cardiopulmonary resuscitation training includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation.

**E.** If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from a counseling facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:
1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
2. For a patient under 18 years of age, according to A.R.S. § 13-3620.

**F.** If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from a counseling facility's employee or personnel member, an administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the patient as follows:
    a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
    b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
    a. The suspected abuse, neglect, or exploitation;
    b. Any action taken according to subsection (F)(1); and
    c. The report in subsection (F)(2);

4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1904. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

**R9-10-1905. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

**R9-10-1906. Personnel**

An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of counseling expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the patients expected to be receiving the counseling from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the counseling listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the counseling listed in the established job description, and

iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the counseling listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides counseling, and
   b. According to policies and procedures;
3. Sufficient personnel members are present on a counseling facility's premises during hours of clinical operation with the qualifications, skills, and knowledge necessary to:
   a. Provide the counseling in the counseling facility's scope of services,
   b. Meet the needs of a patient, and
   c. Ensure the health and safety of a patient;
4. At least one personnel member with cardiopulmonary resuscitation training is present on a counseling facility's premises during hours of clinical operation;
5. At least one personnel member with first aid training is present on a counseling facility's premises during hours of clinical operation;
6. A personnel member only provides counseling the personnel member is qualified to provide;
7. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;
8. A personnel member completes orientation before providing counseling to a patient;
9. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
10. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;
11. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the in-service education, and
   c. The subject or topics covered in the in-service education;
12. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;
13. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:
   a. The individual's name, date of birth, and contact telephone number;
   b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
   c. Documentation of:
      i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
      ii. The individual's education and experience applicable to the individual's job duties;
      iii. The individual's completed orientation and in-service education as required by policies and procedures;
      iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
      v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
      vi. The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable;
      vii. If applicable, cardiopulmonary resuscitation training; and
      viii. If applicable, first aid training; and
14. The record in subsection (13) is:
   a. Maintained while an individual provides services for or at the counseling facility and for at least 24 months after the last date the individual provided services for or at the counseling facility; and
   b. If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

**R9-10-1907. Patient Rights**

**A.** An administrator shall ensure that at the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C).

**B.** An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
   a. Abuse;
   b. Neglect;

c. Exploitation;
d. Coercion;
e. Manipulation;
f. Sexual abuse;
g. Sexual assault;
h. Restraint or seclusion;
i. Retaliation for submitting a complaint to the Department or another entity; or
j. Misappropriation of personal and private property by a counseling facility's personnel member, employee, volunteer, or student; and

3. A patient or the patient's representative:
   a. Either consents to or refuses counseling;
   b. May refuse or withdraw consent for receiving counseling before counseling is initiated;
   c. Is informed of the following:
      i. The counseling facility's policy on health care directives, and
      ii. The patient complaint process;
   d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a counseling facility for identification and administrative purposes; and
   e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record, or
      ii. Financial records.

**C.** A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive counseling that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy during counseling;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the counseling facility is not authorized or not able to provide the behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, the counseling provided to the patient;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

**R9-10-1908. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the patient's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the patient's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
   c. As permitted by law; and
6. A patient's medical record is protected from loss, damage, or unauthorized use.

**B.** If a counseling facility maintains patients' medical records electronically, an administrator shall ensure that:

1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
   a. The patient's name and address, and
   b. The patient's date of birth;
2. A diagnosis or reason for counseling;
3. Documentation of general consent and, if applicable, informed consent for counseling by the patient or the patient's representative;
4. If applicable, the name and contact information of the patient's representative and:
   a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
   b. If the patient's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
5. Documentation of medical history;
6. Orders;
7. Assessment;
8. Interval notes;
9. Progress notes;
10. Documentation of counseling provided to the patient;
11. The name of each individual providing counseling;
12. Disposition of the patient upon discharge;
13. Documentation of the patient's follow-up instructions provided to the patient;
14. A discharge summary; and
15. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

**R9-10-1909. Counseling**

**A.** An administrator of a counseling facility shall ensure that:
1. Counseling provided at the counseling facility is provided under the direction of a behavioral health professional;
2. A personnel member who provides counseling is at least 18 years old; and
3. If a counseling facility provides counseling to a patient who is less than 18 years of age, an employee or a volunteer and the owner comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.

**B.** An administrator of a counseling facility shall ensure that:
1. Before counseling for a patient is initiated, there is a behavioral health assessment for the patient that complies with the requirements in this Section that is:
   a. Available:
      i. In the patient's medical record maintained by the counseling facility;
      ii. If the counseling facility is an affiliated counseling facility, in the patient's integrated medical record; or
      iii. If the counseling facility has an affiliated outpatient treatment center, in the patient's integrated medical record maintained by the counseling facility's affiliated outpatient treatment center; and
   b. Either:
      i. Completed by a personnel member at the counseling facility; or
      ii. Obtained from a behavioral health provider other than the counseling facility;
   2. A behavioral health assessment, obtained from a behavioral health provider other than the counseling facility or available in a medical record or integrated medical record, was completed within 12 months before the date of the patient's current admission;
3. If a behavioral health assessment is obtained from a behavioral health provider other than the counseling facility or is available as stated in subsection (B)(1)(a), the information in the behavioral health assessment is reviewed and updated if additional information that affects the patient's behavioral health assessment is identified;
4. The review and update of the patient's assessment information in subsection (B)(3) is documented in the patient's medical record within 48 hours after the review is completed;
5. If a behavioral health assessment is conducted by a:

a. Behavioral health technician or a registered nurse, within 72 hours after the behavioral health assessment is conducted, a behavioral health professional certified or licensed to provide the counseling needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the counseling needed by the patient; or
b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the counseling needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the counseling needed by the patient;

6. A behavioral health assessment:
   a. Documents a patient's:
      i. Presenting issue;
      ii. Substance use history;
      iii. Co-occurring disorder;
      iv. Medical condition and history;
      v. Legal history, including:
         (1) Custody,
         (2) Guardianship, and
         (3) Pending litigation;
      vi. Criminal justice record;
      vii. Family history;
      viii. Behavioral health treatment history; and
      ix. Symptoms reported by the patient or the patient's representative and referrals needed by the patient, if any;
   b. Includes:
      i. Recommendations for further assessment or examination of the patient's needs;
      ii. A description of the counseling, including type, frequency, and number of hours, that will be provided to the patient; and
      iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
   c. Is documented in patient's medical record;
7. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
8. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
9. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;
10. Documentation of the request in subsection (B)(8) and the opportunity in subsection (B)(9) is in the patient's medical record;
11. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;
12. If information in subsection (B)(6)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;
13. Counseling is:
   a. Offered as described in the counseling facility's scope of services;
   b. Provided according to the type, frequency, and number of hours identified in the patient's assessment; and
   c. Provided by a behavioral health professional or a behavioral health technician;
14. A personnel member providing counseling to address a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
15. Each counseling session is documented in the patient's medical record to include:
   a. The date of the counseling session;
   b. The amount of time spent in the counseling session;
   c. Whether the counseling was individual counseling, family counseling, or group counseling;
   d. The treatment goals addressed in the counseling session; and
   e. The signature of the personnel member who provided the counseling and the date signed.

**C.** An administrator may provide any of the following, according to the applicable requirements in 9 A.A.C. 20, to individuals required to attend by a referring court, if approved by the Department to provide the services:
1. DUI screening,
2. DUI education,
3. DUI treatment, or
4. Misdemeanor domestic violence offender treatment.

**D.** An administrator of a counseling facility authorized to provide the services in subsection (C):
1. Shall comply with the requirements for the specific service in 9 A.A.C. 20, and

2. May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1910. Physical Plant, Environmental Services, and Safety Standards**

**A.** An administrator shall ensure that a counseling facility has either:
1. Both of the following:
   a. A smoke detector installed in each hallway of the counseling facility that is:
      i. Maintained in an operable condition;
      ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and
      iii. Tested monthly; and
   b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
      i. Is available at the counseling facility;
      ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;
      iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
      iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person; or
2. Both of the following that are tested and serviced at least once every 12 months:
   a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and
   b. A sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order.

**B.** An administrator shall ensure that documentation of a test required in subsection (A) is maintained for at least 12 months after the date of the test.

**C.** An administrator shall ensure that on a counseling facility's premises:
1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit signs;
2. Corridors and exits are kept clear of any obstructions;
3. A patient can exit through any exit during hours of clinical operation;
4. An extension cord is not used instead of permanent electrical wiring; and
5. Each electrical outlet and electrical switch has a cover plate that is in good repair.

**D.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**E.** An administrator shall ensure that:
1. A counseling facility's premises are:
   a. Sufficient to provide the counseling facility's scope of services;
   b. Cleaned and disinfected to prevent, minimize, and control illness and infection; and
   c. Free from a condition or situation that may cause an individual to suffer physical injury;
2. If a bathroom is on the premises, the bathroom contains:
   a. A working sink with running water,
   b. A working toilet that flushes and has a seat,
   c. Toilet tissue,
   d. Soap for hand washing,
   e. Paper towels or a mechanical air hand dryer,
   f. Lighting, and
   g. A means of ventilation;
3. If a bathroom is not on the premises, a bathroom is:
   a. Available for a patient's use,
   b. Located in a building in contiguous proximity to the counseling facility, and
   c. Free from a condition or situation that may cause an individual using the bathroom to suffer a physical injury; and
4. A tobacco smoke-free environment is maintained on the premises.

**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp.

14-4). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

**R9-10-1911. Integrated Information**

**A.** An administrator of an affiliated outpatient treatment center may maintain the following information, required in this Article for a counseling facility for which the affiliated outpatient treatment center provides administrative support, integrated with information required in 9 A.A.C. 10, Article 10 for the outpatient treatment center:
1. Quality management plan, documented incidents, and reports required in R9-10-1904;
2. Contracted services information in R9-10-1905;
3. Orientation plan, in-service education plan, and personnel records in R9-10-1906; and
4. Medical records in R9-10-1908.

**B.** An administrator of an affiliated counseling facility that shares administrative support with one or more other affiliated counseling facilities may maintain the information in subsections (A)(1) through (A)(4) integrated with information maintained by the other affiliated counseling facilities.

**C.** If an administrator of an affiliated outpatient treatment center or an affiliated counseling facility maintains integrated information according to subsection (A) or (B), the administrator shall develop, document, and implement a method to ensure that:
1. If the quality management plan is integrated, the incidents documented, concerns identified, and changes or actions taken are identified for each facility;
2. If a person provides contracted services at more than one facility, the types of services the person provides at each facility is identified in the contract information;
3. If an orientation plan is applicable to more than one facility, the orientation a personnel member is expected to obtain for each facility is identified in the orientation plan;
4. If an in-service education plan is applicable to more than one facility, the in-service education a personnel member is expected to obtain for each facility is identified in the in-service education plan;
5. If a personnel member provides counseling at more than one facility, the following is identified in the personnel member's record:
   a. The days and hours the personnel member provides counseling for each facility;
   b. If the personnel member's job description is different for each facility:
      i. Each job description for the personnel member, and
      ii. Verification of the skills and knowledge to provide counseling according to each of the personnel member's job descriptions; and
   c. If a personnel member is a behavioral health technician, documentation of the clinical oversight provided to the personnel member, based on the number and acuity of the patients to whom the personnel member provided counseling at each facility; and
6. If a patient receives counseling at more than one facility, the counseling received and any information related to the counseling received at each facility is identified in the patient's medical record.

**D.** An administrator of a counseling facility receiving administrative support from an affiliated outpatient treatment center or an affiliated counseling facility shall ensure that if the counseling facility:
1. Has integrated information, the integrated information is provided to the Department for review within two hours after the Department's request:
   a. In a written or electronic format at the counseling facility's premises; or
   b. Electronically directly to the Department.
2. No longer receives or shares administrative support that includes integrating the information in subsection (A), the information for the counseling facility required in this Article is maintained by the counseling facility and provided to the Department according to the requirements in this Article.

## ARTICLE 22. NURSING-SUPPORTED GROUP HOMES

**R9-10-2201. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the definitions in A.R.S. § 36-551 apply in this Article unless otherwise specified.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2202. Supplementary Application Requirements and Documentation Submission Requirements**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a nursing-supported group home shall include:
1. In a Department-provided format, whether the applicant is requesting authorization:
   a. To admit residents who:
      i. Are on a ventilator,
      ii. Have a tracheostomy tube, or
      iii. Receive total parenteral nutrition; or
   b. To provide:
      i. Services to individuals under 18 years of age, including the licensed capacity requested;
      ii. Restraint;
      iii. Clinical laboratory services; or
      iv. Respiratory care services; and
2. A copy of the applicant's service provider award letter with the Division.

**B.** A licensee shall submit to the Department, with the relevant fees required in R9-10-106(C) and in a Department-provided format:
1. The information required in subsection (A)(1), as applicable; and
2. Documentation of the licensee's service provider contract with the Division.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2203. Administration**

**A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of a nursing-supported group home;
2. Establish, in writing, the nursing-supported group home's scope of services;
3. Designate, in writing, an administrator for the nursing-supported group home who:
   a. Is at least 21 years old; and
   b. Meets one of the following:
      i. Is a registered nurse,
      ii. Is a nursing care institution administrator, or
      iii. Has a minimum of three-years' experience working as an administrator or personnel member in a nursing-supported group home or other health care institution licensed under this Chapter;
4. Adopt a quality management program according to R9-10-2204;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who meets the requirements in subsection (A)(3), if the administrator is:
   a. Expected not to be present on the premises of the nursing-supported group home for more than 30 calendar days, or
   b. Not present on the premises of the nursing-supported group home for more than 30 calendar days; and
7. Except as permitted in subsection (A)(6), when there is a change of administrator:
   a. Notify the Department according to A.R.S. § 36-425(I), and
   b. Submit to the Department a copy of documentation demonstrating the new administrator's compliance with the requirements in subsection (A)(3).

**B.** An administrator:
1. Is directly accountable to the governing authority of a nursing-supported group home for the daily operation of the nursing-supported group home and all services provided by or at the nursing-supported group home;
2. Has the authority and responsibility to manage the nursing-supported group home;
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the premises of the nursing-supported group home and accountable for the nursing-supported group home when the administrator is not present on the nursing-supported group home's premises; and
4. Ensures the nursing-supported group home's compliance with A.R.S. § 36-411 and, as applicable, A.R.S. § 8-804 or § 46-459.

**C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover the process for checking on a personnel member through the adult protective services registry, established according to A.R.S. § 46-459, or the central registry, established according to A.R.S. § 8-804, as applicable;
   c. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   d. Include methods to prevent abuse or neglect of a resident, including:
      i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and

ii. Reporting of abuse or neglect of a resident;
e. Include how a personnel member may submit a complaint relating to resident care;
f. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
g. Cover cardiopulmonary resuscitation training including:
i. Which personnel members are required to obtain cardiopulmonary resuscitation training;
ii. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the ability to perform cardiopulmonary resuscitation;
iii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
iv. The time-frame for renewal of cardiopulmonary resuscitation training; and
v. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
h. Cover first aid training;
i. Include a method to identify a resident to ensure the resident receives physical health services, habilitation services, and behavioral care as ordered;
j. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;
k. Cover specific steps for:
i. A resident to file a complaint, and
ii. The nursing-supported group home to respond to a resident's complaint;
l. Cover health care directives;
m. Cover medical records, including electronic medical records;
n. Cover a quality management program, including incident reports and supporting documentation;
o. Cover contracted services;
p. Cover resident's personal accounts;
q. Cover petty cash funds;
r. If the nursing-supported group home may admit a resident who is not placed in the nursing-supported group home by the Division, cover:
i. Fees and the process for receiving a fee for a resident,
ii. The reasons and process for terminating residency, and
iii. The process for refunding a fee for a resident;
s. Cover smoking and the use of tobacco products on the premises;
t. Cover the storage and use of alcoholic beverages on the premises; and
u. Cover when an individual may visit a resident in a nursing-supported group home;

2. Policies and procedures for physical health services, habilitation services, and behavioral care are established, documented, and implemented to protect the health and safety of a resident that:
a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;
b. Cover the provision of physical health services, habilitation services, and behavioral care;
c. Cover acuity, including a process for obtaining sufficient nursing personnel and other personnel members to meet the needs of residents;
d. Include when general consent and informed consent are required;
e. Cover storing, dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
f. Cover infection control;
g. Cover interventions to address a resident's inappropriate behavior, including:
i. The hierarchy for use;
ii. Use of time-outs for inappropriate behavior; and
iii. Except in an emergency, require positive techniques for behavior modification to be used before more restrictive methods are used;
h. Cover restraints, both chemical restraints and physical restraints if applicable, that:
i. Require an order, including the frequency of monitoring and assessing the restraint; and
ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a resident's sudden, intense, or out-of-control behavior;
i. Cover telemedicine, if applicable;
j. Cover environmental services that affect resident care;
k. Cover the security of a resident's possessions that are allowed on the premises;
l. Cover methods to encourage participation of a resident's family or friends or other individuals in activities planned according to R9-10-2210(B);
m. Include a method for obtaining an advocate for a resident, if necessary;
n. Cover resident outings;

o. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks; and
p. Cover whether pets and animals are allowed on the premises, including procedures to ensure that any pets or animals allowed on the premises do not endanger the health or safety of residents or the public;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
b. When documentation or information is required by this Chapter to be submitted on behalf of a nursing-supported group home, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the nursing-supported group home.

**D.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a nursing-supported group home's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
2. For a resident under 18 years of age, according to A.R.S. § 13-3620.

**E.** If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a nursing-supported group home's employee or personnel member, an administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the resident as follows:
a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
a. The suspected abuse, neglect, or exploitation;
b. Any action taken according to subsection (E)(1); and
c. The report in subsection (E)(2);
4. Maintain the documentation in subsection (E)(3) for at least 12 months after the date of the report in subsection (E)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (E)(2):
a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (E)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**F.** An administrator shall:
1. Allow a resident advocate to assist a resident or the resident's representative with a request or recommendation, and document in writing any complaint submitted to the nursing-supported group home;
2. Ensure that a monthly schedule of recreational activities for residents is developed, documented, and implemented; and
3. Ensure that the following are conspicuously posted on the premises:
a. The current nursing-supported group home license issued by the Department;
b. The name, address, and telephone number of:
i. The Department's Bureau of Long Term Care Facilities Licensing;
ii. Adult Protective Services of the Department of Economic Security; and
iii. If applicable, Child Protective Services of the Department of Child Safety;
c. A notice that a resident may file a complaint with the Department concerning the nursing-supported group home;
d. The monthly schedule of recreational activities; and
e. One of the following:
i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect; or
ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.

**G.** An administrator shall provide written notification to the Department of a resident's:
1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency medical services provider.

**H.** An administrator shall:
1. Notify a resident's representative, family member, or other individual designated by the resident within one calendar day after:
   a. The resident's death,
   b. There is a significant change in the resident's medical condition, or
   c. The resident has an illness or injury that requires immediate intervention by an emergency medical services provider or treatment by a health care provider; and
2. For an illness or injury in subsection (H)(1)(c), document the following:
   a. The date and time of the illness or injury;
   b. A description of the illness or injury;
   c. If applicable, the names of individuals who observed the injury;
   d. The actions taken by personnel members, according to policies and procedures;
   e. The individuals notified by the personnel members; and
   f. Any action taken to prevent the illness or injury from occurring in the future.

**I.** If an administrator administers a resident's personal account at the request of the resident or the resident's representative, the administrator shall:
1. Comply with policies and procedures established according to subsection (C)(1)(p);
2. Designate a personnel member who is responsible for the personal accounts;
3. Maintain a complete and separate accounting of each personal account;
4. Obtain written authorization from the resident or the resident's representative for a personal account transaction;
5. Document an account transaction and provide a copy of the documentation to the resident or the resident's representative upon request and at least every three months;
6. Transfer all money from the resident's personal account in excess of $50.00 to an interest-bearing account and credit the interest to the resident's personal account; and
7. Within 30 calendar days after the resident's death, transfer, or discharge, return all money in the resident's personal account and a final accounting to the resident, the resident's representative, or the probate jurisdiction administering the resident's estate.

**J.** If a petty cash fund is established for use by residents, the administrator shall ensure that:
1. The policies and procedures established according to subsection (C)(1)(q) include:
   a. A prescribed cash limit of the petty cash fund, and
   b. The hours of the day a resident may access the petty cash fund; and
2. A resident's written acknowledgment is obtained for a petty cash transaction.

**K.** An administrator shall ensure that an acuity plan is developed, documented, and implemented for the nursing-supported group home that:
1. Includes:
   a. A method that establishes the types and numbers of personnel members that are required in the nursing-supported group home to ensure resident health and safety, and
   b. A policy and procedure stating the steps the nursing-supported group home will take to obtain or assign the necessary personnel members to address resident acuity;
2. Is used when making assignments for resident treatment; and
3. Is reviewed and updated, as necessary, at least once every 12 months.

**L.** An administrator shall establish and document the criteria for determining when a resident's absence is unplanned, including the criteria for a resident who:
1. Is absent against medical advice,
2. Is under the age of 18, or
3. Does not return to the nursing-supported group home at the expected time after a planned absence.

**M.** An administrator shall ensure that documentation of the most recent monitoring of the nursing-supported group home, conducted by the Arizona Department of Economic Security under A.R.S. § 36-557(G)(2), is on the premises of the nursing-supported group home.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2204. Quality Management**

An administrator shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to residents;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to resident care; and

e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to resident care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2205. Contracted Services**

An administrator shall ensure that:
1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2206. Personnel**

**A.** An administrator shall ensure that:
1. A personnel member is:
   a. At least 21 years old, or
   b. At least 18 years old and is licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice;
2. An employee is at least 18 years old;
3. A student is at least 18 years old; and
4. A volunteer is at least 21 years old.

**B.** An administrator shall ensure that:
1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of physical health services, habilitation services, or behavioral care expected to be provided by the personnel member according to the established job description; and
      ii. The acuity of the residents receiving physical health services, habilitation services, or behavioral care from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services, habilitation services, or behavioral care listed in the established job description;
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services, habilitation services, or behavioral care listed in the established job description; and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services, habilitation services, or behavioral care listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services, habilitation services, or behavioral care; and
   b. According to policies and procedures; and
3. Sufficient personnel members are present on a nursing-supported group home's premises with the qualifications, skills, and knowledge necessary to:
   a. Provide the services in the nursing-supported group home's scope of services,
   b. Meet the needs of a resident, and
   c. Ensure the health and safety of a resident.

**C.** An administrator shall ensure that an organizational chart of the nursing-supported group home is established, updated as necessary, and maintained on the premises:
1. Outlining the roles, responsibilities, and relationships within the nursing-supported group home; and
2. Including the name and, if applicable, the license or certification credential of each individual shown on the organizational chart.

**D.** An administrator shall ensure that, if a personnel member provides services that require a license under A.R.S. Title 32 or 36, the personnel member is licensed under A.R.S. Title 32 or 36, as applicable.

**E.** An administrator shall ensure that an individual who is a licensed baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision as defined in 4 A.A.C. 6, Article 1.

**F.** An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the nursing-supported group home, and
2. As specified in R9-10-113.

**G.** An administrator shall ensure that:
1. The types and numbers of nurses and other personnel members required according to the acuity plan in R9-10-2203(K) are present in the nursing-supported group home;
2. Documentation of the nurses and other personnel members present on the nursing-supported group home's premises each day is maintained and includes:
   a. The date;
   b. The number of residents;
   c. The name, license or certification credential if applicable, and assigned duties of each nurse or other personnel member who worked that day; and
   d. The actual number of hours each nurse or other personnel member worked that day; and
3. The documentation of nurses and other personnel members required in subsection (G)(2) is maintained for at least 12 months after the date of the documentation.

**H.** An administrator shall ensure that a personnel member is on duty, on the premises, awake, and able to respond, according to policies and procedures, to injuries, symptoms of illness, or fire or other emergencies on the premises.

**I.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's compliance with the requirements in A.R.S. § 36-411;
   d. The nursing-supported group home's check on the individual in the adult protective services registry, established according to A.R.S. § 46-459, or the central registry, established according to A.R.S. § 8-804, as applicable;
   e. Orientation and in-service education as required by policies and procedures;
   f. Training in preventing, recognizing, and reporting abuse or neglect, required according to R9-10-2203(C)(1)(d)(i);
   g. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   h. If applicable, the individual's qualifications and on-going training for each type of restraint used, as required in R9-10-2217;
   i. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-2203(C)(1)(g);
   j. First aid training, if required for the individual according to this Article or policies and procedures; and
   k. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).

**J.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout the individual's period of providing services in or for the nursing-supported group home, and
   b. For at least 24 months after the last date the individual provided services in or for the nursing-supported group home; and
2. For a personnel member who has not provided physical health services, habilitation services, or behavioral care at or for the nursing-supported group home during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**K.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
2. A personnel member completes orientation before providing physical health services, habilitation services, or behavioral care;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and

c. The subject or topics covered in the training; and

6. A work schedule of each personnel member is developed and maintained at the nursing-supported group home for at least 12 months after the date of the work schedule.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2207. Admissions**

An administrator shall ensure that:

1. A resident is admitted only:
   a. On a physician's order or based on a placement evaluation by the Division;
   b. If the resident has or is at risk for having a developmental disability or cognitive disability;
   c. If the resident's placement evaluation indicates that the resident requires continuous nursing services;
   d. If the resident's placement evaluation indicates that the resident's needs can be met by the nursing-supported group home; and
   e. Except when the resident's placement evaluation states that the resident would benefit from being part of a group that includes residents of different ages or social needs, if the resident can be assigned to a room within the nursing-supported group home with other residents of similar ages or social needs;
2. The physician's admitting order or placement evaluation documentation in subsection (1)(a) includes the physical health services, habilitation services, and behavioral care required to meet the immediate needs of a resident, including medication and food services;
3. At the time of a resident's admission, a registered nurse conducts or coordinates an initial assessment on a resident to determine the resident's acuity and ensure the resident's immediate needs are met;
4. The resident's individual service and program plan, as required by A.A.C. R6-6-602, accompanies the resident;
5. A resident's needs do not exceed the medical services, rehabilitation services, and nursing services available at the nursing-supported group home as established in the nursing-supported group home's scope of services;
6. A resident is assigned to the nursing-supported group home based, as applicable, on the patient's:
   a. Documented diagnosis,
   b. Treatment needs,
   c. Developmental level,
   d. Social skills,
   e. Verbal skills, and
   f. Acuity;
7. A resident does not share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that, based on the other resident's documented diagnosis, treatment needs, developmental level, social skills, verbal skills, and personal history, may present a threat to the resident's health and safety;
8. Within 30 calendar days before admission or 10 working days after admission, a medical history and physical examination is completed on a resident by:
   a. A medical practitioner designated for the resident, or
   b. A physician assistant or a registered nurse practitioner designated by the resident's designated medical practitioner;
9. Compliance with the requirements in subsection (8) is documented in the resident's medical record;
10. Except as specified in subsection (11), a resident provides evidence of freedom from infectious tuberculosis:
    a. Before or within seven calendar days after the resident's admission, and
    b. As specified in R9-10-113; and
11. A resident who transfers from a nursing care institution or another nursing-supported group home to the nursing-supported group home is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
    a. Fewer than 12 months have passed since the resident was screened for tuberculosis, and
    b. The documentation of freedom from infectious tuberculosis required in subsection (10) accompanies the resident at the time of transfer.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2208. Transfer; Discharge**

**A.** An administrator, in coordination with the Division if applicable, shall ensure that:

1. A resident is transferred or discharged if:
   a. The nursing-supported group home is not authorized or not able to meet the needs of the resident,
   b. The resident no longer requires continuous nursing services, or

c. The resident's behavior is a threat to the health or safety of the resident or other individuals at the nursing-supported group home; and

2. Documentation of a resident's transfer or discharge includes:
   a. The date of the transfer or discharge,
   b. The reason for the transfer or discharge,
   c. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1), and
   d. If applicable, actions taken by a personnel member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the nursing-supported group home and beyond the nursing-supported group home's scope of services.

**B.** Except for a transfer of a resident due to an emergency, an administrator shall ensure that:
1. A registered nurse coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before the transfer;
   b. Information from the resident's medical record, including the following, is provided to a receiving health care institution;
      i. Orders that are in effect at the time of the transfer; and
      ii. The resident's need for nursing services, rehabilitation services, or habilitation services at the time of transfer; and
   c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the resident during a transfer.

**C.** Except in an emergency, a registered nurse shall ensure that before a resident is discharged:
1. Written follow-up instructions are developed with the resident or the resident's representative that include:
   a. Information necessary to meet the resident's need for medical services and nursing services, including specific care instructions and whether the resident requires any durable medical equipment or supplies; and
   b. The state long-term care ombudsman's name, address, and telephone number;
2. A copy of the written follow-up instructions is provided to the resident or the resident's representative; and
3. A discharge summary:
   a. Is developed by a registered nurse;
   b. Authenticated by the resident's designated medical practitioner or designee; and
   c. Includes:
      i. The resident's need for nursing services, rehabilitation services, or habilitation services at the time of discharge;
      ii. The resident's need for medical services;
      iii. The resident's developmental, behavioral, social, and nutritional status;
      iv. The resident's medical and psychosocial history;
      v. The date of the discharge; and
      vi. The location of the resident after discharge.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2209. Transport**

**A.** Except as provided in subsections (B) and (C), an administrator shall ensure that:
1. A personnel member authorized by policies and procedures coordinates the transport and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before and after the transport,
   b. Information from the resident's medical record is provided to a receiving health care institution, and
   c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transport;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the resident during a transport.

**B.** If the transport of a resident is to provide the resident with rehabilitation services or habilitation services off the premises, an administrator shall ensure that:
1. The rehabilitation services or habilitation services are included in the resident's individual program plan,

2. A registered nurse coordinates the transport and the services provided to the resident, and
3. The resident is transported according to R9-10-2210(A).

**C.** Subsection (A) does not apply to:
1. Except as provided in subsection (B), transportation according to R9-10-2210 to a location other than a licensed health care institution;
2. Transportation provided for a resident by the resident or the resident's representative;
3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative; or
4. A transport to another licensed health care institution in an emergency.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2210. Transportation; Resident Outings**

**A.** An administrator of a nursing-supported group home that uses a vehicle owned or leased by the nursing-supported group home to provide transportation to a resident shall ensure that:
1. The vehicle:
   a. Is safe and in good repair,
   b. Contains a first aid kit,
   c. Contains drinking water sufficient to meet the needs of each resident present in the vehicle, and
   d. Contains a working heating and air conditioning system;
2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
3. A driver of the vehicle:
   a. Is 21 years of age or older;
   b. Has a valid driver license and no driving restriction on the driver's documentation of compliance with the requirements in A.R.S. § 36-411;
   c. Operates the vehicle in a manner that does not endanger a resident in the vehicle;
   d. Does not leave in the vehicle an unattended:
      i. Child;
      ii. Resident who may be a threat to the health, safety, or welfare of the resident or another individual; or
      iii. Resident who is incapable of independent exit from the vehicle; and
   e. Ensures the safe and hazard-free loading and unloading of residents; and
4. Transportation safety is maintained as follows:
   a. An individual in the vehicle is sitting in a seat, which may include the seat of a wheel chair, and wearing a working seat belt while the vehicle is in motion; and
   b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a resident's body.

**B.** An administrator shall ensure that an outing is consistent with the age, physical ability, medical condition, and treatment needs of each resident participating in the outing.

**C.** An administrator shall ensure that:
1. A sufficient number of personnel members are present on an outing to ensure the health and safety of a resident on the outing;
2. Each personnel member on the outing has documentation of current training in cardiopulmonary resuscitation according to R9-10-2203(C)(1)(g) and first aid training;
3. Documentation is developed before an outing that includes:
   a. The name of each resident participating in the outing;
   b. A description of the outing;
   c. The date of the outing;
   d. The anticipated departure and return times;
   e. The name, address, and, if available, telephone number of the outing destination; and
   f. If applicable, the license plate number of a vehicle used to provide transportation for the outing;
4. The documentation described in subsection (C)(3) is updated to include the actual departure and return times and is maintained for at least 12 months after the date of the outing; and
5. Emergency information for a resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
   a. The resident's name;
   b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
   c. The resident's allergies; and
   d. The name and telephone number of a designated individual, who is present on the nursing-supported group home's premises, to notify in case of an emergency.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2211. Resident Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the resident rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C); and
3. Policies and procedures include:
   a. How and when a resident or the resident's representative is informed of resident rights in subsection (C), and
   b. Where resident rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A resident has privacy in:
   a. Treatment,
   b. Bathing and toileting,
   c. Room accommodations, and
   d. Visiting or meeting with another resident or an individual;
2. A resident is treated with dignity, respect, and consideration;
3. A resident is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Except as allowed in R9-10-2217, restraint;
   j. Retaliation for submitting a complaint to the Department or another entity;
   k. Misappropriation of personal and private property by a nursing-supported group home's personnel members, employees, volunteers, or students; or
   l. Segregation solely on the basis of the resident's disability; and
4. A resident or the resident's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of proposed alternatives to psychotropic medication and the associated risks and possible complications of the psychotropic medication;
   d. Is informed of the following:
      i. The health care institution's policy on health care directives;
      ii. If applicable, the policies in R9-10-2203(C)(1)(r); and
      iii. The resident complaint process;
   e. Consents to photographs of the resident before the resident is photographed, except that the resident may be photographed when admitted to a nursing-supported group home for identification and administrative purposes;
   f. May manage the resident's financial affairs;
   g. Has access to and may communicate with any individual, organization, or agency;
   h. Except as provided in the resident's individual program plan, has privacy:
      i. In interactions with other residents or visitors to the nursing-supported group home,
      ii. In the resident's mail, and
      iii. For telephone calls made by or to the resident;
   i. May review the nursing-supported group home's current license survey report and, if applicable, plan of correction in effect;
   j. May review the resident's financial records within two working days and medical record within one working day after the resident's or the resident's representative's request;
   k. May obtain a copy of the resident's financial records and medical record within two working days after the resident's request and in compliance with A.R.S. § 12-2295;
   l. Except as otherwise permitted by law, consents, in writing, to the release of information in the resident's:
      i. Medical record, and
      ii. Financial records;

m. May select a pharmacy of choice if the pharmacy complies with policies and procedures and does not pose a risk to the resident;
n. Is informed of the method for contacting the resident's designated medical practitioner;
o. Is informed of the resident's overall physical and psychosocial well-being, as determined by the resident's comprehensive assessment;
p. Is provided with a copy of those sections of the resident's medical record that are required for continuity of care free of charge, according to A.R.S. § 12-2295, if the resident is transferred or discharged; and
q. Except in the event of an emergency, is informed orally or in writing before the nursing-supported group home makes a change in a resident's room or roommate assignment and notification is documented in the resident's medical record.

**C.** In addition to the rights in A.R.S. § 36-551.01, a resident has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;
3. To choose activities and schedules consistent with the resident's interests that do not interfere with other residents;
4. To participate in social, religious, political, and community activities that do not interfere with other residents;
5. To retain personal possessions including furnishings and clothing as space permits unless use of the personal possession infringes on the rights or health and safety of other residents;
6. To share a room with the resident's spouse if space is available and the spouse consents;
7. To receive a referral to another health care institution if the nursing-supported group home is not authorized or not able to provide physical health services, habilitation services, and behavioral care needed by the resident;
8. To participate or have the resident's representative participate in the development of the resident's individual program plan or decisions concerning treatment;
9. To participate or refuse to participate in research or experimental treatment; and
10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2212. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
   a. Recorded only by an individual authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the resident's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A resident's medical record is available to an individual:
   a. Authorized to access the resident's medial record according to policies and procedures;
   b. If the individual is not authorized to access the resident's medical record according to policies and procedures, with the written consent of the resident or the resident's representative; or
   c. As permitted by law; and
6. A resident's medical record is protected from loss, damage, or unauthorized use.

**B.** If a nursing-supported group home maintains residents' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a resident's medical record contains:
1. Resident information that includes:
   a. The resident's name;
   b. The resident's date of birth; and
   c. Any known allergies, including medication allergies;
2. The admission date and, if applicable, the date of discharge;
3. The admitting diagnosis or presenting symptoms;

4. Documentation of the resident's placement evaluation;
5. Documentation of the resident's individual service and program plan, as required by A.A.C. R6-6-602;
6. Documentation of:
   a. The resident's last periodic evaluation, conducted according to A.A.C. R6-6-604, before the resident's admission; and
   b. Each periodic evaluation, conducted according to A.A.C. R6-6-604, while the resident was admitted to the nursing-supported group home;
7. Documentation of general consent and, if applicable, informed consent;
8. If applicable, the name and contact information of the resident's representative and:
   a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
   b. If the resident's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
9. The name and contact information of an individual to be contacted under R9-10-2203(H)(1);
10. Documentation of the initial assessment required in R9-10-2207(3) to determine acuity;
11. The medical history and physical examination required in R9-10-2215(A)(2);
12. A copy of the resident's living will or other health care directive, if applicable;
13. The name and telephone number of the resident's designated medical practitioner;
14. Orders;
15. Documentation of the resident's comprehensive assessment;
16. Individual program plans, including nursing care plans or medical care plans, if applicable;
17. Documentation of physical health services, habilitation services, and behavioral care provided to the resident;
18. Progress notes, including data needed to evaluate the effectiveness of the methods, schedule, and strategies being used to accomplish the goals in the resident's individual program plan;
19. If applicable, documentation of restraint;
20. If applicable, documentation of any actions other than restraint taken to control or address the resident's behavior to prevent harm to the resident or another individual or to improve the resident's social interactions;
21. If applicable, documentation that evacuation from the nursing-supported group home would cause harm to the resident;
22. The disposition of the resident after discharge;
23. The discharge plan;
24. The discharge summary;
25. Transfer documentation;
26. If applicable:
   a. A laboratory report,
   b. A radiologic report,
   c. A diagnostic report, and
   d. A consultation report;
27. Documentation of freedom from infectious tuberculosis required in R9-10-2207(10);
28. Documentation of a medication administered to the resident that includes:
   a. The date and time of administration;
   b. The name, strength, dosage, and route of administration;
   c. The type of vaccine, if applicable;
   d. For a medication administered for pain on a PRN basis:
      i. An evaluation of the resident's pain before administering the medication, and
      ii. The effect of the medication administered;
   e. For a psychotropic medication administered on a PRN basis:
      i. An evaluation of the resident's symptoms before administering the psychotropic medication, and
      ii. The effect of the psychotropic medication administered;
   f. The identification, signature, and professional designation of the individual administering the medication; and
   g. Any adverse reaction a resident has to the medication; and
29. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2213. Nursing Services**

**A.** An administrator shall ensure that:
1. Nursing services are provided 24 hours a day in a nursing-supported group home;

2. A director of nursing is appointed who:
   a. Is a registered nurse, and
   b. Is responsible for the direction of nursing services;
3. The director of nursing or an individual designated by the administrator participates in the quality management program; and
4. If the director of nursing is responsible for nursing services for 30 or more residents, the director of nursing does not provide direct care to residents on a regular basis.

**B.** A director of nursing shall ensure that:
1. A method is established and documented that identifies the types and numbers of nursing personnel that are necessary to provide nursing services to residents based on the residents' comprehensive assessments; orders for physical health services, rehabilitation services, and behavioral care; and individual program plans and the nursing-supported group home's scope of services;
2. Sufficient nursing personnel, as determined by the method in subsection (B)(1), are assigned to be on the nursing-supported group home premises to meet the needs of a resident for nursing services;
3. At least one nurse is present on the nursing-supported group home's premises;
4. As soon as possible but not more than 24 hours after one of the following events occur, a nurse notifies a resident's designated medical practitioner and, if applicable, the resident's representative, if the resident:
   a. Is injured,
   b. Is involved in an incident that may require medical services, or
   c. Has a significant change in condition; and
5. Only a medication required by an order is administered to a resident.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2214. Individual Program Plan**

**A.** An administrator shall ensure that:
1. A comprehensive assessment of a resident:
   a. Is conducted or coordinated by the director of nursing, in collaboration with an interdisciplinary team that includes:
      i. The resident's designated medical practitioner or designee;
      ii. A registered nurse;
      iii. If the resident is receiving medications as part of physical health services or behavioral care, a pharmacist; and
      iv. Personnel members qualified to provide each type of habilitation services or rehabilitation services identified in a placement evaluation in R9-10-2207(1)(a) or the initial assessment required in R9-10-2207(3);
   b. Is completed for the resident within 30 calendar days after the resident's admission to a nursing-supported group home;
   c. Is updated:
      i. No later than 12 months after the date of the resident's last comprehensive assessment, and
      ii. When the resident experiences a significant change;
   d. Includes the following information for the resident:
      i. Identifying information;
      ii. An evaluation of the resident's hearing, speech, and vision;
      iii. An evaluation of the resident's ability to understand and recall information;
      iv. An evaluation of the resident's mental status;
      v. Whether the resident demonstrates inappropriate behavior;
      vi. Preferences for customary routine and activities;
      vii. An evaluation of the resident's ability to perform activities of daily living;
      viii. Need for a mobility device;
      ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
      x. Any diagnosis that impacts rehabilitation services or other physical health services or behavioral care that the resident may require;
      xi. Any medical conditions that impact the resident's functional status, quality of life, or need for nursing services;
      xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;
      xiii. An evaluation of the resident's oral and dental status;
      xiv. An evaluation of the condition of the resident's skin;
      xv. Identification of any medication or treatment administered to the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
      xvi. Identification of any treatment or medication ordered for the resident;
      xvii. Identification of interventions that may support the resident towards independence;
      xviii. Identification of any assistive devices needed by the resident;
      xix. Identification of the physical health services needed by the resident, including physical health services not provided by the nursing-supported group home;

xx. Identification of measurable goals and behavioral objective for the physical health services, habilitation services, and behavioral care, in priority order, with time limits for attainment;
xxi. Identification of the methods, schedule, and strategies to accomplish the goals in subsection (A)(1)(d)(xviii), including the personnel member responsible;
xxii. Evaluation procedures for determining if the methods and strategies in subsection (A)(1)(d)(xix) are working, including the type of data required and frequency of collection;
xxiii. Whether any restraints have been used for the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
xxiv. If the resident demonstrates inappropriate behavior, as reported according to subsection (A)(1)(d)(v), identification of the methods, schedule, and strategies for replacement of the inappropriate behavior with appropriate behavioral expressions, including the hierarchy for use;
xxv. If restraint is included in subsection (A)(1)(d)(xxiv), the specific restraints that may be used because of the resident's inappropriate behavior;
xxvi. A description of the resident or resident's representative's participation in the comprehensive assessment;
xxvii. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;
xxviii. Potential for rehabilitation, including the resident's strengths and specific developmental or behavioral health needs; and
xxix. Potential for discharge;

e. Is signed and dated by the director of nursing; and
f. Is used to determine or update the resident's acuity;

2. If any of the conditions in subsection (A)(1)(d)(v) are answered in the affirmative during the comprehensive assessment or review, a behavioral health professional reviews a resident's comprehensive assessment or review and individual program plan to ensure that the resident's needs for behavioral care are being met;
3. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing-supported group home unless a physician, an individual designated by the physician, or a registered nurse determines the resident has a significant change in condition; and
4. A resident's comprehensive assessment is reviewed at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition by:
   a. The director of nursing;
   b. A registered nurse providing nursing services to the resident; and
   c. If there is a significant change in the resident's ability to maintain adequate nutrition and hydration, a registered dietitian.

**B.** An administrator shall ensure that an individual program plan for a resident:
1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1);
2. Includes the acuity of the resident;
3. Is reviewed at least annually by the interdisciplinary team required in subsection (A)(1)(a) and revised based on any change to the resident's comprehensive assessment; and
4. Ensures that a resident is provided physical health services, rehabilitation services, habilitation services, and other services or behavioral care that:
   a. Address any medical condition or behavioral care issue identified in the resident's comprehensive assessment, and
   b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2215. Physical Health Services**

**A.** An administrator shall ensure that:
1. A resident has a designated medical practitioner;
2. A physical examination is performed on a resident by the resident's designated medical practitioner or by a physician, physician assistant, or registered nurse practitioner designated by the resident's designated medical practitioner:
   a. If indicated, based on the resident's placement evaluation or comprehensive assessment; and
   b. At least once every 12 months after the date of admission, including an assessment of the acuity of the resident's medical condition;
3. The resident's designated medical practitioner, in conjunction with the director of nursing, develops a medical care plan of treatment for the resident, which is integrated into the resident's individual program plan; and
4. Vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:

a. The resident's designated medical practitioner provides documentation that the vaccination is medically contraindicated;
b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical record that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or
c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the last five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention.

**B.** A director of nursing shall ensure that:
1. A registered nurse participates in the development, review, and updating of a resident's nursing care plan or medical care plan;
2. Personnel members providing direct care to a resident with a nursing care plan or medical care plan receive direction from a nurse; and
3. Nursing personnel provide education and training to:
   a. Residents on hygiene and other behaviors that promote health; and
   b. Personnel members on:
      i. Detecting signs of illness or injury or significant changes in condition,
      ii. First aid, and
      iii. Basic skills for caring for residents.

**C.** An administrator shall ensure that:
1. A resident's need for dental services is determined as part of the resident's initial assessment in R9-10-2207(3);
2. Unless a resident's eligibility for third-party payment for dental services is determined before the resident's initial comprehensive assessment in R9-10-2214(A)(1)(b) due to the resident's immediate need for dental services, the resident's eligibility for third-party payment for dental services is determined as part of the resident's comprehensive assessment;
3. Within one month after the initial comprehensive assessment in R9-10-2214(A)(1)(b), a personnel member coordinates for a resident the scheduling of a dental examination and, if needed, dental treatment:
   a. If the resident is eligible for third-party payment for dental services, and
   b. Unless the nursing-supported group home has documentation that the resident received a dental examination within 12 months before admission;
4. If a resident is eligible for third-party payment for dental services:
   a. A dental examination is scheduled for the resident according to guidelines by the entity providing third-party payment for dental services and at least once every 12 months, and
   b. Dental treatment is scheduled according to guidelines by the entity providing third-party payment for dental services and as needed;
5. Except as provided in subsection (C)(6), if a dental examination of a resident indicates a need for dental treatment, the resident's individual program plan includes the scheduling of dental treatment for the resident when the resident is eligible for third-party payment for dental services;
6. If needed, a resident is provided with emergency dental services;
7. A resident is provided with education and training in oral hygiene; and
8. A resident's medical record contains documentation of:
   a. Each dental examination of the resident,
   b. All dental treatment received by the resident, and
   c. The resident's education and training in oral hygiene.

**D.** An administrator shall ensure that:
1. A resident's vision and hearing are assessed as part of the resident's comprehensive assessment in R9-10-2214(A)(1)(b) and, if applicable, as part of the update of the comprehensive assessment in R9-10-2214(A)(1)(c); and
2. If an issue is identified with the resident's vision or hearing:
   a. The issue is included in the resident's individual program plan,
   b. A personnel member contacts and coordinates with applicable entities to determine any vision or hearing benefits for which the resident may be eligible, and
   c. The nursing-supported group home makes reasonable accommodations to address the issue in compliance with applicable federal and state disability laws.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2216. Behavioral Care**

**A.** An administrator shall ensure that:
1. A resident who receives behavioral care from the nursing-supported group home is evaluated by a behavioral health professional or medical practitioner:

a. Within 30 calendar days before the resident is admitted to the nursing-supported group home or before the resident begins receiving behavioral care, and
b. At least once every six months throughout the duration of the resident's need for behavioral care;
2. A behavioral health professional or medical practitioner:
a. Documents that the behavioral care needed by the resident is within the nursing-supported group home's scope of services, and
b. Includes measurable objectives for the behavioral care and the methods for meeting the objectives in the resident's individual program plan; and
3. The documentation in subsection (A)(2) is included in the resident's medical record.

**B.** If a resident of a nursing-supported group home requires behavioral health services provided by a behavioral health professional on an intermittent basis as part of behavioral care, an administrator shall ensure that:
1. The behavioral health services are provided by a behavioral health professional licensed or certified to provide the type of behavioral health services required by the resident; and
2. Except for a psychotropic drug used as a chemical restraint or administered according to an order from a court of competent jurisdiction, informed consent is obtained from a resident or the resident's representative for a psychotropic drug and documented in the resident's medical record before the psychotropic drug is administered to the resident.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2217. Restraint**

If a nursing-supported group home is authorized to provide restraint, an administrator shall ensure that:
1. Policies and procedures for providing restraint are established, documented, and implemented to protect the health and safety of a resident that:
a. Establish the process for resident assessment, including identification of a resident's medical conditions and criteria for the on-going monitoring of any identified medical condition;
b. Identify each type of restraint used and include for each type of restraint used:
i. The qualifications of a personnel member who can:
(1) Order the restraint,
(2) Place a resident in the restraint,
(3) Monitor a resident in the restraint,
(4) Evaluate a resident's physical and psychological well-being after being placed in the restraint and when released from the restraint, or
(5) Renew the order for restraint;
ii. On-going training requirements for a personnel member who has direct resident contact while the resident is in a restraint; and
iii. Criteria for monitoring and assessing a resident including:
(1) Frequencies of monitoring and assessment based on a resident's medical condition and risks associated with the specific restraint;
(2) For the renewal of an order for restraint, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
(3) Assessment content, which may include, depending on a resident's condition, the resident's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
(4) If a mechanical restraint is used, how often the mechanical restraint is loosened; and
(5) A process for meeting a resident's nutritional needs and elimination needs;
c. Establish the criteria and procedures for renewing an order for restraint;
d. Establish procedures for internal review of the use of restraint; and
e. Establish medical record and personnel record documentation requirements for restraint, if applicable;
2. An order for restraint is:
a. Obtained from a physician or registered nurse practitioner, and
b. Not written as a standing order or on an as-needed basis;
3. Restraint is:
a. Not used as a means of coercion, discipline, convenience, or retaliation;
b. Only used when all of the following conditions are met:
i. Except as provided in subsection (4), after obtaining an order for the restraint;
ii. For the management of a resident's aggressive, violent, or self-destructive behavior;
iii. When less restrictive interventions have been determined to be ineffective; and

iv. To ensure the immediate physical safety of the resident, to prevent imminent harm to the resident or another individual, or to stop physical harm to another individual; and

c. Discontinued at the earliest possible time;

4. If as a result of a resident's aggressive, violent, or self-destructive behavior, harm to the resident or another individual is imminent or the resident or another individual is being physically harmed, a personnel member:
   a. May initiate an emergency application of restraint for the resident before obtaining an order for the restraint, and
   b. Obtains an order for the restraint of the resident during the emergency application of the restraint;
5. An order for restraint includes:
   a. The name of the physician or registered nurse practitioner ordering the restraint;
   b. The date and time that the restraint was ordered;
   c. The specific restraint ordered;
   d. If a drug is ordered as a chemical restraint, the drug's name, strength, dosage, and route of administration;
   e. The specific criteria for release from restraint without an additional order; and
   f. The maximum duration authorized for the restraint;
6. An order for restraint is limited to the duration of the emergency situation and does not exceed three continuous hours;
7. If an order for restraint of a resident is not provided by the resident's designated medical practitioner, the resident's designated medical practitioner is notified as soon as possible;
8. A medical practitioner or personnel member does not participate in restraint, assess or monitor a resident during restraint, or evaluate a resident after restraint, and a physician or registered nurse practitioner does not order restraint, until the medical practitioner or personnel member, completes education and training that:
   a. Includes:
      i. Techniques to identify medical practitioner, personnel member, and resident behaviors, events, and environmental factors that may trigger circumstances that require restraint;
      ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods;
      iii. Techniques for identifying the least restrictive intervention based on an assessment of the resident's medical or behavioral health condition;
      iv. The safe use of restraint, including training in how to recognize and respond to signs of physical and psychological distress in a resident who is restrained or secluded;
      v. Clinical identification of specific behavioral changes that indicate that the restraint is no longer necessary;
      vi. Monitoring and assessing a resident while the resident is in restraint according to policies and procedures; and
      vii. Except for the medical practitioner, training exercises in which the personnel member successfully demonstrates the techniques that the medical practitioner or personnel member has learned for managing emergency situations; and
   b. Is provided by individuals qualified according to policies and procedures;
9. When a resident is placed in restraint:
   a. The restraint is conducted according to policies and procedures;
   b. The restraint is proportionate and appropriate to the severity of the resident's behavior and the resident's:
      i. Chronological and developmental age;
      ii. Size;
      iii. Gender;
      iv. Physical condition;
      v. Medical condition;
      vi. Psychiatric condition; and
      vii. Personal history, including any history of physical or sexual abuse;
   c. The physician or registered nurse practitioner who ordered the restraint is available for consultation throughout the duration of the restraint;
   d. The resident is monitored and assessed according to policies and procedures;
   e. A physician or registered nurse assesses the resident within one hour after the resident is placed in the restraint and determines:
      i. The resident's current behavior,
      ii. The resident's reaction to the restraint used,
      iii. The resident's medical and behavioral condition, and
      iv. Whether to continue or terminate the restraint;
   f. The resident is given the opportunity:
      i. To eat during mealtime, and
      ii. To use the toilet; and
   g. The restraint is discontinued at the earliest possible time, regardless of the length of time identified in the order;
10. A medical practitioner or personnel member documents the following information in a resident's medical record before the end of the shift in which the resident is placed in restraint or, if the resident's restraint does not end during the shift in which it began, during the shift in which the resident's restraint ends:

a. The emergency situation that required the resident to be restrained,
b. The times the resident's restraint actually began and ended,
c. The monitoring required in subsection (9)(d),
d. The time of the assessment required in subsection (9)(e),
e. The names of the medical practitioners and personnel members with direct resident contact while the resident was in the restraint,
f. The times the resident was given the opportunity to eat or use the toilet according to subsection (9)(f), and
g. The resident evaluation required in subsection (12);

11. If an emergency situation continues beyond the time limit of an order for restraint, the order is renewed according to policies and procedures that include:
    a. The specific criteria for release from restraint without an additional order, and
    b. The maximum duration authorized for the restraint; and
12. A resident is evaluated after restraint is no longer being used for the resident.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2218. Rehabilitation Services**

If rehabilitation services are provided on a nursing-supported group home's premises, an administrator shall ensure that:

1. Rehabilitation services are provided:
    a. Under the direction of an individual qualified according to policies and procedures,
    b. By an individual licensed to provide the rehabilitation services, and
    c. According to an order; and
2. The medical record of a resident receiving rehabilitation services includes:
    a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis,
    b. A documented individual program plan that is developed in coordination with the ordering individual and the individual providing the rehabilitation services,
    c. The rehabilitation services provided,
    d. The resident's response to the rehabilitation services, and
    e. The authentication of the individual providing the rehabilitation services.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2219. Clinical Laboratory Services**

If clinical laboratory services are authorized to be provided on a nursing-supported group home's premises, an administrator shall ensure that:

1. Clinical laboratory services and pathology services are provided through a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation, certificate of compliance, or certificate of waiver in subsection (1) is provided to the Department for review upon the Department's request;
3. The nursing-supported group home:
    a. Is able to provide the clinical laboratory services delineated in the nursing-supported group home's scope of services when needed by the residents,
    b. Obtains specimens for the clinical laboratory services delineated in the nursing-supported group home's scope of services without transporting the residents from the nursing-supported group home's premises, and
    c. Has the examination of the specimens performed by a clinical laboratory;
4. Clinical laboratory and pathology test results are:
    a. Available to the ordering physician:
        i. Within 24 hours after the test is complete with results if the test is performed at a laboratory on the nursing-supported group home's premises, or
        ii. Within 24 hours after the test result is received if the test is performed at a laboratory outside of the nursing-supported group home's premises; and
    b. Documented in a resident's medical record;
5. If a test result is obtained that indicates a resident may have an emergency medical condition, as established in policies and procedures, a personnel member notifies:

a. The ordering physician,
b. A registered nurse in the nursing-supported group home,
c. The nursing-supported group home's administrator, or
d. The director of nursing;

6. If a clinical laboratory report is completed on a resident, a copy of the report is included in the resident's medical record;
7. If the nursing-supported group home provides blood or blood products, policies and procedures are established, documented, and implemented for:
   a. Procuring, storing, transfusing, and disposing of blood or blood products;
   b. Blood typing, antibody detection, and blood compatibility testing; and
   c. Investigating transfusion adverse reactions that specify a process for review through the quality management program; and
8. Expired laboratory supplies are discarded according to policies and procedures.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2220. Respiratory Care Services**

If respiratory care services are authorized to be provided on a nursing-supported group home's premises, an administrator shall ensure that:

1. Respiratory care services are provided under the direction of a resident's designated medical practitioner;
2. Respiratory care services are provided according to an order that includes:
   a. The resident's name;
   b. The name and signature of the ordering individual;
   c. The type, frequency, and, if applicable, duration of treatment;
   d. The type and dosage of medication and diluent; and
   e. The oxygen concentration or oxygen liter flow and method of administration;
3. Respiratory care services provided to a resident are documented in the resident's medical record and include:
   a. The date and time of administration;
   b. The type of respiratory care services provided;
   c. The effect of the respiratory care services;
   d. The resident's adverse reaction to the respiratory care services, if any; and
   e. The authentication of the individual providing the respiratory care services; and
4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-2219.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2221. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:

1. Include:
   a. A process for providing information to a resident or the resident's representative about medication prescribed for the resident including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting:
      i. A medication error,
      ii. An adverse response to a medication, or
      iii. A medication overdose;
   c. Procedures to ensure that a pharmacist reviews a resident's medications at least once every three months and provides documentation to the resident's designated medical practitioner and the director of nursing indicating potential medication problems such as incompatible or duplicative medications;
   d. Procedures for documenting medication services; and
   e. Procedures for assisting a resident in obtaining medication; and
2. Specify a process for review through the quality management program of:
   a. A medication administration error, and
   b. An adverse reaction to a medication.

**B.** An administrator shall ensure that:

1. Policies and procedures for medication administration:
   a. Are reviewed and approved by a pharmacist;

b. Specify the individuals who may:
   i. Order medication, and
   ii. Administer medication;
c. Ensure that medication is administered to a resident only as prescribed; and
d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;

2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
3. A medication administered to a resident:
   a. Is administered in compliance with an order, and
   b. Is documented in the resident's medical record; and
4. If a psychotropic medication is administered to a resident, the psychotropic medication:
   a. Is only administered to a resident for a diagnosed medical condition; and
   b. Unless clinically contraindicated or otherwise ordered by the resident's designated medical practitioner or the designated medical practitioner's designee, is gradually reduced in dosage while the resident is simultaneously provided with interventions such as behavior and environment modification in an effort to discontinue the psychotropic medication, unless a dose reduction is attempted and the resident displays behavior justifying the need for the psychotropic medication, and the designated medical practitioner documents the necessity for the continued use and dosage.

**C.** If a nursing-supported group home provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A resident's medication is stored by the nursing-supported group home;
2. The following assistance is provided to a resident:
   a. A reminder when it is time to take the medication;
   b. Opening the medication container for the resident;
   c. Observing the resident while the resident removes the medication from the container;
   d. Verifying that the medication is taken as ordered by the resident's designated medical practitioner by confirming that:
      i. The resident taking the medication is the individual stated on the medication container label,
      ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from the resident's designated medical practitioner dated later than the date on the medication container label, and
      iii. The resident is taking the medication at the time stated on the medication container label or according to an order from the resident's designated medical practitioner dated later than the date on the medication container label; or
   e. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by the resident's designated medical practitioner or a registered nurse;
4. Training for a personnel member, other than a physician, physician assistant, or registered nurse, in assistance in the self-administration of medication:
   a. Is provided by the resident's designated medical practitioner; another physician, physician assistant, or registered nurse; or an individual trained by a physician, physician assistant, or registered nurse; and
   b. Includes:
      i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
      ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
      iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a physician, physician assistant, or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a resident:
   a. Is in compliance with an order, and
   b. Is documented in the resident's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members; and
2. If pharmaceutical services are provided:
   a. The pharmaceutical services are provided under the direction of a pharmacist;
   b. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
   c. A copy of the pharmacy license is provided to the Department upon request.

**E.** When medication is stored at a nursing-supported group home, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;

b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
c. A medication recall and notification of residents who received recalled medication; and
d. Storing, inventorying, and dispensing controlled substances.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the resident's designated medical practitioner or the physician who ordered the medication and the nursing-supported group home's director of nursing.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2222. Infection Control**

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
   a. A method to identify and document infections occurring at the nursing-supported group home;
   b. Analysis of the types, causes, and spread of infections and communicable diseases at the nursing-supported group home;
   c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the nursing-supported group home; and
   d. Documentation of infection control activities including:
      i. The collection and analysis of infection control data,
      ii. The actions taken related to infections and communicable diseases, and
      iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:
   a. Handling and disposal of biohazardous medical waste;
   b. Sterilization, disinfection, and storage of medical equipment and supplies;
   c. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
   d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a resident;
   e. Cleaning of a resident's bedroom, furniture, and bedding after the resident's discharge before the bedroom is reassigned to another resident;
   f. Training of personnel members, employees, and volunteers in infection control practices; and
   g. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
5. Soiled linen and clothing are:
   a. Collected in a manner to minimize or prevent contamination;
   b. Bagged at the site of use; and
   c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
6. A resident's personal laundry is washed separately from towels, sheets, and bedding; and
7. A personnel member, an employee, or a volunteer washes hands or uses a hand disinfection product after a resident contact and after handling soiled linen, soiled clothing, or potentially infectious material.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2223. Food Services**

**A.** An administrator shall ensure that a registered nurse who is part of the interdisciplinary team for a resident requiring a modified or special diet:

1. Consults with a registered dietitian or the resident's designated medical practitioner, as needed, about the resident's modified or special diet;
2. Reviews a food menu before the food menu is used to ensure that the resident's nutritional needs are being met;
3. Documents the review of a food menu; and
4. Is available for consultation regarding the resident's nutritional needs.

**B.** An administrator shall ensure that:

1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance;
   b. Taking into consideration the food allergies and preferences of the residents;

c. Including for a resident the modified or special diet for the resident; and
d. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;

2. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served on each day,
   c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
3. Meals and snacks for each day are planned and served using the applicable guidelines in http://www.health.gov/dietaryguidelines/2015.asp;
4. A resident is provided:
   a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and individual program plan;
   b. Food served in sufficient quantities to meet the resident's nutritional needs and at an appropriate temperature;
   c. Three meals a day with not more than 14 hours between the evening meal and breakfast; and
   d. The opportunity to have additional food between meals, unless a restrictive diet is specified in the resident's individual program plan;
5. A resident is provided with food substitutions of similar nutritional value if:
   a. The resident refuses to eat the food served, or
   b. The resident requests a substitution;
6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning;
7. If food is used as a part of a program to manage a resident's inappropriate behavior:
   a. A special diet is included as part of the resident's individual program plan, and
   b. The special diet is reviewed and evaluated by a physician and a dietitian to ensure the special diet meets the resident's nutritional needs;
8. Meals are served to residents at tables in a dining area and in a manner that allows the resident to eat from an upright position, unless otherwise specified in the resident's individual program plan or by the resident's designated medical practitioner;
9. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils;
10. Personnel members supervise meals in dining areas to:
    a. Direct a resident's self-help dining procedures,
    b. Ensure a resident consumes enough food to meet the resident's nutritional needs, and
    c. Ensure that a resident eats in a manner consistent with the resident's developmental level;
11. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair; and
12. Water is available and accessible to residents.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2224. Emergency and Safety Standards**

**A.** An administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
   a. A floor plan of the facility showing emergency protection equipment, evacuation routes, and exits;
   b. When, how, and where residents will be relocated, including:
      i. Instructions for the evacuation or transfer of residents,
      ii. Assigned responsibilities for each employee and personnel member, and
      iii. A plan for continuing to provide services to meet a resident's needs;
   c. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
   d. A plan for back-up power and water supply;
   e. A plan to ensure a resident's medications will be available to administer to the resident during a disaster;
   f. A plan to ensure a resident is provided nursing services, rehabilitation services, and other services required by the resident during a disaster; and
   g. A plan for obtaining food and water for individuals present in the nursing-supported group home or the nursing-supported group home's relocation site during a disaster;
2. Personnel members receive training on the content and use of the disaster plan required in subsection (A)(1);
3. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;

4. Documentation of a disaster plan review required in subsection (A)(3) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
5. A disaster drill for employees is conducted on each shift at least once every three months and documented;
6. An evacuation drill for employees is conducted on each shift at least once every three months and documented;
7. An evacuation drill for residents:
   a. Is conducted at least once each year on each shift and documented; and
   b. Includes all residents on the premises except for:
      i. A resident whose medical record contains documentation that evacuation from the nursing-supported group home would cause harm to the resident, and
      ii. Sufficient personnel members to ensure the health and safety of residents not evacuated according to subsection (A)(7)(b)(i);
8. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for employees and residents to evacuate to a designated area;
   c. If applicable:
      i. An identification of residents needing assistance for evacuation, and
      ii. An identification of residents who were not evacuated;
   d. Any problems encountered in conducting the evacuation drill; and
   e. Recommendations for improvement, if applicable; and
9. An evacuation path is conspicuously posted on each hallway of each floor of the nursing-supported group home.

**B.** An administrator shall ensure that a nursing-supported group home has either:
1. A fire alarm system and a sprinkler system meeting the following requirements installed and in working order:
   a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01; and
   b. A sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01; or
2. Both of the following:
   a. A fire extinguisher that is:
      i. Labeled as rated at least 2A-10-BC by the Underwriters Laboratories;
      ii. Accessible to personnel members and inaccessible to residents;
      iii. If a disposable fire extinguisher, replaced when its indicator reaches the red zone; and
      iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months, as documented by a tag attached to the fire extinguisher that specifies the date of the last servicing and the identification of the person who serviced the fire extinguisher; and
   b. Smoke detectors that are:
      i. Installed in each bedroom, hallway that adjoins a bedroom, storage room, laundry room, attached garage, and room or hallway adjacent to the kitchen, and other places recommended by the manufacturer;
      ii. Either battery operated or, if hard-wired into the electrical system of the nursing-supported group home, have a back-up battery;
      iii. Capable of alerting all residents in the nursing-supported group home, including a resident with a mobility or sensory impairment;
      iv. In working order; and
      v. Tested at least once a month, with documentation of the test maintained for at least 12 months after the date of the test.

**C.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**D.** An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2225. Environmental Standards**

**A.** An administrator shall ensure that:

1. The premises and equipment are free from a condition or situation that may cause a resident or other individual to suffer physical injury;
2. The premises are free of accumulations of garbage or refuse;
3. Garbage and refuse in the facility are:
   a. Stored in cleanable containers or in sealable plastic bags and
   b. Removed from the facility at least once every seven days;
4. Cleaning compounds and toxic substances are maintained in labeled containers that:
   a. Are stored to prevent a hazard;
   b. Are appropriate to the contents of each container;
   c. If appropriate based on a resident's disability, are locked; and
   d. Are stored in a separate location from food or medicine;
5. Combustible or flammable materials are not stored within three feet of a furnace, heater, water heater, or usable fireplace;
6. Unused furniture, equipment, fabrics, or devices are removed from the facility or maintained in a covered area on the premises that is designated by the licensee for storage in a manner that does not create a hazard; and
7. There are no firearms or ammunition on the premises;

**B.** An administrator shall ensure that:
1. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
2. The premises and its structures and furnishings are:
   a. In a clean condition,
   b. Free of odors, such as urine or rotting food; and
   c. In sufficiently good repair that no object, equipment, or condition present constitutes a hazard; and
3. Standing water is not allowed to accumulate on the premises, except in an area or vessel the purpose of which is to hold standing water.

**C.** An administrator shall ensure that:
1. An unvented space heater or open-flame space heater is not used on the premises;
2. An electric portable heater or electric radiant heater is not used on the premises unless the electric portable heater or electric radiant heater:
   a. Has:
      i. Either a non-porous casing or a grill with a mesh small enough to prevent cloth or a child's finger from entering the casing,
      ii. A tilt switch that shuts off power to the electric portable heater if the electric portable heater tips over,
      iii. An automatic shutoff control to prevent overheating, and
      iv. A thermostat control; and
   b. Is plugged directly into a wall outlet; and
3. A vented space heater used on the premises is:
   a. Safety-approved;
   b. Professionally installed in accordance with the requirements of the local jurisdiction; and
   c. Mounted as a permanent fixture in a wall, floor, or ceiling.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

**R9-10-2226. Physical Plant Standards**

**A.** An administrator shall ensure that:
1. A nursing-supported group home is in compliance with applicable federal and state disability laws;
2. If a nursing-supported group home has a resident with a mobility, sensory, or other physical impairment, documentation is available for review at the nursing-supported group home that:
   a. Is provided by the Division; and
   b. Identifies modifications, if any, needed to the premises to ensure that the premises are:
      i. Accessible to and usable by the resident, and
      ii. Contribute to the resident's health and safety;
3. The premises have been modified as identified by the Division in subsection (A)(2)(b);
4. Ramps, stairs, or steps on the premises are secured firmly to the ground or a permanent structure and have slip-resistant surfaces; and
5. If handrails and grab bars are installed in a nursing-supported group home, handrails and grab bars are securely attached and stationary.

**B.** An administrator shall ensure that:

1. A method of heating and cooling maintains the nursing-supported group home between 65° F and 85° F in areas of the nursing-supported group home occupied by residents;
2. A usable fireplace is covered by a protective screen or covering at all times;
3. Ventilation is provided by an openable window, air conditioning, or other mechanical device;
4. Working, safe appliances for cooling and cooking food are provided in the nursing-supported group home that:
   a. Are safety-approved;
   b. If used to refrigerate food, maintain the food at a temperature of 40° F or below at all times; and
   c. If used to freeze food, maintain the food at a temperature of 0° F or below at all times;
5. Hot water temperatures in the nursing-supported group home are maintained between 95° F and 120° F; and
6. Bathtubs and showers contain slip-resistant strips, rubber bath mats, or slip-resistant surfaces.

**C.** An administrator shall ensure that:
1. Electrical lighting is contained in each room in the nursing-supported group home;
2. Electrical devices and equipment on the premises are safety-approved, safe, and in working order;
3. Electrical outlets on the premises are safe, covered with a faceplate, and installed in accordance with the requirements of the local jurisdiction;
4. Any electrical outlet located within 3 feet of a water source includes a ground fault circuit interrupt (GFCI);
5. An appliance, light, or other device with a frayed or spliced electrical cord is not used on the premises; and
6. An electrical cord, including an extension cord, on the premises is not:
   a. Used as a substitute for permanent wiring,
   b. Run under a rug or carpeting,
   c. Run over a nail, or
   d. Run from one room to another.

**D.** An administrator shall ensure that:
1. A nursing-supported group home contains a safe, working plumbing system;
2. If a nursing-supported group home's plumbing system is connected to a non-municipal sewage disposal system, the plumbing system and connective piping are free of visible leakage; and
3. The premises do not contain unfenced or uncovered wells, ditches, or holes into which an individual may step or fall.

**Historical Note**

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

## 36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.

2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.

3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.

4. Operate sanitariums, hospitals or other facilities assigned to the department by law or by the governor.

5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information to promote good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of educating children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.

6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.

7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.

8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.

9. Encourage and aid in coordinating local programs concerning nutrition of the people of this state.

10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.

11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.

12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.

13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.

14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in enforcing the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).

15. Recruit and train personnel for state, local and district health departments.

16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.

17. License and regulate health care institutions according to chapter 4 of this title.

18. Issue or direct the issuance of licenses and permits required by law.

19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:

(a) Screening in early pregnancy for detecting high-risk conditions.

(b) Comprehensive prenatal health care.

(c) Maternity, delivery and postpartum care.

(d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.

(e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes and behavioral-supported group homes for persons with developmental disabilities. The department shall issue a license to an

accredited facility for a period of the accreditation, except that a licensing period shall not be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definitions

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.

4. Administer and enforce the laws relating to health and sanitation and the rules of the department.

5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.

6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop,

tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health department, environmental department or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of

performance. If in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any monies that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for not longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases that are reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases that are transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meatpacking plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fundraising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is prepared in a kitchen of a private home for commercial purposes consistent with chapter 8, article 2 of this title.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

(j) Spirituous liquor produced on the premises licensed by the department of liquor licenses and control. This exemption includes both of the following:

(i) The area in which production and manufacturing of spirituous liquor occurs, as defined in an active basic permit on file with the United States alcohol and tobacco tax and trade bureau.

(ii) The area licensed by the department of liquor licenses and control as a microbrewery, farm winery or craft distiller that is open to the public and serves spirituous liquor and commercially prepackaged food, crackers or pretzels for consumption on the premises. A producer of spirituous liquor may not provide, allow or expose for common use any cup, glass or other receptacle used for drinking purposes. For the purposes of this item, "common use" means the use of a drinking receptacle for drinking purposes by or for more than one person without the receptacle being thoroughly cleansed and sanitized between consecutive uses by methods prescribed by or acceptable to the department.

(k) Spirituous liquor produced by a producer that is licensed by the department of liquor licenses and control or spirituous liquor imported and sold by wholesalers that is licensed by the department of liquor licenses and control. This exemption includes all commercially prepackaged spirituous liquor and all spirituous liquor poured at a licensed special event, festival or fair in this state.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for

sanitary facilities to be used in identifying, storing, handling and selling all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for submitting samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for preserving or storing food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparing food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these

premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. Confidential information may not be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection and chapter 8, article 2 of this title. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout this state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction if the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of

this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (j) of this section, spirituous liquor and commercially prepackaged food, crackers or pretzels that meet the requirements of subsection I, paragraph 4, subdivision (j) of this section are exempt from the rules prescribed in subsection I of this section.

R. For the purposes of this section:

1. "Cottage food product" has the same meaning prescribed in section 36-931.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

11-593. Reporting of certain deaths; failure to report; violation; classification

A. Any person having knowledge of the occurrence of the death of a human being including a fetal death that is required to be reported pursuant to subsection B, of this section shall promptly notify the nearest peace officer of all information in the person's possession regarding the death and the circumstances surrounding it.

B. Reporting is required in the following circumstances:

1. Death when not under the current care of a health care provider as defined pursuant to section 36-301.

2. Death resulting from violence.

3. Unexpected or unexplained death.

4. Death of a person in a custodial agency as defined in section 13-4401.

5. Unexpected or unexplained death of an infant or child.

6. Death occurring in a suspicious, unusual or nonnatural manner, including death from an accident believed to be related to the deceased person's occupation or employment.

7. Death occurring as a result of anesthetic or surgical procedures.

8. Death suspected to be caused by a previously unreported or undiagnosed disease that constitutes a threat to public safety.

9. Death involving unidentifiable bodies.

C. The peace officer shall promptly notify the county medical examiner or alternate medical examiner and, except in deaths occurring as a result of surgical or anesthetic procedures, shall make or cause to be made an investigation of the facts and circumstances surrounding the death and report the results to the medical examiner or alternate medical examiner. If there is no county medical examiner or alternate medical examiner appointed and serving within the county, the county sheriff shall be notified by the peace officer and the sheriff shall in turn notify and secure a licensed physician having the qualifications of an alternate medical examiner to assume the powers and duties prescribed by section 11-594.

D. Every person who knows of the existence of a body where death occurred as specified in subsection A of this section and who knowingly fails to notify the nearest peace officer as soon as possible unless the person has good reason to believe that notice has already been given is guilty of a class 2 misdemeanor.

E. If the deceased was under treatment for an accident or illness by prayer or spiritual means alone, in accordance with the tenets and practices of a well-recognized church or religious denomination, and death occurred without a physician or nurse practitioner in attendance, the person who has knowledge of the death shall report all information in the person's possession regarding the death and circumstances surrounding it directly to the county medical examiner or the alternate medical examiner who may waive an external examination or autopsy if the county medical examiner or alternate medical examiner is satisfied that the death of the person resulted from natural causes.

F. Each county shall provide to the department of public safety fingerprints of all deceased persons for whom the circumstances of death require an external examination or autopsy and whose deaths are required to be investigated pursuant to this section. These fingerprints shall be on a form provided by the department of public safety and shall be accompanied by any other information regarding the physical description and the date and place of death the department of public safety requires. Fingerprints taken pursuant to this section shall be used only for the purpose of purging criminal history files. All information and data in the department of public safety that are furnished in compliance with this section are confidential and may be disclosed only on written approval of the director of the department of public safety to the juvenile court, social agencies and public health and law enforcement agencies licensed or regulated by this state.

## 32-1909. Donated medicine; donors; authorized recipients; requirements; immunity; definitions

A. A donor may donate medicine to an authorized recipient, and an authorized recipient may receive donated medicine from donors. Before a donor may make its first donation to an authorized recipient, the authorized recipient must verify and record all the following:

1. That the donor is legally authorized to possess the medicine.

2. The donor's name, address and telephone number and permit or license number, if applicable.

3. That the donor will remove or redact any patient names and prescription numbers on donated medicine or will otherwise maintain patient confidentiality by executing a confidentiality agreement with the authorized recipient.

B. Notwithstanding any other law, an authorized recipient may transfer donated medicine to another authorized recipient or to an entity participating in a drug donation program operated by another state. Medicine transferred pursuant to this section may be transferred only once.

C. An authorized recipient may accept into inventory only donated medicine that meets all of the following:

1. Is in unopened, tamper-evident packaging or that has been repackaged under this section.

2. Is not adulterated or misbranded.

3. Has been maintained in accordance and in compliance with the United States food and drug administration risk evaluation and mitigation strategies pursuant to 21 United States Code section 355-1, if applicable.

4. Is accompanied by an attestation from the donor stating that the medicine being donated has been kept in a temperature-controlled environment and has not been adulterated.

D. An authorized recipient may accept into inventory a donated biologic only if the donated biologic meets the requirements of subsection C of this section and is donated by a health care professional or an entity legally authorized to posses the biologic.

E. Donated medicine that does not meet the requirements of subsection C of this section must be disposed of by returning it to the donor, destroying it in an incinerator, medical waste hauler or other lawful method or transferring it to a returns processor. A record of disposed medicine shall contain a description of the disposal method, the date of disposal and the name, strength and quantity of each medicine disposed of. No other record of disposal is required.

F. A drug manufacturer, repackager, dispenser or wholesaler, other than a returns processor, that participates in this program shall comply with the requirements of 21 United States Code sections 360eee-1 through 360eee-4 relating to drug supply chain security.

G. All donated medicine received by an authorized recipient but not yet accepted into inventory shall be kept in a separate designated area. Before or when accepting a donation or transfer into inventory, the authorized recipient shall maintain a written or electronic inventory of the donation consisting of the name, strength and quantity of each accepted medicine and the name, address and telephone number of the donor. This record is not required if the donor and authorized recipient are under common ownership or common control. No other record of donation is required.

H. An authorized recipient must store and maintain donated medicine physically or electronically separated from other inventory and in a secure and temperature-controlled environment that meets the drug manufacturers' recommendations and United States pharmacopeia standards.

I. Repackaged medicine shall be labeled with the drug's name, strength and expiration date and shall be kept in a separate designated area until inspected and initialed by a health care professional. If multiple packaged donated medicines with varied expiration dates are repackaged together, the earliest expiration date shall be used.

J. An authorized recipient may administer or dispense only donated medicine that meets all of the following:

1. Meets the requirements of subsection C of this section based on an inspection by a health care professional.

2. If dispensed to an eligible patient, is repackaged into a new container or has all previous patient information on the donated container redacted or removed.

3. Is properly labeled in accordance with board rules.

4. Has an expiration or beyond-use date brought forward from the donated medicine that will not expire before the medicine is completely used by the eligible patient based on the prescribing practitioner's directions for use or, for over-the-counter medicine, on the package's label.

K. An authorized recipient may dispense or administer donated medicine to an eligible patient only if otherwise allowed by law. Donated medicine may be dispensed or administered only to eligible patients pursuant to a valid prescription order and must have patient-specific written or electronic records maintained in accordance with board rules.

L. Donated medicine may not be dispensed or administered to an eligible patient if the prescriber writes or clearly displays on the face of the prescription form "DAW", "dispense as written" or any other language that indicates a substitution is not allowed.

M. The donation, transfer, receipt or facilitation of donated medicine pursuant to this section is not considered wholesale distribution and does not require licensing as a wholesale distributor.

N. Medicine donated under this section may not be resold and is considered nonsaleable. Charging a handling, dispensing or administrative fee under this section is not reselling a donated medicine. The board shall prescribe in rule the limits on the fees that an authorized recipient may charge under this section considering the medicine's retail cost for a monthly supply.

O. When performing any action under this section or otherwise processing donated medicine for tax, manufacturer or other credit, an authorized recipient is considered to be acting as a returns processor and shall comply with all recordkeeping requirements for nonsaleable returns under federal law.

P. An authorized recipient shall retain all records required by this section in a physical or electronic format for a period of at least seven years. A donor and authorized recipient may contract with each other or a third party to create or maintain records on each other's behalf. An identifier, such as a serial number or barcode, may be used in place of any information required to be in a record or on a label pursuant to this section if the identifier allows for such information to be readily retrievable. On request by the board, the identifier used for requested records shall be replaced with the original information. An identifier may not be used on patient labels when dispensing or administering a donated medicine.

Q. A donation or other transfer of possession or control is not a change of ownership unless it is specified as such by the authorized recipient. If a record of the donation's transaction information or history is required, the history must begin with the donor of the medicine and include all prior donations and, if the medicine was previously dispensed, must include only drug information required to be on the patient label in accordance with board rules.

R. A donor or authorized recipient shall make all records available for audit by the board within five business days after the request.

S. The following are not subject to civil liability, criminal liability or professional disciplinary action if acting in good faith under this section:

1. A person involved in the supply chain of donated medicine, including a donor, authorized recipient, manufacturer, repackager, wholesaler or pharmacy.

2. A person, including any employee, officer, volunteer, owner, partner, member, director, contractor or other person or entity associated with the person, that in compliance with this section prescribes, donates, receives, dispenses, administers, transfers, replenishes or repackages medicine, or facilitates any of the above pursuant to this section.

T. This section does not prohibit otherwise legal activities related to nonprescription drugs.

U. For the purposes of this section:

1. "Authorized recipient" means any entity that has a license or permit in good standing in this state and that is legally authorized to possess medicine, including a wholesaler, distributor, reverse distributor, repackager, hospital, pharmacy or health care institution.

2. "Donor":

(a) Means any person, any individual member of the public or any entity legally authorized to possess medicine, including a manufacturer, wholesaler, distributor, third-party logistic provider, pharmacy, dispenser, clinic, surgical center, health center, detention and rehabilitation center, laboratory, medical school, pharmacy school, health care professional or health care facility.

(b) Includes government agencies and entities that are federally authorized to possess medicine, including drug manufacturers, repackagers, relabelers, outsourcing facilities, prisons and importers authorized by the United States food and drug administration.

3. "Eligible patient" means an individual who is indigent, uninsured, underinsured or enrolled in a public health benefits program.

4. "Health care professional" means a health care provider who is licensed or certified pursuant to this title and authorized to dispense or administer prescription drugs.

5. "Medicine" means both prescription and nonprescription drugs, including drugs approved by the United States food and drug administration and labeled for investigational use.

6. "Returns processor" has the same meaning prescribed in 21 United States Code section 360eee and includes a reverse distributor.

7. "Unopened, tamper-evident packaging" has the same meaning as United States pharmacopeia packaging and storage requirements, including unopened unit-dose, multiple-dose and immediate, secondary and tertiary packaging.

36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for constructing, modifying and licensing health care institutions necessary to ensure the public health, safety and

welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to administering medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The standards shall require that a physician who is licensed pursuant to title 32, chapter 13 or 17 medically discharge patients from surgery and shall allow an outpatient surgical center to require that either an anesthesia provider who is licensed pursuant to title 32, chapter 13, 15 or 17 or a physician who is licensed pursuant to title 32, chapter 13 or 17 remain present on the premises until all patients are discharged from the recovery room. Except as otherwise provided in this subsection, the director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.

2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.

3. Prescribe the criteria for the licensure inspection process.

4. Prescribe standards for selecting health care-related demonstration projects.

5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees.

6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.

7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.

C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.

D. The director shall establish a model in rule for the department to monitor health care institutions on-site that are found to not be in substantial compliance with the applicable licensure requirements. The director shall establish on-site monitoring fees for health care institutions that are subject to the on-site monitoring requirements. The department may not charge a fee pursuant to this subsection for a complaint or compliance-related survey or inspection if a health care institution is in substantial compliance.

E. The department may provide in-service training to health care institutions that request in-service training relating to regulatory compliance outside of the survey process. The director shall establish in rule in-service training fees for health care institutions that request in-service training from the department.

F. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

G. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:

(a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.

(b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.

(c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.

(d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.

2. The department may:

(a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.

(b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-407.02. Health care institutions; clergy visitation; health and safety precautions; immunity; civil action; definitions

A. If a health care institution's visitation policy allows in-person visitation of any kind, the health care institution must allow a clergy member to visit a resident who requests an in-person visit or consents to be visited in person for religious purposes by the clergy member, including during a declared state of emergency. If a resident is unable, due to dementia or a similar cognitive impairment, to request an in-person visit or to consent to be visited in person by a clergy member for religious purposes, the request or consent must be made or given by the resident's legal representative.

B. Notwithstanding any other provision in this chapter, when a resident's death is imminent, a health care institution must allow a clergy member to visit the resident in person for religious purposes if either of the following applies:

1. The resident requests or consents to be visited by the clergy member.

2. The resident's legal representative requests that the resident be visited by the clergy member.

C. A health care institution may require clergy to comply with reasonable health and safety precautions, including undergoing health screenings and wearing personal protective equipment, that are imposed by the health care institution in connection with in-person visitation for preventing the spread of communicable diseases. If such a requirement would substantially burden the clergy member's free exercise of religion while carrying out the religious purpose for which the clergy member is visiting while with the resident in the resident's room or visiting area designated by the health care institution, the health care institution may require compliance with such precautions only if compliance in that instance furthers a compelling interest and the health care institution imposes the least restrictive burden on the clergy member's exercise of religion. Notwithstanding any other provision of this chapter, a health care institution may restrict visits of a clergy member who fails a health screening measure or tests positive for a communicable disease.

D. A health care institution and its employees and contractors are not liable to a person visiting a resident or to a resident of the health care institution for civil damages for injury or death due to actual or alleged exposure to a communicable disease resulting from or related to a visitation in compliance with this section unless it is proven by clear and convincing evidence that the health care institution failed to substantially comply with the health care institution's applicable health and safety precautions. The immunity prescribed in this subsection does not apply to any act or omission unless there is clear and convincing evidence that the act or omission constitutes gross negligence or wilful or wanton misconduct.

E. A person or religious organization may bring a civil action against a health care institution alleging a violation of this section. Any person that successfully asserts a claim or defense under this section may recover declaratory relief, injunctive relief, reasonable attorney fees and costs and any other appropriate relief.

F. For the purposes of this section:

1. "Health care institution" has the same meaning prescribed in section 36-420.

2. "Resident" means a person living at or receiving inpatient services from a health care institution.

36-407.03. Hospitals; visitation policy; exceptions

A. A hospital shall develop a visitation policy that allows a patient to have daily in-person visitation by a designated visitor of the patient's choice, which may include the patient's spouse or one parent or child of the patient. A hospital's policies regarding visitation shall ensure that the patient and the patient's visitors may have physical contact, especially during end-of-life visitation, unless a physician determines based on the patient's condition that the visitation does not meet health and safety standards or is reasonably likely to harm the patient. If a physician denies visitation with a patient pursuant to this section, the patient or the patient's representative, which may include the patient's spouse, parent or child, may request a meeting, as provided by the visitation policy, with the physician and the hospital's chief medical officer, chief of staff or chief executive officer to receive a review and explanation within twenty-four hours of the physician's decision to deny visitation. If the designated visitor's request to visit is denied or not resolved at the meeting, the visitor may file a complaint with the department. All visitors must comply with reasonable health and safety precautions imposed by the hospital in connection with the visit.

B. This section does not apply to the Arizona state hospital, any other licensed facility under the jurisdiction of the superintendent of the Arizona state hospital or chapter 5 of this title.

## 36-420. Health care institutions; cardiopulmonary resuscitation; first aid; immunity; falls; definition

A. Each health care institution and the health care institution's respective employees have an affirmative duty of care for their residents as prescribed in subsection B of this section.

B. Each health care institution:

1. Shall initiate cardiopulmonary resuscitation in accordance with its certification training for cardiopulmonary resuscitation before the arrival of emergency medical services, to a resident who is nonresponsive or has a cessation of normal respiration. The cardiopulmonary resuscitation shall be in accordance with that resident's advance directives, if known. Staff who are certified in cardiopulmonary resuscitation shall be available at all times.

2. Shall provide appropriate first aid in accordance with its certification training for first aid before the arrival of emergency medical services to a resident who is in distress and to a noninjured resident who has fallen, appears to be uninjured and is unable to reasonably recover independently. The first aid shall be in accordance with the resident's advance directives, if known. Staff who are certified in first aid shall be available at all times.

3. May not have, establish or implement policies that prevent employees from providing appropriate cardiopulmonary resuscitation and first aid.

C. A health care institution that renders cardiopulmonary resuscitation or first aid as described in subsection B of this section is not liable for any civil damages as the result of any act or omission by the person rendering such care. This liability exclusion applies only if the cardiopulmonary resuscitation or first aid is rendered in good faith and consistent with cardiopulmonary resuscitation or first aid certification standards, as applicable. This liability exclusion does not apply to a person who acts with gross negligence while rendering care.

D. A person who in good faith renders first aid to a person who has fallen is not liable for any civil damages as the result of any act or omission by the person rendering the first aid to the fallen person, unless the person acted with gross negligence while rendering the first aid, if the person rendering aid acted under any of the following circumstances:

1. At the direction of the emergency dispatch operator.

2. To prevent further imminent and serious injury to the fallen person.

3. The fallen person appeared to be uninjured, stated that the person was not injured and requested assistance.

E. The department shall enforce this section consistent with the centers for medicare and medicaid services regulations for health care institutions that are subject to those regulations.

F. For the purposes of this section, "health care institution" means an assisted living center, an assisted living facility, an assisted living home, hospice, a nursing care institution or a residential care institution that is licensed pursuant to this chapter.

36-420.01. Health care institutions; fall prevention and fall recovery; training programs; definition

A. Each health care institution shall develop and administer a training program for all staff regarding fall prevention and fall recovery. The training program shall include initial training and continued competency training in fall prevention and fall recovery. A health care institution may use information and training materials from the department's Arizona falls prevention coalition in developing the training program.

B. For the purposes of this section, "health care institution" has the same meaning prescribed in section 36-420.

36-420.03. Health care employers; workplace violence prevention plan; investigation; reporting; nondiscrimination; definitions

A. Not later than July 1, 2023, health care employers shall develop, implement and maintain a written workplace violence prevention plan that does all of the following:

1. Includes components that are specifically tailored to the conditions and hazards of the health care employer's sites and patient-specific risk factors.

2. Identifies the individual who is responsible for implementing and overseeing the plan.

3. Requires the conspicuous posting of signs in public areas throughout the health care employer's sites, including all emergency facilities, that are at least twelve inches by twelve inches in size and that provide notice that assault on a health care worker may be prosecuted as a felony.

4. Includes reporting, incident response and postincident investigation procedures, including procedures:

(a) For health care workers to report workplace violence risks, hazards and incidents.

(b) For health care employers to respond to reports of workplace violence.

(c) For health care employers to perform a postincident investigation and debriefing of all reported incidents of workplace violence with the participation of health care workers.

5. Requires health care employers to provide information to health care workers about a worker's ability to report any assault to law enforcement and, on request, to assist the worker in reporting the assault.

B. Each health care employer shall make its workplace violence prevention plan available at all times to all health care workers and contractors who provide patient care.

C. As soon as practicable after a workplace violence incident is reported to the health care employer, the health care employer shall investigate the incident and shall do all of the following:

1. Review the circumstances of the incident.

2. Solicit input from involved health care workers and supervisors about the cause of the incident and whether further corrective measures could have prevented the incident.

3. Document the findings, recommendations and corrective measures taken, if applicable, for each investigation conducted.

D. Each health care employer shall provide training and education to its health care workers who may be exposed to workplace violence hazards and risks.

E. Each health care employer shall maintain:

1. Records that relate to each of the employer's workplace violence prevention plans, including identifying, evaluating and correcting hazards and risks and training procedures.

2. An incident log for recording all reported workplace violence incidents and records of all incident investigations. The log shall include the date, time and location of the incident, the name of every person who is involved in the incident, a description of the incident and the nature and extent of injuries to health care workers.

F. The health care employer shall annually evaluate the implementation and effectiveness of the workplace violence prevention plan, including a review of the violent incident log and compliance with any training. The annual evaluation shall be documented.

G. The health care employer shall adopt a policy that prohibits any person from discriminating or retaliating against any health care worker for either:

1. Reporting to or seeking assistance or intervention from the employer, law enforcement, local emergency services or a government agency or participating in an incident investigation.

2. Reasonably acting in self defense or defense of others in response to an imminent threat of physical harm.

H. A health care employer may not discriminate or retaliate against a health care worker for either:

1. Reporting to or seeking assistance or intervention from the employer, law enforcement, local emergency services or a government agency or for exercising any other rights under this section.

2. Reasonably acting in self defense or defense of others in response to an imminent threat of physical harm.

I. This section does not affect the legal obligations of a health care employer and health care worker pursuant to the protection of patients' rights.

J. This section does not apply to the Arizona state hospital or any other licensed facility that is under the jurisdiction of the superintendent of the Arizona state hospital.

K. For the purposes of this section:

1. "Health care employer" means a health care institution that is licensed pursuant to this title as a hospital, freestanding emergency services facility or urgent care facility and that has more than fifty employees.

2. "Health care worker" means an employee of a health care employer or a person who has a contract with a health care employer to provide health care or related services.

36-421. Construction or modification of a health care institution

A. A license application for a health care institution shall include, on a form provided by the department, a notarized attestation from an architect registered pursuant to title 32, chapter 1 that verifies the architectural plans and specifications meet or exceed standards adopted by the department. These plans and specifications shall meet the minimum standards for licensure within the class or subclass of health care institution for which it is intended. The application shall include the name and address of each owner and lessee of any agricultural land that is regulated pursuant to section 3-365.

B. Construction or modification of a licensed health care institution shall meet the minimum standards for licensure within the class or subclass of health care institution for which it is intended.

C. An applicant shall comply with all state statutes and rules and local codes and ordinances required for the health care institution's construction.

D. A health care institution or its facility shall not be licensed if it is located on property that is less than four hundred feet from agricultural land that is regulated pursuant to section 3-365, except that the owner of the agricultural land may agree to comply with the buffer zone requirements of section 3-365. If the owner agrees in writing to comply with the buffer zone requirements and records the agreement in the office of the county recorder as a restrictive covenant running with the title to the land, the health care institution or facility may be licensed and located within the affected buffer zone. The agreement may include any stipulations regarding the health care institution or facility, including conditions for future expansion of the health care institution or facility and changes in the operational status of the health care institution or facility that will result in a breach of the agreement. This subsection does not apply to the issuance of a license for a health care institution located in the same location for which a health care institution license was previously issued.

E. Notwithstanding any law to the contrary, a health care institution that was licensed as a level 1 psychiatric acute behavioral health facility-inpatient facility as of January 1, 2012 and that is not certified under title XIX of the social security act shall be licensed as a hospital and is not required to comply with the physical plant standards for a general hospital, rural general hospital or special hospital prescribed by the department.

F. An adult behavioral health therapeutic home is not required to comply with the building codes or zoning standards for a health care institution prescribed by the department.

G. The Arizona pioneers' home is not required to comply with subsection A of this section and the physical plant standards for a health care institution prescribed by the department.

H. A nursing-supported group home is not required to comply with the zoning standards for a health care institution prescribed by the department.

I. For the purposes of this section, health care institution does not include a home health agency or a hospice service agency.

36-422. Application for license; notification of proposed change in status; joint licenses; definitions

A. A person who wishes to apply for a license to operate a health care institution pursuant to this chapter shall submit to the department all of the following:

1. An application on a written or electronic form that is prescribed, prepared and furnished by the department and that contains all of the following:

(a) The name and location of the health care institution.

(b) Whether the health care institution is to be operated as a proprietary or nonproprietary institution.

(c) The name of the governing authority. The applicant shall be the governing authority having the operative ownership of, or the governmental agency charged with the administration of, the health care institution sought to be licensed. If the applicant is a partnership that is not a limited partnership, the partners shall apply jointly, and the partners are jointly the governing authority for purposes of this article.

(d) The name and business or residential address of each controlling person and an affirmation that none of the controlling persons has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a license or certificate issued by a health profession regulatory board pursuant to title 32 or issued by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution revoked. If a controlling person has been denied a license or certificate by a health profession regulatory board pursuant to title 32 or by a state agency pursuant to chapter 6, article 7 or chapter 17 of this title or a license to operate a health care institution in this state or another state or has had a health care professional license or a license to operate a health care institution revoked, the controlling person shall include in the application a comprehensive description of the circumstances for the denial or the revocation.

(e) The class or subclass of health care institution to be established or operated.

(f) The types and extent of the health care services to be provided, including emergency services, community health services and services to indigent patients.

(g) The name and qualifications of the chief administrative officer implementing direction in that specific health care institution.

(h) Other pertinent information required by the department for the proper administration of this chapter and department rules.

2. The attestation required by section 36-421, subsection A.

3. The applicable application fee.

B. An application submitted pursuant to this section shall contain the written or electronic signature of:

1. If the applicant is an individual, the owner of the health care institution.

2. If the applicant is a partnership, limited liability company or corporation, two of the officers of the corporation or managing members of the partnership or limited liability company or the sole member of the limited liability company if it has only one member.

3. If the applicant is a governmental unit, the head of the governmental unit.

C. An application for licensure shall be submitted at least sixty but not more than one hundred twenty days before the anticipated date of operation. An application for a substantial compliance survey submitted pursuant to section 36-425, subsection G shall be submitted at least thirty days before the date on which the substantial compliance survey is requested.

D. If a current licensee intends to terminate the operation of a licensed health care institution or if a change of ownership is planned, the current licensee shall notify the director in writing at least thirty days before the termination of operation or change in ownership is to take place. The current licensee is responsible for preventing any interruption of services required to sustain the life, health and safety of the patients or residents. A new owner shall not begin operating the health care institution until the director issues a license to the new owner.

E. A licensed health care institution for which operations have not been terminated for more than thirty days may be relicensed pursuant to the codes and standards for architectural plans and specifications that were applicable under its most recent license.

F. If a person operates a hospital in a county with a population of more than five hundred thousand persons in a setting that includes satellite facilities of the hospital that are located separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within one-half mile of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and its designated satellite facilities that are located farther than one-half mile from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements. Each facility included under a single group license is subject to the department's licensure requirements that are applicable to that category of facility. Subject to compliance with applicable licensure or accreditation requirements, the department shall reissue individual licenses for the facility of a hospital located in separate buildings from the main hospital building when requested by the hospital. This subsection does not apply to nursing care institutions and residential care institutions. The department is not limited in conducting inspections of an accredited health care institution to ensure that the institution meets department licensure requirements. If a person operates a hospital in a county with a population of five hundred thousand persons or less in a setting that includes satellite facilities of the hospital that are located

separately from the main hospital building, the department at the request of the applicant or licensee shall issue a single group license to the hospital and its designated satellite facilities located within thirty-five miles of the main hospital building if all of the facilities meet or exceed department licensure requirements for the designated facilities. At the request of the applicant or licensee, the department shall also issue a single group license that includes the hospital and its designated satellite facilities that are located farther than thirty-five miles from the main hospital building if all of these facilities meet or exceed applicable department licensure requirements.

G. If a county with a population of more than one million persons or a special health care district in a county with a population of more than one million persons operates an accredited hospital that includes the hospital's accredited facilities that are located separately from the main hospital building and the accrediting body's standards as applied to all facilities meet or exceed the department's licensure requirements, the department shall issue a single license to the hospital and its facilities if requested to do so by the hospital. If a hospital complies with applicable licensure or accreditation requirements, the department shall reissue individual licenses for each hospital facility that is located in a separate building from the main hospital building if requested to do so by the hospital. This subsection does not limit the department's duty to inspect a health care institution to determine its compliance with department licensure standards. This subsection does not apply to nursing care institutions and residential care institutions.

H. An applicant or licensee must notify the department within thirty days after any change regarding a controlling person and provide the information and affirmation required pursuant to subsection A, paragraph 1, subdivision (d) of this section.

I. A behavioral health residential facility that provides services to children must notify the department within thirty days after the facility begins contracting exclusively with the federal government, receives only federal monies and does not contract with this state.

J. This section does not limit the application of federal laws and regulations to an applicant or licensee that is certified as a medicare or an Arizona health care cost containment system provider under federal law.

K. Except for an outpatient treatment center that provides dialysis services or abortion procedures or that is exempt from licensure pursuant to section 36-402, subsection A, paragraph 12, a person wishing to begin operating an outpatient treatment center before a licensing inspection is completed shall submit all of the following:

1. The license application required pursuant to this section.

2. All applicable application and license fees.

3. A written request for a temporary license that includes:

(a) The anticipated date of operation.

(b) An attestation signed by the applicant that the applicant and the facility comply with and will continue to comply with the applicable licensing statutes and rules.

L. Within seven days after the department's receipt of the items required in subsection K of this section, but not before the anticipated operation date submitted pursuant to subsection C of this section, the department shall issue a temporary license that includes:

1. The name of the facility.

2. The name of the licensee.

3. The facility's class or subclass.

4. The temporary license's effective date.

5. The location of the licensed premises.

M. A facility may begin operating on the effective date of the temporary license.

N. The director may cease the issuance of temporary licenses at any time if the director believes that public health and safety is endangered.

O. An outpatient treatment center that is exempt from licensure pursuant to section 36-402, subsection A, paragraph 12 is subject to reasonable inspection by the department if the director has reasonable cause to believe that patient harm is or may be occurring at that outpatient treatment center. A substantiated complaint that harm is occurring at an exempt outpatient treatment center is a violation of this chapter against the license of the hospital listed in the notice required by section 36-402, subsection A, paragraph 12.

P. Each hospital that is licensed pursuant to this chapter shall provide to and maintain with the department a current list of exempt outpatient treatment centers that have the same direct owner or indirect owner as the hospital.

Q. For the purposes of this section:

1. "Accredited" means accredited by a nationally recognized accreditation organization.

2. "Satellite facility" means an outpatient facility at which the hospital provides outpatient medical services.

36-434.01. Outpatient surgical centers; hospitals; surgical smoke evacuation systems; definitions

A. Beginning July 1, 2024, each outpatient surgical center or hospital shall adopt and implement policies to prevent exposure to surgical smoke by using a smoke evacuation system for each procedure that generates surgical smoke.

B. The department shall ensure compliance with this section during any on-site inspection and in response to any complaint received relating to a violation of this section.

C. For the purposes of this section:

1. "Smoke evacuation system" means smoke evacuation equipment and technologies designed to capture, filter and remove surgical smoke at the site of origin and to prevent surgical smoke from making ocular contact or contact with an individual's respiratory tract.

2. "Surgical smoke":

(a) Means the surgical plume that is generated from the use of an energy-generating surgical device.

(b) Includes smoke plume, bio-aerosols, laser-generated airborne contaminants and lung-damaging dust.

36-402. Exemptions

A. This chapter and the rules adopted by the director pursuant to this chapter do not authorize the licensure, supervision, regulation or control of:

1. The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely on treatment by prayer or spiritual means in accordance with the creed or tenets of any well-recognized church or religious denomination.

2. Establishments, such as motels, hotels and boarding houses, that provide domiciliary and ancillary commercial services but do not provide adaptive, medical, hospital, nursing, behavioral health, health-related or supervisory care services.

3. Private offices and clinics of health care providers licensed under title 32 that are not freestanding urgent care centers, unless:

(a) Patients of the office or clinic are kept overnight as bed patients or treated otherwise under general anesthesia, except when treatment by general anesthesia is regulated by title 32, chapter 11.

(b) The office or clinic is an abortion clinic. For the purposes of this subdivision, "abortion clinic" has the same meaning prescribed in section 36-449.01.

(c) The office or clinic is a pain management clinic. For the purposes of this subdivision, "pain management clinic" has the same meaning prescribed in section 36-448.01.

4. Dispensaries and first aid stations that are located within business or industrial establishments and that are maintained solely for the use of employees if the facility does not contain inpatient beds and is under the supervision of a physician or a registered nurse practitioner.

5. The collection, processing or distribution of whole human blood, blood components, plasma, blood fractions or derivatives that are procured, processed or distributed by federally licensed and regulated blood banks.

6. Places where four or fewer adults who are not related to the administrator or owner receive adult day health services for compensation on a regular basis.

7. Places at which persons receive health-related services only from relatives or from legal guardians or places that do not purport to be establishments that regularly provide health-related services and at which one or two persons receive health-related services on a twenty-four-hour basis.

8. The personal residence of a terminally ill person, or the personal residence of that person's relative or guardian, where that person receives hospice services from a hospice service agency.

9. All medical and health-related facilities and services that are provided to inmates who are confined in a state prison. The state department of corrections shall annually evaluate the medical and health-related facilities and services that are provided to inmates to determine that the facilities and services meet the applicable standards that are adopted by the director of the department of health services. The state department of corrections shall report the results of its annual evaluation and the actual findings, including a plan of correction for any deficiencies, to the director of the department of health services. The department of health services shall conduct validation surveys on a percentage of the medical and health-related facilities, the number of which shall be determined by the state department of corrections and the department of health services. The director of the state department of corrections shall maintain the annual evaluation reports. This paragraph does not apply to licensed behavioral or mental health inpatient treatment facilities that the state department of corrections operates.

10. A facility that provides medical and health services to inmates who are confined in a county jail. The sheriff shall annually evaluate the facility to determine if it meets the applicable standards that are adopted by either a national corrections commission on health care or an American correctional association, or the sheriff shall annually submit the facility to a similar separate inspection by an outside agency with medical standards. The sheriff must submit the certificate of accreditation or proof of successful inspection to the department annually and keep a copy of the certificate or proof of inspection.

11. Community education, advocacy or recovery support groups that are not owned or operated by or contracted to provide services with a health care institution.

12. An outpatient treatment center that has the same direct owner or indirect owner as a hospital licensed pursuant to this chapter, that is staffed by health care providers who are licensed pursuant to title 32 and that provides notice to the department of its decision to be exempt from licensure under this chapter, unless:

(a) Patients are kept overnight in the outpatient treatment center or are treated under general anesthesia, except when the treatment by general anesthesia is regulated pursuant to title 32, chapter 11.

(b) The outpatient treatment center is an abortion clinic as defined in section 36-449.01.

(c) The outpatient treatment center is a pain management clinic as defined in section 36-448.01.

B. A medical and health-related facility that provides medical and health services exclusively to persons who are incarcerated, detained or confined under court order or court jurisdiction is exempt from the patient-per-room capacity requirements provided in rule if the facility:

1. Does not exceed its intended medical and custodial purposes.

2. Adopts policies and procedures to comply with the national commission on correctional health care standards, or equivalent standards.

3. As soon as practicable, becomes accredited by the national commission on correctional health care, or by an equivalent organization.

4. Once accreditation is obtained, submits a certificate of accreditation to the department of health services annually.

5. Maintains a copy of the certificate of accreditation.

6. Maintains patient and custodial records, including on-site current photographs and fingerprints, if permitted by applicable law.

7. Makes patient lists with inmate identifiers available to the state department of corrections on reasonable request.

8. Provides timely notice of any major incident involving public safety to the appropriate law enforcement agency and allows that agency access to the facility for the purposes of law enforcement and investigation.

C. Subsection B of this section does not apply to health care institutions that exclusively provide behavioral health services.

36-439.01. Colocation of licensees

Notwithstanding any other provision of this chapter, one or more licensed outpatient treatment centers or exempt outpatient treatment centers that provide medical, nursing and health-related services may colocate or colocate with one or more licensees or exempt outpatient treatment centers that provide behavioral health services or with one or more licensed counseling facilities and may share common areas at the collaborating outpatient treatment center premises and share nontreatment personnel pursuant to the requirements of this article.

36-439.04. Colocation; outpatient treatment centers; health care providers

A. The governing authority of a licensed collaborating outpatient treatment center or a collaborating exempt outpatient treatment center, by agreement, may share common areas and may share nontreatment personnel with one or more exempt health care providers or one or more licensed counseling facilities pursuant to section 36-439.02.

B. Treatment areas that are licensed under an outpatient treatment center may also be used by an exempt health care provider or an exempt outpatient treatment center if the provider's treatment areas and hours of operation are clearly identified by signage to the public and notice to the department.

C. Notwithstanding subsections A and B of this section, a licensed or exempt outpatient treatment center may contract with or employ an exempt health care provider to provide health care services to the licensed or exempt outpatient treatment center's patients.

36-439.05. Outpatient treatment center employees; behavioral health services; private office or clinic of an exempt health care provider

A. Notwithstanding any other provision in this article, an employee of a licensed outpatient treatment center or an exempt outpatient treatment center that provides behavioral health services may provide behavioral health services at a private office or clinic that is operated by an exempt health care provider under the following circumstances:

1. The services are provided to a patient of the exempt health care provider, the exempt outpatient treatment center or the licensed outpatient treatment center.

2. The licensed outpatient treatment center or the exempt outpatient treatment center and the exempt health care provider have a written agreement specifying all of the following:

(a) The services to be provided.

(b) The responsibility for billing for the services provided.

(c) Liability for the actions of the licensed outpatient treatment center's or the exempt outpatient treatment center's employee.

(d) The responsibility for maintenance, access to and confidentiality of medical records.

(e) That the medical records for the behavioral health services provided by the licensed outpatient treatment center's or the exempt outpatient treatment center's employee are stored at the outpatient treatment center, in addition to any provisions for maintaining and storing the medical records at other sites.

B. A licensed outpatient treatment center and an exempt outpatient treatment center shall report to the department any unexpected death, self-injury or other injury of a patient under the care of its employee that occurs on the premises of an exempt health care provider and whether the injury required medical attention. The department may report the incident to the licensing board of any health care professional who is involved in the incident.

C. Unlicensed employees of a licensed outpatient treatment center or an exempt outpatient treatment center may provide services at the private office or clinic of the exempt health care professional only when a licensed health care professional who is employed by the licensed or exempt outpatient treatment center is on-site.

**D-6.**

**DEPARTMENT OF HEALTH SERVICES**
Title 9, Chapter 10, Articles 1-7

**Amend:** R9-10-115; R9-10-701; R9-10-702; R9-10-703; R9-10-706; R9-10-707; R9-10-709; R9-10-710; R9-10-712; R9-10-713; R9-10-715; R9-10-716; R9-10-717; R9-10-718; R9-10-719; R9-10-720; R9-10-722; R9-10-802; R9-10-803; R9-10-806; R9-10-807; R9-10-809; R9-10-810; R9-10-811; R9-10-817; R9-10-818; R9-10-821

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - REGULAR RULEMAKING

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** **June 17, 2025**

**SUBJECT:** **DEPARTMENT OF HEALTH SERVICES**
Title 9, Chapter 10, Articles 1, 7, and 8

**Amend:** R9-10-115; R9-10-701; R9-10-702; R9-10-703; R9-10-706; R9-10-707; R9-10-709; R9-10-710; R9-10-712; R9-10-713; R9-10-715; R9-10-716; R9-10-717; R9-10-718; R9-10-719; R9-10-720; R9-10-722; R9-10-802; R9-10-803; R9-10-806; R9-10-807; R9-10-809; R9-10-810; R9-10-811; R9-10-817; R9-10-818; R9-10-821

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**Summary:**

This regular rulemaking from the Department of Health Services (Department) seeks to amend twenty-seven (27) rules in Title 9, Chapter 10 regarding Health Care Institutions Licensing. The amendments are across Articles 1, 7, and 8. The rulemaking relates to Five-Year Review Reports approved by the Council on June 4 2024 (Article 7, Behavioral Health Residential Facilities) and October 3, 2023 (Article 8, Assisted Living Facilities). The goals of the amendments are to incorporate statutory changes from four law changes since 2021 (Laws 2021, Ch. 137, Laws 2022, Ch. 34, Ch.179, Ch. 296), to correct cross-references with other rules, and to make the rules more concise and understandable. Specifically, the amendments are summarized below:

- Article 1

One rule in Article 1 will be amended to include what a health care institution must require for behavioral health paraprofessionals and behavioral health technicians. The Department indicated in their last 5YRR that these changes will expand the number of applicants to fill these positions.

- Article 7

The Department indicates that the changes to Article 7 are intended to better align with statutory updates to improve health and safety standards, ensure facilities develop visitation procedures including clergy, exempt respite services for individuals under 18 from licensing requirements, clarify when treatments must be documented in writing, clarifying evacuation procedures, improving accessibility for residents, and the documentation/implementation of procedures to prevent abuse or neglect of residents

- Article 8

The Department indicates that the changes to Article 8 are intended to better ensure residents are aware of their rights and access to Disability Rights Arizona, adding a rule that allows certified nursing assistants (CNA) to work as caregivers if trained in medication administration, clarifying that all medical orders must be dated, timed, and authenticated by medical professionals, removing the requirement of Department review of architectural plans in accordance with statutory changes that allow for a notarized attestation from a licensed architect, and the documentation/implementation of procedures to prevent abuse or neglect of residents.

**1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?**

The Department cites both general and specific statutory authority for these rules.

**2. Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

**3. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Department indicates it did not review any study relevant to this rulemaking.

**4. Summary of the agency's economic impact analysis:**

The Department states that it engages in this rulemaking to adhere to statutory law changes, address issues identified in recent five-year reports, make the rules clearer and more concise and understandable, update cross-references, correct grammatical errors, and

amend rules necessary for the proper administration and enforcement of the laws relating to public health. This rulemaking consists of several rule amendments to the Arizona Administrative Code Title 9, Chapter 10. The Department anticipates these rules may increase the regulatory burden or cost on some affected persons, but believes the benefits far outweigh any potential costs.

**5. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department has determined that there are no less intrusive or less costly alternatives for achieving the purpose of the rulemaking. It does estimate up to minimal ($1,000 or less) costs to the Department for implementation of and education/training for the rules; minimal to moderate (up to $10,000) costs to Behavioral Health Residential Facilities, Assisted Living Facilities, and the general public related to compliance; and minimal costs to healthcare providers related to compliance. However, the Department believes expected long-term benefits will outweigh the expected costs.

**6. What are the economic impacts on stakeholders?**

The Department identifies itself, behavioral health residential facilities, assisted living facilities, health care providers, and the general public as those directly affected by the rules and those who stand to bear the costs or benefit from them. The Department believes that there will be a significant benefit for having rules that are expected to enhance resident care and operational efficiency. The Department expects behavioral health residential facilities and assisted living facilities to benefit in the long-term from the updated rules that the Department believes better protect the public, accurately reflect industry standards and practices, and are consistent with federal and state statutes and rules. The Department further expects health care providers to benefit from these rules that it believes will improve resident care, safety, and regulatory compliance. The Department also states that the public will benefit from expected improvements in care and safety.

**7. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

Between the Notice of Proposed Rulemaking published in the Administrative Register on January 17, 2025 and the Rulemaking now before the Council, the Department has implemented the following changes:

- R9-10-115(8)(f)(i) and R9-10-706(B)(6)(f)(i)
    - The Department corrected a typo from 18 credit hours to 18 hours
- R9-10-806(C)(1)(x)
    - A new subsection was added to require the certificate of completion, according to R9-10-126. This subsection was added as a result of a rulemaking approved by the Council on June 3, 2025.
- R9-10-811(C)(18)

- The cross reference was updated to reflect the rulemaking approved by the Council on June 3, 2025.

In the preamble, the Department states that the base rules in R9-10-803, R9-10-806, R9-10-811, R9-10-816, R9-10-817, and R9-10-820 were amended as a result of the rulemaking submitted to GRRC on April 22, 2025. That rulemaking was approved by the Council during the June 3, 2025 meeting. The June 3 rulemaking impacted the numbering that was present in the Notice of Proposed Rulemaking. The June 3 rulemaking did not impact any text from the Notice of Proposed Rulemaking to the Rulemaking now before the Council, outside of the two instances indicated above. Council Staff believes these changes to be non-substantive and in compliance with A.R.S. § 41-1025.

**8. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Department indicates that they received no public comments on these rules. The Department does indicate that two stakeholders from Community Bridges did attend an oral proceeding, but did not provide any comments during that proceeding.

**9. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates that the rules being amended do not require a permit or a license.

**10. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates that there is no corresponding federal law for the rules.

**11. Conclusion**

This regular rulemaking from the Department of Health Services (Department) seeks to amend twenty-seven (27) rules in Title 9, Chapter 10 regarding Health Care Institutions Licensing. The amendments are across Articles 1, 7 (Behavioral Health Facilities), and 8 and relate to Five-Year Review Reports approved by the Council on October 3, 2023 and June 4, 2024. The amendments are intended to implement statutory changes that occurred in 2021 and 2022, and to amend rules by making them more clear, concise, and understandable. The amendments focus on medical donation protocols, architectural plans of facilities, visitation policies, preventing multiple units of a behavioral health residential facility from operating under a single license, aligning rules with statutes concerning reporting of abuse, neglect, or exploitation, clarifying annual staff training, ensuring all medical orders need to be documented, and to clarify the level of care a certified nursing assistant may provide.

The Department is seeking the standard 60-day delayed effective date pursuant to A.R.S. § 41-1032(A).

Council staff recommends approval of this rulemaking.

ARIZONA
DEPARTMENT OF
HEALTH SERVICES

April 24, 2025

**VIA EMAIL: grrc@azdoa.gov**
Jessica Klein, Esq., Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Department of Health Services, 9 A.A.C. 10, Articles 1, 7, and 8

Dear Ms. Klein:

Enclosed are the administrative rules identified above which I am submitting, as the Designee of the Director of the Department of Health Services, for approval by the Governor's Regulatory Review Council (Council). The following information is provided for your use in reviewing the enclosed rule package pursuant to A.R.S. § 41-1052 and A.A.C. R1-6-202:

1. The close of record date: February 18, 2025

2. Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:
The rulemaking for 9 A.A.C. 10 relates to the five-year review reports for Article 7. Behavioral Health Residential Facilities, approved by the Council on June 4, 2024, and Article 8. Assisted Living Facilities, approved by the Council on October 3, 2023.

3. Whether the rulemaking establishes a new fee and, if so, the statutes authorizing the fee:
The rulemaking does not establish a fee.

4. Whether the rulemaking contains a fee increase:
The rulemaking does not contain a fee increase.

5. Whether an immediate effective date is requested pursuant to A.R.S. § 41-1032:
The Department is not requesting an immediate effective date for the rules.

The Department certifies that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on its evaluation of or justification for the rule.

The Department certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee there are no new full-time employees necessary to implement and enforce the rule.

The following documents are enclosed:

1. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of each rule;
2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055; and
3. General and specific statutes authorizing the rules, including relevant statutory definitions.

The Department's point of contact for questions about the rulemaking documents is Lucinda Sallaway at Lucinda.Sallaway@azdhs.gov.

Sincerely,

Stacie Gravito
Director's Designee
SG: ls

Enclosures

**NOTICE OF FINAL RULEMAKING**

**TITLE 9. HEALTH SERVICES**

**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES –**

**HEALTH CARE INSTITUTIONS: LICENSING**

**ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES**

**ARTICLE 8. ASSISTED LIVING FACILITIES**

**PREAMBLE**

**1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039(B) by the governor on:**

April 22, 2025

| **2. Article, Part, or Section Affected (as applicable)** | **Rulemaking Action** |
|---|---|
| R9-10-115 | Amend |
| R9-10-701 | Amend |
| R9-10-702 | Amend |
| R9-10-703 | Amend |
| R9-10-706 | Amend |
| R9-10-707 | Amend |
| R9-10-709 | Amend |
| R9-10-710 | Amend |
| R9-10-712 | Amend |
| R9-10-713 | Amend |
| R9-10-715 | Amend |
| R9-10-716 | Amend |
| R9-10-717 | Amend |
| R9-10-718 | Amend |
| R9-10-719 | Amend |
| R9-10-720 | Amend |
| R9-10-722 | Amend |
| R9-10-802 | Amend |
| R9-10-803 | Amend |
| R9-10-806 | Amend |
| R9-10-807 | Amend |
| R9-10-809 | Amend |
| R9-10-810 | Amend |
| R9-10-811 | Amend |
| R9-10-817 | Amend |
| R9-10-818 | Amend |
| R9-10-821 | Amend |

**3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

Authorizing statute: A.R.S. §§ 36-132(A)(1) and (17) and 36-136(G)

Implementing statute: A.R.S. §§ 36-405 through 36-407, 36-502.01

**4. The effective date of the rule:**

This rule shall become effective 60 days after a certified original and preamble are filed in the Office of the Secretary of State pursuant to A.R.S. § 41-1032(A). The effective date is (to be filled in by *Register* editor).

**a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

Not applicable

**b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):**

Not applicable

**5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:**

Notice of Rulemaking Docket Opening: 30 A.A.R. 507, March 22, 2024, Issue Number: 12, File Number: [R24-46]

Notice of Proposed Rulemaking: 31 A.A.R. 246, January 17, 2025, Issue Number: 3, File Number: [R24-306]

**6. The agency's contact person who can answer questions about the rulemaking:**

Name: Thomas Salow
Title: Assistant Director
Division: Public Health Licensing
Address: 150 N. 18th Ave., Suite 500, Phoenix, AZ 85007
Telephone: (602) 542-6383
Email: thomas.salow@azdhs.gov
or
Name: Stacie Gravito
Title: Office Chief, Administrative Counsel and Rules
Division: Policy and Intergovernmental Affairs
Address: 150 N. 18th Ave., Suite 540, Phoenix, AZ 85007
Telephone: (602) 542-1020
Email: stacie.gravito@azdhs.gov

**7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions. In order to ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 require the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions. The Department has adopted rules to implement these statutes in Arizona Administrative Code Title 9, Chapter 10. The Department plans to amend the rules to the following statutory changes: Laws 2022, Ch. 179, requires the Department to ensure a health care institution's visitation policy allows a clergy member to visit a resident, Laws 2022, Ch. 296, requires the Department to ensure a hospital develops a visitation policy, especially during end-of-life care, Laws 2022, Ch. 34, amends the requirements for architectural plans and specifications for health care institutions construction or modifications, and Laws 2021, Ch. 137, related to medical donation. After receiving rulemaking approval pursuant to A.R.S. § 41-1039, the Department plans to conduct a rulemaking to adhere to the statutory changes identified above, address issues identified in recent five-year reports approved by the Governor's Regulatory Review Council (GRRC), make the rules clearer and more concise and understandable, update cross-references, correct grammatical errors, and amend rules necessary for the proper administration and enforcement of the laws relating to public health. The Department anticipates that the rules may increase the

regulatory burden or cost on some affected persons. However, the Department believes that the benefits of the rules will far outweigh any potential cost. Any proposed changes will conform to the rulemaking format and style requirements of GRRC and the Office of the Secretary of State.

**8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

The Department did not review or rely on any study related to this rulemaking package.

**9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**10. A summary of the economic, small business, and consumer impact:**

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) requires the Arizona Department of Health Services (Department) to protect the health of the people in Arizona and license and regulate health care institutions. To ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 require the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions. The Department has adopted rules to implement these statutes in Arizona Administrative Code Title 9, Chapter 10. This analysis covers the costs and benefits associated with the rule changes in Articles 7 and 8, related to implementing Laws 2021, Ch 137, Laws 2022, Ch. 179, Laws 2022, Ch. 296, and Laws 2022, Ch. 34; addressing issues identified in recent five-year review reports; and amending rules necessary for the proper administration and enforcement of the laws relating to public health. The annual cost and revenue changes are designated as minimal when $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. Costs are listed as significant when meaningful or important, but not readily subject to quantification.

As mentioned, the Department is revising its rules to comply with recent statutory changes and enhance regulatory clarity, with rule updates aimed at improving resident care and operational efficiency. Laws 2021, Ch. 137, focuses on medical donation protocols, and Laws 2022, Ch. 34, 179, and 296, address architectural plans and visitation policies. A key amendment in the rules is implementing the requirements prescribed in A.R.S. § 36-407.02, which mandates that hospitals develop visitation policies allowing patients daily in-person visits from designated individuals, such as family members, and ensuring clergy access for religious visitation, particularly during end-of-life situations. The rules also specify that if a visitation is denied, patients have the right to request a review within 24 hours. Hospitals must ensure physical contact between patients and visitors, barring health or safety risks determined by a physician. Furthermore, the Department is adding a requirement that behavioral health residential facilities obtain separate licenses for each single dwelling unit to close loopholes that previously allowed multiple units to operate under one license. To support this, a new term and definition will be introduced into the rules for clarity.

Other updates include aligning language in R9-10-703 and R9-10-803 with state statutes concerning the reporting of abuse, neglect, or exploitation. Revisions to rules on meal and snack plans in behavioral health and assisted living facilities will now reflect the most recent federal dietary guidelines. Additionally, updates to medication donation processes per A.R.S. § 32-1909 require that donated medications be handled in original, tamper-evident packaging, with specific stipulations on expiration dates and packaging conditions. The Department is also refining cross-references, correcting grammatical errors, and updating rule titles, such as changing "Physical Health Services" to "Personal Care Services" for consistency across Chapter 10. Though the new rules may require some minimal implementation costs, the Department believes these changes will ultimately enhance care quality, improve operational processes, and ensure long-term benefits for residents and healthcare facilities alike.

A.R.S. §§ 36-132(A)(17) and 36-405(A) & (B) grants the Department authority to license and regulate health care institutions, and the Department is making extensive amendments to 9 A.A.C. 10, Article 7, which governs Behavioral Health Residential Facilities (BHRFs), Adult Residential Care Institutions, and Secured BHRFs. The proposed changes, affecting 15 Sections in Article 7

and one Section in Article 1, are designed to align with recent statutory updates and improve health and safety standards. A key update involves the implementation of Laws 2021, Ch. 355, which exempts respite services for individuals under 18 from licensure requirements, reflected in multiple rule amendments. The Department is also updating R9-10-703 to clarify that treatment services must be documented in writing and ensure policies are in place to prevent abuse or neglect of residents, including mandatory annual staff training. Additional rule changes across Article 7 focus on improving operational safety, such as streamlining evacuation drill requirements (R9-10-720) and enhancing physical plant standards, including installing grab bars in bathrooms and requiring bedroom egress windows to improve safety.

The Department is amending ten sections in 9 A.A.C. 10, Article 8, which regulate assisted living facilities. One of the key amendments in R9-10-803 requires managers to ensure that residents who do not speak English or have disabilities are aware of their rights, and updates the title of The Arizona Center for Disability Law to Disability Rights Arizona. The Department is also implementing a new rule in R9-10-806 requiring documentation of completion of a certified nursing assistant (CNA) program with medication training, allowing CNAs to work as caregivers. This change is intended to address the issue of falsified caregiver certificates and expand the workforce by utilizing CNAs trained in medication administration. Additionally, revisions to R9-10-807 and R9-10-809 focus on correcting grammatical errors and simplifying language for clarity. New requirements in R9-10-811 mandate that medical orders must be dated, timed, and authenticated by medical professionals, while changes in R9-10-821 reflect the removal of the Department's requirement to review architectural plans for health care institutions, following statutory changes in Laws 2022, Ch. 34. Instead, a notarized attestation from a licensed architect verifying compliance will be required. Overall, these rule changes aim to improve regulatory efficiency, public safety, and compliance with industry standards, with minimal to moderate economic impact on assisted living facilities.

The proposed rule changes are expected to have a minimal-to-moderate economic impact on healthcare providers, behavioral health professionals, social workers, and residents. Healthcare providers may face minimal costs for staff training, compliance with new documentation and safety standards, and facility upgrades. Behavioral health facilities could incur moderate costs due to stricter staff qualifications and licensing requirements. Despite these costs, the Department expects significant benefits from improved patient outcomes through better-qualified staff. Social workers may see an increase in administrative duties but minimal financial impact. Residents and families, while benefiting from enhanced care and safety, may experience indirect cost increases as facilities adjust. However, the long-term benefits of improved care and regulatory compliance are expected to outweigh any costs incurred. The new rules are expected to significantly benefit the public by ensuring behavioral health facilities and assisted living facilities are operated by qualified professionals, improving care quality and resident safety. While healthcare providers may face increased operational costs, such as stricter safety standards and staff training, these costs may be passed on to residents and their families. However, the long-term benefits, including reduced abuse, neglect, and potential public health cost savings, are anticipated to outweigh any short-term financial impacts.

Small businesses, such as privately-owned behavioral health residential facilities and assisted living facilities, may face minimal-to-moderate costs due to increased compliance requirements, including mandatory staff training, policy updates, enhanced documentation, and adherence to stricter safety standards. These costs could involve investments in infrastructure and ensuring staff qualifications. However, the Department expects significant long-term benefits, such as improved care quality, safety, and regulatory compliance. These improvements could lead to operational efficiency, reduced liability risks, and enhanced facility reputation, ultimately outweighing the initial costs.

In conclusion, the proposed amendments implement rule changes to comply with recent statutory updates, enhance regulatory clarity, and improve the quality of care in behavioral health and assisted living facilities. While the new rules may impose minimal-to-moderate costs on healthcare providers, small businesses, and behavioral health professionals due to increased compliance requirements, the long-term benefits are expected to outweigh the initial financial impacts. These changes aim to improve resident safety, reduce abuse and neglect, and ensure regulatory compliance, leading to better patient outcomes, enhanced operational

efficiency, and a strengthened reputation for healthcare facilities. Overall, the Department's amendments are designed to safeguard public health and safety while maintaining economic balance for the affected entities.

**11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

The "base rules" in R9-10-803, R9-10-806, R9-10-811, R9-10-816, R9-10-817, and R9-10-820 were amended to reflect a recent rulemaking that the Department submitted to GRRC on April 22, 2025, which amends 9 A.A.C. 10 Articles 1 and 8. In addition, the Department amended a typo R9-10-115(8)(f)(i) and R9-10-706(B)(6)(f)(i) from "18 credit hours" to "18 hours."

**12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

No public or stakeholder comments were submitted regarding this rulemaking. The Department held an Oral Proceeding on February 18, 2025, which was attended by two stakeholders, Miriam Thompson and Ashley Sellers, both representing Community Bridges. However, no comments were provided during the proceeding.

**13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:**

There are no other matters prescribed by statute applicable specifically to the Department or this specific rulemaking.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

The rule does not require the issuance of a regulatory permit. Therefore, a general permit is not applicable.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

There are no federal rules applicable to the subject of the rule.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

**14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:**

Not applicable

**15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

Not applicable

**16. The full text of the rules follows:**

Rule text begins on the next page.

**TITLE 9. HEALTH SERVICES**
**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES –**
**HEALTH CARE INSTITUTIONS: LICENSING**

**ARTICLE 1. GENERAL**

R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians

**ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES**

R9-10-701. Definitions
R9-10-702. Supplemental Application and Documentation Submission Requirements
R9-10-703. Administration
R9-10-706. Personnel

**ARTICLE 8. ASSISTED LIVING FACILITIES**



**ARTICLE 1. GENERAL**

**R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians**

If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented that:
    a. Delineate the services a behavioral health paraprofessional is allowed to provide at or for the health care institution;
    b. Cover supervision of a behavioral health paraprofessional, including documentation of supervision;
    c. Establish the qualifications for a behavioral health professional providing supervision to a behavioral health paraprofessional;
    d. Delineate the services a behavioral health technician is allowed to provide at or for the health care institution;
    e. Cover clinical oversight for a behavioral health technician, including documentation of clinical oversight;
    f. Establish the qualifications for a behavioral health professional providing clinical oversight to a behavioral health technician;
    g. Delineate the methods used to provide clinical oversight, including when clinical oversight is provided on an individual basis or in a group setting; and
    h. Establish the process by which information pertaining to services provided by a behavioral health technician is provided to the behavioral health professional who is responsible for the clinical oversight of the behavioral health technician;
2. A behavioral health paraprofessional receives supervision according to policies and procedures;
3. Clinical oversight is provided to a behavioral health technician to ensure that patient needs are met based on, for each behavioral health technician:
    a. The scope and extent of the services provided,
    b. The acuity of the patients receiving services, and
    c. The number of patients receiving services;
4. A behavioral health technician receives clinical oversight at least once during each two week period, if the behavioral health technician provides services related to patient care at the health care institution during the two week period;
5. When clinical oversight is provided electronically:
    a. The clinical oversight is provided verbally with direct and immediate interaction between the behavioral health professional providing and the behavioral health technician receiving the clinical oversight,
    b. A secure connection is used, and
    c. The identities of the behavioral health professional providing and the behavioral health technician receiving the clinical oversight are verified before clinical oversight is provided; and

6. A behavioral health professional provides supervision to a behavioral health paraprofessional or clinical oversight to a behavioral health technician within the behavioral health professional's scope of practice established in the applicable licensing requirements under A.R.S. Title 32~~.~~;

7. A behavioral health paraprofessional has:
   a. An associate's degree,
   b. A high school diploma, or
   c. A high school equivalency diploma; and

8. A behavioral health technician:
   a. Has a master's degree or bachelor's degree in a field related to behavioral health;
   b. Is a registered nurse;
   c. Is a physician assistant who is not working as a medical practitioner;
   d. Has a bachelor's degree and at least one year of full-time behavioral health work experience;
   e. Has an associate's degree and at least two years of full-time behavioral health work experience;
   f. Has a high school diploma or high school equivalency diploma and:
      i. 18 hours of post-high school education in a field related to behavioral health completed no more than four years before the date the individual begins providing behavioral health services and two years of full-time behavioral health work experience; or
      ii. Four years of full-time behavioral health work experience;
   g. Is licensed as a practical nurse, according to A.R.S. Title 32, Chapter 15, with at least two years of full-time behavioral health work experience; or
   h. Is a paraprofessional credentialed by a nationally recognized behavior analyst certification board.

## ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

**R9-10-701. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

1. "Emergency safety response" means physically holding a resident to manage the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual.
2. "Privacy area" means a licensed space in a health care institution that is designated for treatment, visitors, and voluntary time-outs that is unlocked, lighted, and ensures resident confidentiality.

**R9-10-702. Supplemental Application and Documentation Submission Requirements**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a behavioral health residential facility shall include on the application:

1. Whether the applicant is planning to provide:
   a. Behavioral health services to individuals under 18 years of age, including the licensed capacity requested; or
   b. Behavioral health services to individuals 18 years of age and older, including the licensed capacity requested; ~~or~~
   ~~c. Respite services;~~
2. Whether the applicant is requesting authorization to provide an outdoor behavioral health care program, including:
   a. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 12 to 17 years of age, and
   b. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 18 to 24 years of age;
3. Whether the applicant is requesting authorization to provide:
   a. Court-ordered evaluation,
   b. Court-ordered treatment,
   c. Behavioral health services to individuals 18 years of age or older whose behavioral health issue limits the individuals' ability to function independently, ~~or~~
   d. Personal care services~~;~~, or
   e. Respite services;
4. Whether the applicant is requesting authorization to provide recidivism reduction services as an adult residential care institution, including the requested licensed capacity for providing recidivism reduction services;
5. For a behavioral health residential facility requesting authorization to provide respite services, the requested number of individuals the behavioral health residential facility plans to admit for respite services who:
   a. Are included in the requested licensed capacities in subsections (A)(1)(a) and (b),
   b. Are under 18 years of age and who do not stay overnight in the behavioral health residential facility, and
   c. Are 18 years of age and older and who do not stay overnight in the behavioral health residential facility; and

6. For an outdoor behavioral health care program, a copy of the outdoor behavioral health care program's current accreditation report.

**B.** No change

**C.** A behavioral health residential facility shall obtain a separate license for each single dwelling unit.

**R9-10-703. Administration**

**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a behavioral health residential facility;
2. Establish, in writing:
   a. A behavioral health residential facility's scope of services, including specific types of treatment and services to be provided;~~.~~ and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-704;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
   a. Expected not to be present on the behavioral health residential facility's premises for more than 30 calendar days, or
   b. Not present on the behavioral health residential facility's premises for more than 30 calendar days; ~~and~~
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator~~.~~; and
8. Ensure the health, safety, or welfare of a resident is not placed at risk of harm;

**B.** No change

1. No change
2. No change
3. No change

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a resident;
   d. Include methods on how to prevent abuse or neglect of a resident, including annual training of personnel members on how to recognize the signs, symptoms, and reporting of abuse or neglect;
   ~~d.~~e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   ~~e.~~f. Cover cardiopulmonary resuscitation training including:
      i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
      iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
      iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
   ~~f.~~g. Cover implementation of the requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;
   ~~g.~~h. Cover implementation of the requirements in A.R.S. § 8-804, if applicable;
   ~~h.~~i. Cover first aid training;
   ~~i.~~j. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
   ~~j.~~k. Cover resident rights, including assisting a resident who does not speak English or who has a physical or other disability to become aware of resident rights;
   ~~k.~~l. Cover specific steps for:
      i. A resident to file a complaint, and
      ii. The behavioral health residential facility to respond to a resident complaint;
   ~~l.~~m. Cover health care directives;
   ~~m.~~n. Cover medical records, including electronic medical records;
   ~~n.~~o. Cover a quality management program, including incident reports and supporting documentation;

~~o.~~p. Cover contracted services; and

~~p.~~q. Cover when an individual may visit a resident in a behavioral health residential facility;

2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover resident screening, admission, assessment, treatment plan, transport, transfer, discharge planning, and discharge;
   b. Cover the provision of behavioral health services and physical health services;
   c. Include when general consent and informed consent are required;
   d. Cover emergency safety responses;
   e. Cover a resident's personal funds account;
   f. Cover dispensing medication, administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
   g. Cover prescribing a controlled substance to minimize substance abuse by a resident;
   h. Cover respite services, including, as applicable, respite services for individuals who are admitted:
      i. To receive respite services for up to 30 calendar days as a resident of the behavioral health residential facility, and
      ii. For respite services and do not stay overnight in the behavioral health residential facility;
   i. Cover services provided by an outdoor behavioral health care program, if applicable;
   j. Cover infection control;
   k. Cover resident time-out;
   l. Cover resident outings;
   m. Cover environmental services that affect resident care;
   n. Cover whether pets and other animals are allowed on the premises, including procedures to ensure that any pets or other animals allowed on the premises do not endanger the health or safety of residents or the public;
   o. If animals are used as part of a therapeutic program, cover:
      i. Inoculation/vaccination requirements, and
      ii. Methods to minimize risks to a resident's health and safety;
   p. Cover the process for receiving a fee from a resident and refunding a fee to a resident;
   q. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks;
   r. Cover the security of a resident's possessions that are allowed on the premises;
   s. Cover smoking and the use of tobacco products on the premises; ~~and~~
   t. Cover how the behavioral health residential facility will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
   u. Cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02; and
   v. Cover the provision of naloxone nasal spray, including requirements for:
      i. Informing the administrator, personnel members, employees, volunteers, students, and residents of the availability and location of the naloxone nasal spray on the premises of the behavioral health residential facility;
      ii. Providing training to the administrator, personnel members, employees, volunteers, and students on the correct use of naloxone nasal spray; and
      iii. Ensuring the naloxone nasal spray available is not beyond the listed expiration date;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health residential facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health residential facility.

**D.** No change
1. No change
2. No change
3. No change

**E.** No change

**F.** No change

1. No change
2. No change

**G.** No change

1. No change
2. No change

**H.** If abuse, neglect, ~~or~~ exploitation, or reportable offense of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a behavioral health residential facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, ~~or~~ exploitation, or reportable offense of the resident as follows:

1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
2. For a resident under 18 years of age, according to A.R.S. § 13-3620.

**I.** If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe abuse, neglect, ~~or~~ exploitation, or reportable offense has occurred on the premises or while a resident is receiving services from a behavioral health residential facility's employee or personnel member, the administrator shall:

1. If applicable, take immediate action to stop the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense;
2. Report the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense of the resident:
   a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
   b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
   a. The suspected abuse, neglect, ~~or~~ exploitation, or reportable offense;
   b. Any action taken according to subsection (I)(1); and
   c. The report in subsection (I)(2);
4. Maintain the documentation in subsection (I)(3) for at least 12 months after the date of the report in subsection (I)(2);
5. Initiate an investigation of the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense and document the following information within five working days after the report required in (I)(2):
   a. The dates, times, and description of the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense;
   b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (I)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**J.** No change

**K.** An administrator shall:

1. Establish, ~~and~~ document, and implement requirements regarding residents, personnel members, employees, and other individuals entering and exiting the premises;
2. For a behavioral health residential facility licensed according to A.R.S. § 36-425.06 and in addition to the requirements in subsection (K)(1), establish and document requirements for a resident admitted according to A.R.S. § 13-4521 or A.R.S. § 36-550.09, consistent with R9-10-722(D);
3. Establish and document guidelines for meeting the needs of an individual residing at a behavioral health residential facility with a resident, such as a child accompanying a parent in treatment, if applicable;
4. If applicable, ensure that children under the age of 12, who are not admitted to a behavioral health residential facility, are residing at the behavioral health residential facility ~~and being~~ are cared for by ~~employees or personnel members~~ a parent and does not exceed the licensed capacity~~, ensure that:~~
   ~~a. An employee or personnel member caring for children has current cardiopulmonary resuscitation and first aid training specific to the ages of children being cared for; and~~
   ~~b. The staff-to-children ratios in A.A.C. R9-5-404(A) are maintained, based on the age of the youngest child in the group;~~
5. Establish, ~~and~~ document, and implement the process for responding to a resident's need for immediate and unscheduled behavioral health services or physical health services;
6. Establish, ~~and~~ document, and implement the criteria for determining when a resident's absence is unauthorized, including criteria for a resident who:
   a. Was admitted under A.R.S. Title 36, Chapter 5, Articles 3, 4, 5, or 10;
   b. Is absent against medical advice; or
   c. Is under the age of 18;

7. If a resident's absence is unauthorized as determined according to the criteria in subsection ~~(K)(5)~~ (K)(4), within an hour after determining that the resident's absence is unauthorized, notify:
   a. For a resident who is under 18 years of age, the resident's parent or legal guardian; and
   b. For a resident who is under a court's jurisdiction, the appropriate court;
8. Maintain a written log of unauthorized absences for at least 12 months after the date of a resident's absence that includes the:
   a. Name of a resident absent without authorization,
   b. Name of the individual to whom the report required in subsection (K)(6) was submitted, and
   c. Date of the report; and
9. Evaluate and take action related to unauthorized absences under the quality management program in R9-10-704.

**L.** No change

**M.** No change

1. No change
2. No change
3. No change

**N.** No change

1. No change
2. No change
3. No change
4. No change

**O.** If an administrator determines that a resident is incapable of handling the resident's financial affairs, the administrator shall:

1. Not act as a resident's representative and not allow an employee or a family member of an employee to act as a resident's representative for a resident who is not a family member of the employee;

~~1.~~2. Notify the resident's representative or contact a public fiduciary or a trust officer to take responsibility of the resident's financial affairs, and

~~2.~~3. Maintain documentation of the notification required in subsection ~~(O)(1)~~ (O)(2) in the resident's medical record for at least 12 months after the date of the notification.

**P.** If an administrator manages a resident's money through a personal funds account, the administrator shall ensure that:

1. Policies and ~~procedure~~ procedures are established, ~~developed~~ documented, and implemented for:
   a. Using resident's funds in a personal funds account,
   b. Protecting resident's funds in a personal funds account,
   c. Investigating a complaint about the use of resident's funds in a personal funds account and ensuring that the complaint is investigated by an individual who does not manage the personal funds account,
   d. Processing each deposit into and withdrawal from a personal funds account, and
   e. Maintaining a record for each deposit into and withdrawal from a personal funds account; and
2. The personal funds account is only initiated after receiving a written request that:
   a. Is provided:
      i. Voluntarily by the resident,
      ii. By the resident's representative, or
      iii. By a court of competent jurisdiction;
   b. May be withdrawn at any time; and
   c. Is maintained in the resident's record.

**R9-10-706. Personnel**

**A.** No change

1. No change
2. No change

**B.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the residents receiving behavioral health services or physical health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description,

ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description, and

iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;

2. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

~~2.~~3. A personnel member's skills and knowledge are verified and documented:

a. Before the personnel member provides physical health services or behavioral health services, and

b. According to policies and procedures; and

~~3.~~4. Sufficient personnel members are present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to:

a. Provide the services in the behavioral health residential facility's scope of services,

b. Meet the unique needs of a resident including children, adults age 65 or older, individuals with a substance abuse problem, individuals who are seriously mentally ill, individuals who have a co-morbidity, or individuals who may be victims or perpetrators of domestic violence, as applicable, and

c. Ensure the health and safety of a resident.

5. A behavioral health paraprofessional has:

a. An associate's degree,

b. A high school diploma, or

c. A high school equivalency diploma.

6. A behavioral health technician:

a. Has a master's degree or bachelor's degree in a field related to behavioral health;

b. Is a registered nurse;

c. Is a physician assistant who is not working as a medical practitioner;

d. Has a bachelor's degree and at least one year of full-time behavioral health work experience;

e. Has an associate's degree and at least two years of full-time behavioral health work experience;

f. Has a high school diploma or high school equivalency diploma and:

i. 18 hours of post-high school education in a field related to behavioral health completed no more than four years before the date the individual begins providing behavioral health services and two years of full-time behavioral health work experience; or

ii. Four years of full-time behavioral health work experience;

g. Is licensed as a practical nurse, according to A.R.S. Title 32, Chapter 15, with at least two years of full-time behavioral health work experience; or

h. A paraprofessional credentialed by a nationally recognized behavior analyst certification board.

**C.** No change

**D.** No change

**E.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
   c. No change
4. No change
5. No change
   a. No change
   b. No change
   c. No change

**F.** No change

1. No change
2. No change

**G.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:

1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and

3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. The individual's compliance with requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;
   f. The individual's compliance with the requirements in A.R.S. § 8-804, if applicable;
   g. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   h. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-703(C)(1)(e);
   i. First aid training, if required for the individual according to this Article or policies and procedures; ~~and~~
   j. Training in the use of naloxone nasal spray; and
   ~~j.~~k. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).

**H.** No change
1. No change
   a. No change
   b. No change
2. No change

**I.** No change
1. No change
2. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
         (1) No change
         (2) No change
         (3) No change

**J.** No change
1. No change
2. No change

**K.** An administrator shall ensure that:
1. At least one personnel member is present and awake at the behavioral health residential facility when a resident is on the premises;
2. In addition to the personnel member in subsection (K)(1), at least one personnel member is on-call and available to come to the behavioral health residential facility if needed;
3. There is a daily staffing schedule that:
   a. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;
   b. Includes documentation of the employees who work each calendar day and the hours worked by each employee; and
   c. Is maintained for at least 12 months after the last date on the documentation;
4. A behavioral health professional is employed by the behavioral health residential facility and present at the behavioral health residential facility or on-call;
5. A registered nurse is employed by the behavioral health residential facility and present at the behavioral health residential facility or on-call; and
6. If a resident requires services that the behavioral health residential facility is not authorized or not able to provide, a personnel member arranges for the resident to be transported to a hospital or another health care institution where the services can be provided.

**R9-10-707. Admission; Assessment**

**A.** An administrator shall ensure that:

1. A resident is admitted based upon:
   a. The resident's primary condition for which the resident is admitted to the behavioral health residential facility being a behavioral health issue, and
   b. The resident's behavioral health issue and treatment needs are within the behavioral health residential facility's scope of services;
2. A behavioral health professional, authorized by policies and procedures to admit a resident, is available;
3. Except as provided in subsection (A)(4), general consent is obtained from:
   a. An adult resident or the resident's representative before or at the time of admission, or
   b. A resident's representative, if the resident is not an adult;
4. General consent is not required from a patient receiving a court-ordered evaluation or court-ordered treatment;
5. The general consent obtained in subsection (A)(3) is documented in the resident's medical record;
6. Except as provided in subsection (E)(1)(a), a medical practitioner performs a medical history and physical examination or a registered nurse performs a nursing assessment on a resident within 30 calendar days before admission or within 72 hours after admission and documents the medical history and physical examination or nursing assessment in the resident's medical record within 72 hours after admission;
7. If a medical practitioner performs a medical history and physical examination or a nurse performs a nursing assessment on a resident before admission, the medical practitioner enters an interval note or the nurse enters a progress note in the resident's medical record within seven calendar days after admission;
8. If a behavioral health assessment is conducted by a:
   a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the resident; or
   b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, supervises the behavioral health paraprofessional during the completion of the assessment and signs the assessment to ensure that the assessment identifies the behavioral health services needed by the resident;
9. Except as provided in subsection (A)(10), a behavioral health assessment for a resident is completed before treatment for the resident is initiated;
10. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the behavioral health residential facility or if the behavioral health residential facility has a medical record for the resident that contains a behavioral health assessment that was completed within 12 months before the date of the resident's current admission:
    a. The resident's assessment information is reviewed before treatment for the resident is initiated and updated if additional information that affects the resident's assessment is identified, and
    b. The review and update of the resident's assessment information is documented in the resident's medical record within 48 hours after the review is completed;
11. A behavioral health assessment:
    a. Documents a resident's:
       i. Presenting issue;
       ii. Substance abuse history;
       iii. ~~Co-occurring disorder~~ Co-morbidity;
       iv. Legal history, including:
          (1) Custody,
          (2) Guardianship, and
          (3) Pending litigation;
       v. Criminal justice record;
       vi. Family history;
       vii. Behavioral health treatment history;
       viii. Symptoms reported by the resident; and
       ix. Referrals needed by the resident, if any;
    b. Includes:
       i. Recommendations for further assessment or examination of the resident's needs,
       ii. The physical health services or ancillary services that will be provided to the resident until the resident's treatment plan is completed, and

iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and

c. Is documented in resident's medical record;

12. A resident is referred to a medical practitioner if a determination is made that the resident requires immediate physical health services or the resident's behavioral health issue may be related to the resident's medical condition; and

13. Except as provided in subsection (E)(1)(d), a resident provides evidence of freedom from infectious tuberculosis:

a. Before or within seven calendar days after the resident's admission, and

b. As specified in R9-10-113.

**B.** No change

1. No change
2. No change
3. No change

**C.** No change

**D.** No change

**E.** Except for respite services for individuals under 18 years of age, as specified in A.R.S. § 36-425.08, if ~~If~~ a behavioral health residential facility is authorized to provide respite services, an administrator shall ensure that:

1. Upon admission of a resident for respite services:

a. Except as provided in subsection (F), a medical history and physical examination of the resident:

i. Is performed; or

ii. If dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;

b. A treatment plan that meets the requirements in R9-10-708:

i. Is developed; or

ii. If dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;

c. If a treatment plan, dated within the previous 12 months, is available, the treatment plan is reviewed, updated, and documented in the resident's medical record; and

d. The resident is not required to comply with the requirements in subsection (A)(13) if the resident is not expected to be present in the behavioral health residential facility:

i. For more than seven consecutive days, or

ii. For 10 ~~days~~ or more days in a 90-consecutive-day period;

2. The common area required in R9-10-722(B)(1)(b) provides at least 25 square feet for each resident, including residents who do not stay overnight; and

3. In addition to the requirements in R9-10-722(B)(3), toilets and hand-washing sinks are available to residents, including residents who do not stay overnight, as follows:

a. There is at least one working toilet that flushes and has a seat and one sink with running water for every 10 residents,

b. There are at least two working toilets that flush and have seats and two sinks with running water if there are 11 to 25 residents, and

c. There is at least one additional working toilet that flushes and has a seat and one additional sink with running water for each additional 20 residents.

**F.** No change

**R9-10-709. Discharge**

**A.** No change

1. No change

a. No change

b. No change

c. No change

2. No change
3. No change

**B.** No change

1. No change
2. No change
3. No change

**C.** No change

**D.** No change

**E.** No change

**F.** No change

1. No change
2. No change

**G.** ~~An~~ Except for respite services for individuals under 18 years of age, as specified in A.R.S. § 36-425.08, an administrator shall ensure that a discharge summary for a resident:

1. Is entered into the resident's medical record within 10 working days after a resident's discharge; and
2. Includes:
   a. The following information authenticated by a medical practitioner or behavioral health professional:
      i. The resident's presenting issue and other physical health and behavioral health issues identified in the resident's treatment plan;
      ii. A summary of the treatment provided to the resident;
      iii. The resident's progress in meeting treatment goals, including treatment goals that were and were not achieved; and
      iv. The name, dosage, and frequency of each medication ordered for the resident by a medical practitioner at the behavioral health residential facility at the time of the resident's discharge; and
   b. A description of the disposition of the resident's possessions, funds, or medications brought to the behavioral health residential facility by the resident.

**H.** No change

**R9-10-710. Transport; Transfer**

**A.** No change

1. No change
2. No change
   a. No change
   b. No change
   c. No change
3. No change
   a. No change
   b. No change
   c. No change
   d. No change

**B.** Subsection (A) does not apply to:

1. Transportation to a location other than a licensed health care institution, or
2. Transportation provided for a resident by the resident or the resident's representative, or arranged by a resident or the resident's representative.~~,~~
3. ~~Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or.~~
4. ~~A transport to another licensed health care institution in an emergency.~~

**C.** Except for a transfer of a resident due to an emergency, an administrator shall ensure that:

1. No change
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before the transfer;
   b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains the risks and benefits ~~of the transfer~~ associated with the transfer process to the resident or the resident's representative; and
3. No change
   a. No change
   b. No change
   c. No change
   d. No change

**R9-10-712. Medical Records**

**A.** No change

1. No change
2. No change
   a. No change
   b. No change
   c. No change

3. No change
    a. No change
    b. No change
    c. No change
4. No change
5. No change
    a. No change
    b. No change
    c. No change
6. No change
7. No change

**B.** No change

1. No change
2. No change

**C.** An administrator shall ensure that a resident's medical record contains:

1. Resident information that includes:
    a. The resident's name;
    b. The resident's address;
    c. The resident's date of birth; and
    d. Any known allergies, including medication allergies;
2. The name of the admitting medical practitioner or behavioral health professional;
3. An admitting diagnosis or presenting behavioral health issues;
4. The date of admission and, if applicable, date of discharge;
5. If applicable, the name and contact information of the resident's representative and:
    a. If the resident is 18 years of age or older or an emancipated minor, the document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
    b. If the resident's representative:
        i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
        ii. Is a legal guardian, a copy of the court order establishing guardianship;
6. If applicable, documented general consent and informed consent for treatment by the resident or the resident's representative;
7. Documentation of medical history and results of a physical examination;
8. A copy of resident's health care directive, if applicable;
9. Orders;
10. If applicable, documentation that evaluation or treatment was ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01;
11. Assessment;
12. Treatment plans;
13. Interval notes;
14. Progress notes;
15. Documentation of behavioral health services and physical health services provided to the resident;
16. If applicable, documentation of the use of an emergency safety response;
17. If applicable, documentation of time-out required in R9-10-714(6);
18. Except as allowed in R9-10-707(E)(1)(d), documentation of freedom from infectious tuberculosis required in R9-10-707(A)(13);
19. The disposition of the resident after discharge;
20. The discharge plan;
21. The discharge summary, if applicable;
22. If applicable:
    a. Laboratory reports,
    b. Radiologic reports,
    c. Diagnostic reports, and
    d. Consultation reports; and
23. Documentation of medication administered to the resident <u>or for which the resident received assistance in the self-administration of medication</u> that includes:

a. The date and time of administration;
b. The name, strength, dosage, and route of administration;
c. For a medication administered for pain, when administered initially or on a PRN basis:
i. An assessment of the resident's pain before administering the medication, and
ii. The effect of the medication administered;
d. For a psychotropic medication, when administered initially or on a PRN basis:
i. An assessment of the resident's behavior before administering the psychotropic medication, and
ii. The effect of the psychotropic medication administered;
e. The identification, signature, and professional designation of the individual administering or providing assistance in the self-administration of the medication; and
f. Any adverse reaction a resident has to the medication.

**R9-10-713. Transportation; Resident Outings**

**A.** No change
1. No change
a. No change
b. No change
c. No change
d. No change
2. No change
3. No change
a. No change
b. No change
c. No change
d. No change
i. No change
ii. No change
iii. No change
e. No change
4. No change
a. No change
b. No change

**B.** An administrator shall ensure that:
1. An outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each resident participating in the outing;
~~2. At least two personnel members are present on an outing;~~
~~3.~~2. ~~In addition to the personnel members required in subsection (B)(2), a~~ A sufficient number of personnel members are present to ensure each resident's health and safety on the outing;
~~4.~~3. Documentation is developed before an outing that includes:
a. The name of each resident participating in the outing;
b. A description of the outing;
c. The date of the outing;
d. The anticipated departure and return times;
e. The name, address, and, if available, telephone number of the outing destination; and
f. If applicable, the license plate number of each vehicle used to transport a resident;
~~5.~~4. The documentation described in subsection ~~(B)(4)~~ (B)(3) is updated to include the actual departure and return times and is maintained for at least 12 months after the date of the outing; and
~~6.~~5. Emergency information for each resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
a. The resident's name;
b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
c. The resident's allergies; and
d. The name and telephone number of a designated individual to notify in case of an emergency, who is present on the behavioral health residential facility's premises.

**R9-10-715. ~~Physical Health Services~~ Personal Care Services**

An administrator of a behavioral health residential facility that is authorized to provide personal care services shall ensure that:

1. Personnel members who provide personal care services have documentation of completion of a caregiver training program that complies with A.A.C. R4-33-702(A)(5);
2. Residents receive personal care services according to the requirements in R9-10-814(A), (D), (E), and (F); and
3. A resident who has a stage 3 or stage 4 pressure sore is not admitted to the behavioral health residential facility.

**R9-10-716. Behavioral Health Services**

**A.** An administrator shall ensure that:
1. If a behavioral health residential facility is authorized to provide court-ordered evaluation or court-ordered treatment:
   a. Court-ordered evaluation is provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 4; and
   b. Court-ordered treatment is provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 5;
2. If a behavioral health residential facility is authorized to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently or is authorized to provide behavioral health services to individuals under 18 years of age, a resident admitted to the behavioral health residential facility with limited ability to function independently receives:
   a. Behavioral health services and personal care services as indicated in the resident's treatment plan, and
   b. Continuous protective oversight;
3. A resident admitted to the behavioral health residential facility who needs behavioral health services to maintain or enhance the resident's ability to function independently:
   a. Receives behavioral health services, and, if indicated in the resident's treatment plan, personal care services; and
   b. Is provided an opportunity to participate in activities designed to maintain or enhance the resident's ability to function independently while:
      i. The resident receives services to maintain the resident's health, safety, or personal hygiene; or
      ii. Homemaking functions are performed for the resident;
4. Behavioral health services are provided to meet the needs of a resident and are consistent with a behavioral health residential facility's scope of services;
5. Behavioral health services listed in the behavioral health residential facility's scope of services are provided on the premises;
6. Before a resident participates in behavioral health services provided in a setting or activity with more than one resident participating, the diagnoses, treatment needs, developmental levels, social skills, verbal skills, and personal histories, including any history of physical or sexual abuse, of the residents participating are reviewed to ensure that the:
   a. Health and safety of each resident is protected, and
   b. Treatment needs of each resident participating are being met; and
7. A resident does not:
   a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or
   b. Share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that may present a threat to the resident's health or safety, based on the other resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history.

**B.** ~~An~~ Except for respite services for individuals under 18 years of age, as specified in A.R.S. § 36-425.08, an administrator shall ensure that counseling is:
1. Offered as described in the behavioral health residential facility's scope of services,
2. Provided according to the frequency and number of hours identified in the resident's treatment plan, and
3. Provided by a behavioral health professional or a behavioral health technician.

**C.** ~~An~~ Except for respite services for individuals under 18 years of age, as specified in A.R.S. § 36-425.08, an administrator shall ensure that:
1. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
2. Each counseling session is documented in a resident's medical record to include:
   a. The date of the counseling session;
   b. The amount of time spent in the counseling session;
   c. Whether the counseling was individual counseling, family counseling, or group counseling;
   d. The treatment goals addressed in the counseling session; and
   e. The signature of the personnel member who provided the counseling and the date signed.

**D.** No change

1. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
            (1) No change
            (2) No change
    b. No change
2. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
        v. No change
b. No change
c. No change
d. No change
e. No change

**E.** No change

1. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
    b. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change

**F.** No change

1. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
    b. No change
        i. No change
        ii. No change
2. No change
    a. No change
    b. No change
    c. No change
3. No change

**R9-10-717. Outdoor Behavioral Health Care Programs**

**A.** No change

1. No change
2. No change
3. No change
4. No change

a. No change
b. No change
c. No change
d. No change

**B.** An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program shall ensure that:

1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a resident such as cut, chopped, ground, pureed, or thickened;
2. A food menu is prepared based on the number of calendar days scheduled for the behavioral health care program;
3. Meals and snacks provided by the behavioral health care program are served according to menus;
4. Meals and snacks for each day are planned using the applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2015~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture.
5. A resident is provided:
   a. A diet that meets the resident's nutritional needs as specified in the resident's assessment or treatment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(5)(d);
   c. The option to have a daily evening snack or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if the resident agrees;
6. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan;
7. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
8. Food is protected from potential contamination; and
9. Food being maintained in coolers containing ice is not in direct contact with ice or water if water may enter the food because of the nature of the food's packaging, wrapping, or container or the positioning of the food in the ice or water.

**C.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
4. No change
   a. No change
   b. No change
5. No change
6. No change
7. No change
8. No change
9. No change
   a. No change
   b. No change
   c. No change
10. No change

**R9-10-718. Medication Services**

**A.** Except for respite services for individuals under 18 years of age, as specified in A.R.S. § 36-425.08, an ~~An~~ administrator shall ensure that policies and procedures for medication services are established, documented, and implemented that:

1. Include:
   a. A process for providing information to a resident about medication prescribed for the resident including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,
      iii. The prescribed medication's potential side effects, and
      iv. Potential adverse reactions that could result from not taking the medication as prescribed;
   b. Procedures for preventing, responding to, and reporting any of the following:
      i. A medication error,
      ii. An adverse reaction to a medication, or
      iii. A medication overdose;

c. Procedures to ensure that a resident's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;

d. Procedures for documenting, as applicable, medication administration and assistance in the self-administration of medication;

e. A process for monitoring a resident who self-administers medication;

f. Procedures for assisting a resident in obtaining medication; and

g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and

2. Specify a process for review through the quality management program of:

a. A medication administration error, and

b. An adverse reaction to a medication.

**B.** No change

1. No change
   a. No change
   b. No change
      i. No change
      ii. No change
   c. No change
   d. No change
2. No change
3. No change
   a. No change
   b. No change

**C.** No change

1. No change
2. No change
   a. No change
   b. No change
   c. No change
   d. No change
      i. No change
      ii. No change
      iii. No change
   e. No change
3. No change
4. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
5. No change
6. No change
   a. No change
   b. No change

**D.** No change

1. No change
2. No change
3. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   b. No change
   c. No change
   d. No change

**E.** When medication is stored at a behavioral health residential facility, an administrator shall ensure that:

1. Except for naloxone nasal spray, medication ~~Medication~~ is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; ~~and~~
   d. Storing, inventorying, and dispensing controlled substances~~.~~; and
   e. If applicable, donated medicine according to A.R.S. § 32-1909.

**F.** No change

**R9-10-719. Food Services**

**A.** No change

1. No change
   a. No change
   b. No change
2. No change
3. No change
4. No change
5. No change

**B.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, a registered dietitian or director of food services shall ensure that:

1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
2. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served, except for respite services for individuals under 18 years of age, as specified in ~~-~~A.R.S. § 36-425.08,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
3. Meals and snacks provided by the behavioral health residential facility are served according to posted menus;
4. Meals and snacks for each day are planned using the applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2015~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
5. A resident is provided:
   a. A diet that meets the resident's nutritional needs as specified in the resident's assessment or treatment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(5)(d);
   c. The option to have a daily evening snack identified in subsection (B)(5)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      i. The resident agrees; and
      ii. The resident is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
6. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
7. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan.

**C.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change
      i. No change

ii. No change
iii. No change
iv. No change
v. No change
vi. No change

4. No change
5. No change
6. No change

**R9-10-720. Emergency and Safety Standards**

**A.** No change

1. No change
2. No change

**B.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
   a. When, how, and where residents will be relocated;
   b. How each resident's medical record will be available to individuals providing services to the resident during a disaster;
   c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
   d. A plan for obtaining food and water for individuals present in the behavioral health residential facility, under the care and supervision of personnel members, or in the behavioral health residential facility's relocation site during a disaster;
2. The disaster plan required in subsection (B)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (B)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and residents on the premises is conducted at least once every six months ~~on each shift~~;
6. Documentation of each evacuation drill is created, is maintained for 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for all employees and residents to evacuate the behavioral health residential facility;
   c. Names of employees participating in the evacuation drill;
   d. An identification of residents needing assistance for evacuation;
   e. Any problems encountered in conducting the evacuation drill; and
   f. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health residential facility.

**C.** An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal~~.~~;
2. Make any repairs or corrections stated on the fire inspection report~~, and~~;
3. Maintain documentation of a current fire inspection~~.~~;
4. Ensure that naloxone nasal spray is available and accessible to the administrator, personnel members, employees, volunteers, students and residents of the behavioral health residential facility.

**R9-10-722. Physical Plant Standards**

**A.** No change

1. No change
2. No change

**B.** An administrator shall ensure that:

1. A behavioral health residential facility has a:
   a. ~~Room that provides privacy~~ Privacy area for a resident or residents to receive treatment or visitors that is not a resident bedroom or a dining area~~.~~, and

b. Common area and a dining area that ~~contain~~ contains furniture and materials to accommodate the recreational and socialization needs of the residents and other individuals in the behavioral health residential facility;

2. At least one bathroom is accessible from a common area that:
   a. May be used by residents and visitors;
   b. Provides privacy when in use; and
   c. Contains the following:
      i. At least one working sink with running water,
      ii. At least one working toilet that flushes and has a seat,
      iii. Toilet tissue for each toilet,
      iv. Soap in a dispenser accessible from each sink,
      v. Paper towels in a dispenser or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A window that opens or another means of ventilation;
3. For every six residents who stay overnight at the behavioral health residential facility, there is at least one working toilet that flushes and has a seat, and one sink with running water;
4. For every eight residents who stay overnight at the behavioral health residential facility, there is at least one working bathtub or shower;
5. A resident bathroom provides privacy when in use and contains:
   a. A shatter-proof mirror, unless the resident's treatment plan allows for otherwise;
   b. A window that opens or another means of ventilation; and
   c. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
   d. Grab bars in the bathroom designed to minimize the opportunity for a resident to cause self-injury;
6. If a resident bathroom door locks from the inside, an employee has a key and access to the bathroom;
7. Each resident is provided a sleeping area that is in a bedroom; and
8. A resident bedroom complies with the following:
   a. Is not used as a common area;
   b. Is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of an individual occupying the bedroom;
   c. Contains a door that opens into a hallway, common area, or outdoors;
   d. Is constructed and furnished to provide unimpeded access to the door;
   e. Has window or door covers that provide resident privacy;
   f. Has floor to ceiling walls;
   g. Is a:
      i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
      ii. Shared bedroom that:
         (1) Is shared by no more than eight residents;
         (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and
         (3) Provides at least three feet of floor space between beds or bunk beds;
   h. Contains for each resident occupying the bedroom:
      i. A bed that is at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and linens; and
      ii. Individual storage space for personal effects and clothing such as shelves, a dresser, or chest of drawers;
   i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
   j. Has sufficient lighting for a resident occupying the bedroom to read; ~~and~~
   k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury~~.~~; and
   l. Has a window or door that can be used for direct egress to outside the building, if the facility does not have a fire sprinkler system.

**C.** A behavioral health residential facility that was licensed as a Level 4 transitional agency before October 1, 2013, may continue to use a shared bedroom that provides at least 40 square feet of floor space, not including a closet, for each individual occupying the shared bedroom. If there is a modification to the shared bedroom, the behavioral health residential facility shall comply with the requirement in subsection (B)(8)(g).

**D.** No change

1. No change
2. No change
   a. No change
      i. No change
      ii. No change
   b. No change
      i. No change
      ii. No change
   c. No change

**E.** No change
1. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
   b. No change
2. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
      i. No change
      ii. No change
      iii. No change
3. No change

**F.** No change

## ARTICLE 8. ASSISTED LIVING FACILITIES

**R9-10-802. Supplemental Application Requirements; Exemption**

**A.** No change
1. No change
   a. No change
   b. No change
   c. No change
2. No change
   a. No change
   b. No change

**B.** No change
1. No change
2. No change

**C.** An assisted living facility shall obtain a separate license for each single dwelling unit.

**R9-10-803. Administration**

**A.** No change
1. No change
2. No change
3. No change
   a. No change
   b. No change
      i. No change
      ii. No change
4. No change
5. No change
6. No change
   a. No change
   b. No change

7. No change
8. No change
9. No change
10. No change

**B.** No change

1. No change
2. No change
3. No change
   a. No change
   b. No change

**C.** A manager shall ensure that policies and procedures are:

1. Established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills and knowledge, education, and experience for employees and volunteers;
   b. Cover orientation and in-service education for employees and volunteers;
   c. Include how an employee may submit a complaint related to resident care;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Except as provided in subsection (M), cover cardiopulmonary resuscitation training for applicable employees and volunteers, including:
      i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the employee's or volunteer's ability to perform cardiopulmonary resuscitation;
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
      iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
      iv. The documentation that verifies that the employee or volunteer has received cardiopulmonary resuscitation training;
   f. Cover first aid training;
   g. Cover how a caregiver will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
   h. Cover staffing and recordkeeping;
   i. Cover resident ~~acceptance and resident~~ rights, including assisting a resident who does not speak English or who has a physical or other disability to become aware of resident rights;
   j. Cover termination of residency, including termination initiated by:
      i. ~~Termination initiated by the~~ The manager of an assisted living facility, and
      ii. ~~Termination initiated by a~~ A resident or the resident's representative;
   k. Cover the provision of assisted living services, including:
      i. Coordinating the provision of assisted living services,
      ii. Making vaccination for influenza and pneumonia available to residents according to A.R.S. § 36-406(1)(d), and
      iii. Obtaining resident preferences for food and the provision of assisted living services;
   l. Cover the provision of respite services or adult day health services, if applicable;
   m. Cover methods by which the assisted living facility is aware of the general or specific whereabouts of a resident, based on the level of assisted living services provided to the resident and the assisted living services the assisted living facility is authorized to provide;
   n. Cover resident medical records, including electronic medical records;
   o. Cover personal funds accounts, if applicable;
   p. Cover specific steps for:
      i. A resident to file a complaint, and
      ii. The assisted living facility to respond to a resident's complaint;
   q. Cover health care directives;
   r. Cover assistance in the self-administration of medication, and medication administration;
   s. Cover food services;
   t. Cover contracted services;
   u. Cover equipment inspection and maintenance, if applicable;
   v. Cover infection control; ~~and~~
   w. Cover a quality management program, including incident ~~report~~ reports and supporting documentation; and
   x. Cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02;
2. Available to employees and volunteers of the assisted living facility; and

3. Reviewed at least once every three years and updated as needed.

**D.** A manager shall ensure that the following are conspicuously posted:

1. A list of resident rights;
2. The assisted living facility's license;
3. Current phone numbers of:
   a. The unit in the Department responsible for licensing and monitoring the assisted living facility,
   b. Adult Protective Services in the Department of Economic Security,
   c. The State Long-Term Care Ombudsman, and
   d. ~~The Arizona Center for Disability Law~~ Disability Rights Arizona; and
4. The location at which a copy of the most recent Department inspection report and any plan of correction resulting from the Department inspection may be viewed.

**E.** No change

1. No change
2. No change

**F.** No change

1. No change
2. No change
3. No change

**G.** A manager shall:

1. Not act as a resident's representative and not allow an employee or a family member of an employee to act as a resident's representative for a resident who is not a family member of the employee;
2. No change
   a. No change
   b. No change
   c. No change
   d. No change
3. No change
4. No change

**H.** No change

**I.** If abuse, neglect, ~~or~~ exploitation , or reportable offense of a resident is alleged or suspected to have occurred before the resident was accepted or while the resident is not on the premises and not receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall report the alleged or suspected abuse, neglect, ~~or~~ exploitation, or reportable offense of the resident according to A.R.S. § 46-454.

**J.** If a manager has a reasonable basis, according to A.R.S. 9-§ 46-454, to believe abuse, neglect, ~~or~~ exploitation, or reportable offense has occurred on the premises or while a resident is receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall:

1. If applicable, take immediate action to stop the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense;
2. Report the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense of the resident according to A.R.S. § 46-454;
3. Document:
   a. The suspected abuse, neglect, ~~or~~ exploitation, or reportable offense;
   b. Any action taken according to subsection (J)(1); and
   c. The report in subsection (J)(2);
4. Maintain the documentation in subsection (J)(3) for at least 12 months after the date of the report in subsection(J)(2);
5. Initiate an investigation of the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense and document the following information within five working days after the report required in subsection (J)(2):
   a. The dates, times, and description of the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense;
   b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense; and
   d. The actions taken by the manager to prevent the suspected abuse, neglect, ~~or~~ exploitation, or reportable offense from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (J)(5) for at least 12 months after the date the investigation was initiated.

**K.** No change

1. No change
2. No change
3. No change

**L.** No change

1. No change
   a. No change
   b. No change
   c. No change
2. No change
   a. No change
   b. No change
   c. No change

**M.** ~~A~~ In addition to the requirements in R9-10-803(C), a manager of an assisted living ~~home~~ facility may establish, in policies and procedures, requirements that a caregiver obtains and provides documentation of cardiopulmonary resuscitation training specific to adults, which includes a demonstration of the caregiver's ability to perform cardiopulmonary resuscitation, from one of the following organizations:

1. American Red Cross,
2. American Heart Association, or
3. National Safety Council.

**R9-10-806. Personnel**

**A.** A manager shall ensure that:

1. A caregiver:
   a. Is 18 years of age or older; and
   b. Provides documentation of one of the following:
      i. Completion of a caregiver training program approved by the Department or the Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers, or as described in A.R.S. § 36-446.15;
      ii. Completion of a board-approved certified nursing assistant program that includes medication training;
      ~~ii.~~ iii. For supervisory care services, employment as a manager or caregiver of a supervisory care home before November 1, 1998;
      ~~iii.~~ iv. For supervisory care services or personal care services, employment as a manager or caregiver of a supportive residential living center before November 1, 1998; or
      ~~iv.~~ v. For supervisory care services, personal care services, or directed services, one of the following:
         (1) A nursing care institution administrator's license issued by the Board of Examiners;
         (2) A nurse's license issued to the individual under A.R.S. Title 32, Chapter 15;
         (3) Documentation of employment as a manager or caregiver of an unclassified residential care institution before November 1, 1998; or
         (4) Documentation of sponsorship of or employment as a caregiver in an adult foster care home before November 1, 1998;
2. An assistant caregiver:
   a. Is 16 years of age or older, and
   b. Interacts with residents under the supervision of a manager or caregiver;
3. The qualifications, skills, and knowledge required for a caregiver or assistant caregiver:
   a. Are based on:
      i. The type of assisted living services, behavioral health services, or behavioral care expected to be provided by the caregiver or assistant caregiver according to the established job description; and
      ii. The acuity of the residents receiving assisted living services, behavioral health services, or behavioral care from the caregiver or assistant caregiver according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description;
      ii. The type and duration of education that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description; and
      iii. The type and duration of experience that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the

expected assisted living services, behavioral health services, or behavioral care listed in the established job description;

4. A caregiver's or assistant caregiver's skills and knowledge are verified and documented:
   a. Before the caregiver or assistant caregiver provides physical health services or behavioral health services, and
   b. According to policies and procedures;
5. An assisted living facility has a manager, caregivers, and assistant caregivers with the qualifications, experience, skills, and knowledge necessary to:
   a. Provide the assisted living services, behavioral health services, behavioral care, and ancillary services in the assisted living facility's scope of services;
   b. Meet the needs of a resident; and
   c. Ensure the health and safety of a resident;
6. At least one manager or caregiver is present and awake at an assisted living center when a resident is on the premises;
7. Documentation is maintained for at least 12 months after the last date on the documentation of the caregivers and assistant caregivers working each day, including the hours worked by each;
8. A manager, a caregiver, and an assistant caregiver, or an employee or a volunteer who has or is expected to have more than eight hours per week of direct interaction with residents, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the assisted living facility, and
   b. As specified in R9-10-113;
9. Before providing assisted living services to a resident, a caregiver or an assistant caregiver receives orientation that is specific to the duties to be performed by the caregiver or assistant caregiver; ~~and~~
10. Before providing assisted living services to a resident, a manager or caregiver provides current documentation of first aid training and cardiopulmonary resuscitation training certification specific to adults~~.~~; and
11. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

**B.** No change
1. No change
   a. No change
      i. No change
      ii. No change
   b. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change
      i. No change
      ii. No change

**C.** A manager shall ensure that a personnel record for each employee or volunteer:
1. Includes:
   a. The individual's name, date of birth, and contact telephone number;
   b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
   c. Documentation of:
      i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
      ii. The individual's education and experience applicable to the individual's job duties;
      iii. The individual's completed orientation and in-service education required by policies and procedures;
      iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or in policies and procedures;
      v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
      vi. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(8);
      vii. Cardiopulmonary resuscitation training, if required for the individual in this Article or policies and procedures;
      viii First aid training, if required for the individual in this Article or policies and procedures;
      ix. ~~Documentation of compliance~~ Compliance with the requirements in A.R.S. § 36-411(A) and (C); and
      x. The certificate of completion, according to R9-10-126;
2. Is maintained:

a. Throughout the individual's period of providing services in or for the assisted living facility, and
b. For at least 24 months after the last date the individual provided services in or for the assisted living facility; and

3. For a manager, a caregiver, or an assistant caregiver who has not provided physical health services or behavioral health services at or for the assisted living facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.

**R9-10-807. Residency and Residency Agreements**

**A.** No change
1. No change
2. No change

**B.** No change
1. No change
   a. No change
      i. No change
      ii. No change
      iii. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
2. No change
   a. No change
   b. No change

**C.** No change
1. No change
   a. No change
   b. No change
   c. No change
2. No change
3. No change
4. No change
5. No change

**D.** No change
1. No change
2. No change
   a. No change
   b. No change
   c. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change

**E.** No change
1. No change
2. No change
3. No change
4. No change

**F.** A manager shall:
1. Before or at the time of an individual's acceptance by an assisted living facility, provide to the resident or resident's representative a copy of:
   a. The residency agreement in subsection (D),
   b. Resident's rights, and

c. The policy and procedure on health care directives; and

2. Maintain the original ~~of the~~ residency agreement in subsection (D) in the resident's medical record.

**G.** A manager may terminate the residency of a resident as follows:

1. Without notice, if the resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in an assisted living facility;
2. With a 14-calendar-day written notice of termination of residency:
   a. For nonpayment of fees, charges, or ~~deposit~~ deposits; or
   b. Under any of the conditions in subsection (C); or
3. With a 30-calendar-day written notice of termination of residency, for any other reason.

**H.** A manager shall ensure that the written notice of termination of residency in subsection (G) includes:

1. The date of notice;
2. The reason for termination;
3. The policy for refunding fees, charges, or deposits;
4. The ~~deposition~~ disposition of a resident's fees, charges, and deposits; and
5. Contact information for the State Long-Term Care Ombudsman.

**I.** No change

1. No change
2. No change

**J.** No change

**R9-10-809. Transport; Transfer**

**A.** Except as provided in subsection (B), a manager shall ensure that:

1. No change
2. No change
   a. No change
   b. No change
3. Documentation includes:
   a. If applicable, any communication with an individual at a receiving health care institution;
   b. The date and time of the transport; ~~and~~
   c. If applicable, the name of the caregiver accompanying the resident during a transport~~.~~;
   d. If applicable, the information required in A.R.S. 36-420.04.

**B.** Subsection (A) does not apply to:

1. Transportation to a location other than a licensed health care institution, or
2. Transportation provided for a resident by the resident or the resident's representative, or arranged by a resident or the resident's representative~~,~~.
3. ~~Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or~~
4. ~~A transport to another licensed health care institution in an emergency.~~

**C.** Except for a transfer of a resident due to an emergency, a manager shall ensure that:

1. A caregiver coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before the transfer;
   b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A caregiver explains the risks and benefits ~~of the transfer~~ associated with the transfer process to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the caregiver accompanying the resident during a transfer.

**R9-10-810. Resident Rights**

**A.** No change

**B.** A manager shall ensure that:

1. No change
2. No change
   a. No change
   b. No change

c. No change
d. No change
e. No change
f. No change
g. No change
h. No change
i. No change
j. No change
k. No change

3. No change
   a. No change
      i. No change
      ii. No change
   b. No change
   c. No change
      i. No change
      ii. No change
   d. No change
      i. No change
      ii. No change
   e. No change
   f. No change
      i. No change
      ii. No change
      iii. No change

**C.** A resident has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive assisted living services that support and respect the resident's individuality, choices, strengths, and abilities;
3. To receive privacy in:
   a. Care for personal needs;
   b. Correspondence, communications, and visitation; and
   c. Financial and personal affairs;
4. To maintain, use, and display personal items unless the personal items constitute a hazard;
5. To choose to participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities;
6. To review, upon written request, the resident's own medical record;
7. To receive a referral to another health care institution if the assisted living facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
8. To choose to access services from a health care provider, health care institution, or pharmacy other than the assisted living facility where the resident is residing and receiving services or a health care provider, health care institution, or pharmacy recommended by the assisted living facility;
9. To participate or have the resident's representative participate in the development of, or decisions concerning, the resident's service plan; ~~and~~
10. To participate in religious visitation by a clergy member according to A.R.S. § 36-407.02; and
~~10.~~11. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

**R9-10-811. Medical Records**

**A.** A manager shall ensure that:

1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
   a. Only recorded by an individual authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the resident's medical record and includes the time of the order;

b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and

c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;

~~3.~~4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;

~~4.~~5. A resident's medical record is available to an individual:

a. Authorized according to policies and procedures to access the resident's medical record;

b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or

c. As permitted by law; and

~~5.~~6. A resident's medical record is protected from loss, damage, or unauthorized use.

**B.** No change

1. No change
2. No change

**C.** A manager shall ensure that a resident's medical record contains:

1. Resident information that includes:
   a. The resident's name, and
   b. The resident's date of birth;
2. The names, addresses, and telephone numbers of:
   a. The resident's primary care provider;
   b. Other persons, such as a home health agency or hospice service agency, involved in the care of the resident; and
   c. An individual to be contacted in the event of an emergency, significant change in the resident's condition, or termination of residency;
3. If applicable, the name and contact information of the resident's representative and:
   a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
   b. If the resident's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
4. The date of acceptance and, if applicable, the date of termination of residency;
5. Documentation of the resident's needs required in R9-10-807(B);
6. Documentation of general consent and informed consent, if applicable;
7. Except as allowed in R9-10-808(B)(2), documentation of freedom from infectious tuberculosis as required in R9-10-807(A);
8. A copy of the resident's health care directive, if applicable;
9. The resident's signed residency agreement and any amendments;
10. Resident's service plan and updates;
11. Documentation of assisted living services provided to the resident;
12. A medication order from a medical practitioner for each medication that is administered to the resident or for which the resident receives assistance in the self-administration of the medication;
13. Documentation of medication administered to the resident or for which the resident received assistance in the self-administration of medication that includes:
    a. The date and time of administration or assistance;
    b. The name, strength, dosage, and route of administration;
    c. The name and signature of the individual administering or providing assistance in the self-administration of medication; and
    d. An unexpected reaction the resident has to the medication;
14. Documentation of the resident's refusal of a medication, if applicable;
15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
16. If applicable, documentation of a determination by a medical practitioner that evacuation from the assisted living facility during an evacuation drill would cause harm to the resident;

17. Documentation of notification of the resident of the availability of vaccination for influenza and pneumonia, according to A.R.S. § 36-406(1)(d);
18. Documentation of the resident's orientation to exits from the assisted living facility required in R9-10-819(B);
19. If a resident is receiving behavioral health services other than behavioral care, documentation of the determination in R9-10-813(3);
20. If a resident is receiving behavioral care, documentation of the determination in R9-10-812(3);
21. If applicable, for a resident who is unable to direct self-care, the information required in R9-10-815(F);
22. Documentation of any significant change in a resident's behavior, physical, cognitive, or functional condition and the action taken by a manager or caregiver to address the resident's changing needs;
23. Documentation of the notification required in R9-10-803(G) if the resident is incapable of handling financial affairs; and
24. If the resident no longer resides and receives assisted living services from the assisted living facility:
    a. A written notice of termination of residency; or
    b. If the resident terminated residency, the date the resident terminated residency.

**R9-10-817. Medication Services**

**A.** No change
1. No change
    a. No change
    b. No change
    c. No change
    d. No change
        i. No change
        ii. No change
    e. No change
    f. No change
2. No change
    a. No change
    b. No change
    c. No change

**B.** If an assisted living facility provides medication administration, a manager shall ensure that:
1. Medication is stored by the assisted living facility;
2. Policies and procedures for medication administration:
    a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;
    b. Include a process for documenting an individual, authorized, according to the definition of "administer" in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;
    c. Ensure that medication is administered to a resident only as prescribed; and
    d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record; and
3. A medication administered to a resident:
    a. Is administered by an individual under the direction of a medical practitioner,
    b. Is administered in compliance with a medication order, and
    c. Is documented in the resident's medical record.

**C.** No change
1. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
        i. No change
        ii. No change
        iii. No change
    e. No change
    f. No change
3. No change
4. No change
    a. No change

b. No change

**D.** No change

1. No change
2. No change

**E.** No change

1. No change
2. No change
3. No change
4. No change
5. No change

**F** When medication is stored by an assisted living facility, a manager shall ensure that:

1. Except for naloxone nasal spray, medication ~~Medication~~ is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; ~~and~~
   d. Storing, inventorying, and dispensing controlled substances~~.~~; and
   e. If applicable, donated medicine according to A.R.S. § 32-1909.

**G.** A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.

**H.** No change

1. No change
2. No change

**R9-10-818. Food Services**

**A.** A manager shall ensure that:

1. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu is served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the assisted living facility are served according to posted menus;
3. If the assisted living facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the assisted living facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the assisted living facility;
4. The assisted living facility is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
5. Meals and snacks for each day are planned using the applicable guidelines in ~~http://www.health.gov/dietaryguidelines/2015~~ the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
6. A resident is provided a diet that meets the resident's nutritional needs as specified in the resident's service plan;
7. Water is available and accessible to residents at all times, unless otherwise stated in a medical practitioner's order; and
8. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the provision of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the resident.

**B.** No change

1. No change
2. No change

**C.** No change

1. No change
2. No change
3. No change

a. No change
b. No change

4. No change
   a. No change
   b. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
5. No change
6. No change
7. No change

**D.** No change
1. No change
2. No change

**R9-10-821. Physical Plant Standards**

**A.** A manager shall ensure that an assisted living center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that:
1. Are applicable to the level of services planned to be provided or being provided; and
2. Were in effect on the date the assisted living facility submitted the application packet including the notarized attestation of architectural plans ~~and specifications to the Department for approval~~, according to R9-10-104.

**B.** No change
1. No change
   a. No change
   b. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change
   c. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
      vii. No change
5. No change
   a. No change
   b. No change
   c. No change
6. No change
7. No change

**C.** No change
1. No change
2. No change
3. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change

**D.** No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
3. No change
4. No change
    a. No change
    b. No change
        i. No change
        ii. No change
    c. No change
    d. No change
    e. No change
    f. No change
5. No change
    a. No change
    b. No change
    c. No change
6. No change
    a. No change
    b. No change
    c. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
        v. No change
        vi. No change
        vii. No change
        viii. No change
    d. No change
    e. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
    f. No change
        i. No change
        ii. No change
7. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
    f. No change

**E.** No change

1. No change
2. No change
3. No change

**F.** If there is a swimming pool on the premises of the assisted living facility, a manager shall ensure that:

1. Unless the assisted living facility has documentation of having received an exception from the Department before October 1, 2013, the swimming pool is enclosed by a wall or fence that:
    a. Is at least five feet in height as measured on the exterior of the wall or fence;
    b. Has no vertical openings greater ~~that~~ <u>than</u> four inches across;

c. Has no horizontal openings, except as described in subsection (F)(1)(e);

d. Is not chain-link;

e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and

f. Has a self-closing, self-latching gate that:

i. Opens away from the swimming pool,

ii. Has a latch located at least 54 inches from the ground, and

iii. Is locked when the swimming pool is not in use;

2. A life preserver or shepherd's crook is available and accessible in the swimming pool area; and

3. Pool safety requirements are conspicuously posted in the swimming pool area.

**G.** No change


**TITLE 9. HEALTH SERVICES**

**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES -**
**HEALTH CARE INSTITUTIONS: LICENSING**
**ARTICLE 1. GENERAL,**
**ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES, and**
**ARTICLE 8. ASSISTED LIVING FACILITIES**

# ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

**February 2025**

# ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT
# TITLE 9. HEALTH SERVICES
# CHAPTER 10. DEPARTMENT OF HEALTH SERVICES -
# HEALTH CARE INSTITUTIONS: LICENSING
# ARTICLE 1. GENERAL,
# ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES
# ARTICLE 8. ASSISTED LIVING FACILITIES

## 1. An identification of the rulemaking

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) require the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions. To ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 require the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions. The Department has adopted rules to implement these statutes in Arizona Administrative Code Title 9, Chapter 10. The Department plans to amend the rules to the following statutory changes: Laws 2022, Ch. 179, requires the Department to ensure a health care institution's visitation policy allows a clergy member to visit a resident, Laws 2022, Ch. 296, requires the Department to ensure a hospital develops a visitation policy, especially during end-of-life care, and Laws 2022, Ch. 34, amends the requirements for architectural plans and specifications for health care institutions construction or modifications. After receiving rulemaking approval pursuant to A.R.S. § 41-1039, the Department plans to conduct a rulemaking to adhere to the statutory changes identified above, address issues identified in recent five-year reports approved by the Governor's Regulatory Review Council (GRRC), make the rules clearer and more concise and understandable, update cross-references, correct grammatical errors, and amend rules necessary for the proper administration and enforcement of the laws relating to public health. The Department anticipates that the rules may increase the regulatory burden or cost on some affected persons. However, the Department believes that the benefits of the rules will far outweigh any potential cost. Any proposed changes will conform to the rulemaking format and style requirements of GRRC and the Office of the Secretary of State.

## 2. Cost/Benefit Analysis

This analysis covers the costs and benefits associated with the rule changes related to implementing Laws 2021, Ch 137, Laws 2022, Ch. 179, Laws 2022, Ch. 296, and Laws 2022, Ch. 34; addressing issues identified in recent five-year review reports; and amending rules necessary for the proper administration and enforcement of the laws relating to public health. The annual cost and revenue changes are designated as minimal when $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs

or revenues. Costs are listed as significant when meaningful or important, but not readily subject to quantification.

**3. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rules**

a. The Department
b. Behavioral health residential facilities
c. Assisted living facilities
d. Health care providers (including behavioral health professionals), social workers, and residents and their families
d. The general public

**A. The Department**

Throughout the rules, the Department is implementing new rules to align with statutory requirements including; Laws 2021, Ch. 137, related to medical donation; Laws 2022, Ch. 34 – Architectural Plans and Specifications; Laws 2022, Ch. 179 and Laws 2022, Ch. 296 both related to visitation policy. In addition, other changes are being made to align with other rules in Chapter 10, update cross-references, and correct grammatical errors. For example, the Department is amending the title of R9-10-715 from "Physical Health Services" to "Personal Care Services" for consistency with other Articles in Chapter 10. In addition, the Department is adding a new requirement in R9-10-702 and R9-10-802 for a behavioral health residential facility to obtain a separate license for each single dwelling unit. The new rule is expected to close loopholes that may allow future licensees to operate multiple dwelling units under a single license. The Department expects to receive a significant benefit from the updated rules to ensure public health and safety as well as sufficient oversight of facilities.

Laws 2022, Ch. 179 and Laws 2022, Ch. 296, both related to visitation policy, establish A.R.S. § 36-407.02. The new statute requires hospitals to develop a visitation policy that allows a patient to have daily in-person visitation by a designated visitor of the patient's choice, including the patient's spouse, parent, or child. If a physician denies visitation, the patient or the patient's representative may request a meeting with the physician and one of the outlined hospital officials to receive a review and explanation within 24 hours of the decision to deny visitation. Additionally, the statute requires health care institutions to allow clergy members to visit a resident if the healthcare institution's visitation policy allows any kind of in-person visitation or when a resident's death is imminent. A hospital's visitation policy must ensure that the patient and the patient's visitors may have physical contact, especially during end-of-life visitation, unless a physician determines based on the patient's condition that the visitation does not meet health and safety standards or is reasonably likely to harm the patient. A visitor may file a complaint with the Department if the designated visitor's request for visitation is

denied or not resolved at the meeting with hospital officials. Due to these changes, the Department is amending language in R9-10-703, R9-10-803, R9-10-810 to add a requirement for policies and procedures to cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02.

Additionally, the Department is aligning language in R9-10-703 and R9-10-803 with A.R.S. § 13-3620 and 46-454, stipulating that any "reportable offense" must be reported when addressing suspected cases of abuse, neglect, or exploitation. Moreover, revisions to the meal and snack plan outlined in R9-10-717, R9-10-719, and R9-10-817 will incorporate the latest dietary guidelines from the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

In R9-10-718 and R9-10-816, the Department is incorporating the requirements in A.R.S. § 32-1909, regarding the policies and procedures of accepting medications from donors to behavioral health residential facilities and assisted living facilities as authorized recipients. Laws 2021, Ch. 137, related to medical donation, amends A.R.S. § 32-1909. The bill establishes requirements and prohibitions for donating, accepting, and dispensing donated prescription medications. The statute requires that prescription medications be accepted or dispensed by the program only in the original, sealed, and tamper-evident unit dose packaging, except that opened prescription medications packaged in single unit doses can be accepted and dispensed if the single unit dose packaging is undisturbed. Prescription donations cannot be accepted if the medication expires within six months or if the medication is deemed to be adulterated. The Arizona State Board of Pharmacy has established a Prescription Medication Donation Program (Program) to accept and dispense prescription medications, HCIs that opt-in to the Program and meet prescribed criteria may accept donated medications. The Department is amending rules in Chapter 10 to require that when medication is stored, an administrator shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a resident for medical donation, in compliance with A.R.S. § 32-1909.

In addition to updating the rules to align with new statutory changes, the Department is making other changes to the rules to improve the effectiveness of rules, make the rules more clear, concise, and understandable, address issues identified in recent five-year review reports, and correct cross-references and grammatical errors throughout Articles 7 & 8.

Overall, the Department estimates that the new changes may require up to minimal costs to implement the new changes and work with affected stakeholders to properly educate and implement the new rules, but believes that there will be a significant benefit for having rules that are expected to enhance resident care and operational efficiency in the long term.

**B. Behavioral Health Residential Facilities**

A.R.S. §§ 36-132(A)(17) and 36-405(A) & (B) authorize the Department to license and regulate health care institutions. 9 A.A.C. 10, Article 7 governs Behavioral Health Residential Facilities, Adult Residential Care Institutions, and Secured Behavioral Health Residential Facilities. The Department is amending 15 Sections in Article 7, as well as one Sections in Article 1 in correspondence with the new changes in Article 7. The proposed new changes to the rules in Article 7 will affect all of these behavioral health subclasses.

As of September 3, 2024, there are 904 licensed behavioral health residential facilities in Arizona. The Department received 632 initial applications in FY 2024. Between July 1, 2023 to September 1, 2025, the Department also conducted 583 initial application inspections, 1,594 compliance surveys, 906 complaint surveys, 662 monitoring surveys, and 573 surveys resulted in an enforcement action to include an assessment of $279,300 in monetary penalties, 82 application denials, 91 Notices of Intent to Revoke issued, and 2 Summary Suspensions issued. There were 768 behavioral health residential facilities that surrendered their license and 18 behavioral health residential facilities with licenses revoked in FY2024.

Throughout Article 7, the Department is amending rules to implement Laws 2021, Ch. 355, § 1, which requires the Department to allow for an exception from licensure requirements for respite services for individuals under 18 years of age at behavioral health residential facilities, as specified in A.R.S. 36-425.08. Changes in the rules to reflect this exemption are in R9-10-702, R9-10-707, R9-10-709, R9-10-716, R9-10-718, and R9-10-719.

In R9-10-703, the Department is adding a requirement that the specific types of treatment and services to be provided be documented in writing. The Department does not expect there to be costs associated with this change. This is a clarification that treatment is required at the facility. Also, in R9-10-703, the Department is amending rules to be consistent with A.R.S. § 13-3620 and 46-454, by adding a requirement in the rules for policies and procedures to include methods on how to prevent abuse or neglect of a resident, including annual training of personnel members on how to recognize the signs, symptoms, and reporting of abuse or neglect.

The Department is enacting several revisions across multiple regulations. Firstly, in R9-10-720, evacuation drill requirements are being streamlined, no longer necessitating drills during each shift. Additionally, amendments to R9-10-722 focus on enhancing health and safety standards within facilities, including specifications such as installing grab bars in bathrooms to mitigate self-injury risks and ensuring each resident's bedroom has a direct egress point to the exterior. These changes align with existing regulations in Chapter 10, emphasizing the need for consistency and resident safety. Furthermore, in R9-10-703 and R9-10-718, established requirements must now be implemented. R9-10-703 is also being updated to reference A.R.S. § 13-4521 regarding resident documentation requirements. Obsolete mandates are being removed, and rules are being adjusted to align with others in Chapter 10, such as prohibiting administrators from acting as a resident's representative if they're

unable to handle financial affairs. Lastly, in R9-10-706 and R9-10-707, the term "co-occuring" is being replaced with "co-morbidity." These changes are anticipated to enhance safety protocols, streamline operations, and promote regulatory coherence. Additionally, they may incur initial implementation costs but are expected to yield long-term benefits by ensuring resident well-being and compliance with regulatory standards.

The Department is amending several rules to include the allowance for naloxone to be available and used at a behavioral health facility. In R9-10-703, R9-10-706, R9-10-718, R9-10-720, the Department is adding a requirement for policies and procedures to cover the provision of naloxone. Per the CDC, naloxone is a life-saving medication used to reverse an opioid overdose, including heroin, fentanyl, and prescription opioid medications. Naloxone can be quickly given through nasal spray (Narcan®) in the nose. Naloxone is safe and easy to use, works almost immediately, and is not addictive. Naloxone has very few negative effects and has no effect if opioids are not in a person's system. Arizona's Good Samaritan Law, A.R.S. § 32-1471, protects those giving emergency medical care at the scene of a medical emergency, including giving naloxone. Having naloxone available provides an extra layer of protection for those at a higher risk of overdose. Bystanders such as friends, family, non-health care providers, and persons who use drugs can reverse an opioid overdose with naloxone.

Furthermore, in R9-10-706, the Department is creating a new subsection to require that an administrator ensure that the qualifications, skills, and knowledge required for each type of personnel member meet the unique needs of the client populations served by the agency, such as children, adults age 65 or older, individuals with a substance abuse problem, individuals who are seriously mentally ill, individuals who have co-occurring disorders, or individuals who may be victims or perpetrators of domestic violence. Also, in R9-10-706, the Department added eligibility requirements for a behavioral health paraprofessional and behavioral health technician. In correspondence with this change, the Department is also amending the eligibility requirements for a behavioral health paraprofessional and behavioral health technician in Article 1, R9-10-115, consistent with the new changes in R9-10-706. Also in R9-10-706, the Department is adding a clarification that a behavioral health professional or registered nurse is employed at the behavioral health residential facility. Overall, the Department is implementing these changes to align with the proper scope of practices for these professionals. The Department expects that facilities may incur moderate costs due to the new requirements, but receive a significant benefit from having qualified staff working in a behavioral health residential facility. In addition, the Department expects that increasing the qualification requirements will save costs incurred by both the Department, individuals, and facilities on legal fees and time spent on the process of revoking a license.

The Department is amending the rules in R9-10-710 to remove the current rule that exempts a transport to another licensed health care institution in an emergency from the documentation and communication

requirements. This change may impose a minimal cost involving the time to document and communicate with emergency personnel and provide justification for an emergency transport.

Also, the Department is amending rules in R9-10-712 to add a reference to when a resident receives assistance in the self-administration of medication. Also, in R9-10-712, the Department is adding specifications in the documentation regarding the date and time, name, strength, dosage, and route of the medication, the staff personnel providing assistance, and any unexpected reaction to the medication. This change also aligns with Article 8 and is expected to provide a significant benefit for having more transparent documentation. In R9-10-712, references are added regarding medication administration assistance, alongside specifications for documentation. This aligns with Article 8 and is anticipated to notably enhance resident care. Furthermore, in R9-10-713, the Department is lowering the requirements by removing subsection (B)(2), which requires there to be at least two staff members present on an outing. The current (B)(3), states that sufficient staff is required on an outing. The Department expects that some facilities may receive a significant benefit and save minimal costs by not having to have more than one employee on an outing if it is not required. Additionally, in R9-10-716, standards for providing behavioral health services at residential facilities are being clarified and expanded to ensure resident health and safety. These adjustments may involve up to minimal implementation costs, but are expected to provide a significant benefit by enhancing resident care and compliance.

The Department is streamlining requirements outlined in R9-10-720, no longer mandating evacuation drills to be conducted during each shift. Furthermore, amendments to rules in R9-10-722 are being made for health and safety purposes, particularly regarding physical plant standards. These amendments include specifications such as ensuring that grab bars in bathrooms are designed to mitigate the risk of self-injury by residents and requiring each resident's bedroom to have a window or door providing direct egress to the exterior of the building. These adjustments are in line with the regulations set forth in other Articles within Chapter 10. The Department emphasizes the importance of including a mandate for windows in bedrooms to ensure consistency and enhance safety measures, particularly for egress and fire safety purposes, thus prioritizing the well-being of the residents.

The overall economic impact of the rulemaking on behavioral health residential facilities is expected to be minimal. New requirements and changes in the existing requirements are designed to improve public safety and regulatory efficiency should also have a minimal to moderate economic impact. Behavioral health residential facilities are expected to benefit from the updated rules that better protect the public, and accurately reflect industry standards and practices, are consistent with federal and state statutes and rules.

### C. Assisted Living Facilities

The rules in 9 A.A.C. 10, Article 8, were promulgated to comply with Laws 2011, Ch. 96 that required the Department to adopt rules for health care institutions to reduce monetary or regulatory costs on a person or

individuals and facilitate licensing of "integrated health programs that provide both behavioral and physical health services." A.R.S. § 36-401(8) defines an "assisted living facility" as a residential care institution, including an adult foster care home, that provides or contracts to provide supervisory care services, personal care services, or directed care services on a continuous basis. The Department currently licenses and regulates adult foster care homes according to the assisted living facility rules. In this rulemaking, the Department is amending ten Sections in Article 8.

In R9-10-803 the Department is amending rules for a manager to ensure that policies and procedures related to a resident's rights include assisting a resident who does not speak English or who has a physical or other disability to become aware of resident rights. Additionally, in R9-10-803, the Department is updating the title of The Arizona Center for Disability Law to Disability Rights Arizona. In R9-10-806, the Department is adding a new subsection requiring documentation of completion of a board-approved certified nursing assistant (CNA) program that includes medication training. Due to the high number of enforcement actions related to falsified or invalid caregiver certificates, the Department proposes that caregiver certificates must be issued after August 3, 2013, to ensure they can be verified. Additionally, the Department aims to expand the workforce by allowing CNAs who receive medication training to also work as caregivers. The nursing board currently provides medication training for CNAs.

In R9-10-807 and R9-10-809, the Department is amending the rules to correct grammatical errors and rewording language to be more simple, clear, concise, and understandable. In R9-10-811, the Department is creating a new subsection to address requirements for an order including that the order is dated, timed, and authenticated by a medical practitioner or behavioral health professional according to policies and procedures.

Laws 2022, Ch. 34, related to architectural plans and specifications, amends A.R.S. §§ 36-405, 36-421, and 36-422. The new statutory changes remove the requirement that an HCI license application include architectural plans and specifications and instead requires a notarized attestation from a licensed architect that verifies architectural plans meet or exceed the Department's standards. In addition, the new statutory changes repeals the Department's authority to establish fees for architectural plans and specifications reviews. Due to these changes, the Department is amending language in R9-10-820. The Department anticipates that the new changes will provide a significant benefit

The overall economic impact of the rulemaking on assisted living facilities is expected to be minimal-to-moderate. New requirements and changes in the existing requirements are designed to improve public safety and regulatory efficiency should also have a minimal to moderate economic impact. Assisted living facilities are expected to benefit from the updated rules that better protect the public, and accurately reflect industry standards and practices, are consistent with federal and state statutes and rules.

**D. Health care providers (including behavioral health professionals), social workers, and residents and their families**

The proposed rule changes are expected to have a minimal-to-moderate economic impact on healthcare providers, behavioral health professionals, social workers, and residents and their families. Healthcare providers may incur minimal costs related to increased staff training, compliance with new documentation and medication handling requirements, and facility upgrades to meet physical safety standards. Behavioral health facilities may incur minimal-to-moderate costs due to stricter staff qualifications and licensing requirements for single dwelling units. However, the Department believes that despite the increased costs of compliance, health care providers will receive a significant benefit by following rules that require qualified staff to work within their scope, resulting in better patient outcomes. Social workers may experience a rise in administrative tasks and reporting responsibilities but should see minimal direct financial impact. Residents and their families, while benefiting from improved safety, care standards, and visitation rights, may experience indirect cost increases as facilities adjust to the new regulations. However, the long-term benefits of improved resident care, safety, and regulatory compliance are anticipated to outweigh the initial financial burdens.

**C. General Public**

The general public is expected to receive a significant benefit from the new rules by having behavioral health residential facilities and assisted living facilities operated properly by qualified health professionals. The economic impact of the new rules on the general public is expected to be minimal to moderate. Increased operational costs for healthcare providers, including compliance with stricter safety standards, staff training, and reporting requirements, may result in increased business fees that could be passed on to residents and their families. However, the rule changes are designed to improve care quality, reduce instances of abuse and neglect, and enhance resident safety, which could lead to long-term public health cost savings. Overall, while there may be some short-term financial effects, the benefits of improved care and safety are expected to outweigh the costs.

**A statement of the probable impact of the rules on small businesses**

Small businesses may incur minimal-to-moderate costs due to increased compliance requirements, such as mandatory staff training, policy updates, documentation, and adherence to stricter safety standards. These requirements could lead to increased operational costs, including investments in infrastructure (e.g., installing safety equipment like grab bars or ensuring direct egress from resident rooms) and ensuring that all staff members meet the updated qualifications. However, the Department estimates that small businesses are likely to

receive a significant long-term benefit from the new rules. By enhancing care quality, safety, and regulatory compliance, small businesses may see improvements in operational efficiency and reduced liability risks, ultimately lowering costs associated with legal issues, penalties, or facility closures. Moreover, aligning with state and federal standards could improve the reputation of these facilities, attracting more clients and strengthening business viability. Overall, while small businesses may incur up to moderate costs during the initial implementation phase, the long-term benefits of regulatory compliance, enhanced safety, and improved service quality are expected to be a significant benefit and outweigh any costs incurred.

**a. Identification of the small businesses subject to the rules**

Small businesses subject to the rule may include behavioral health residential facilities and assisted living facilities that are privately owned.

**b. The administrative and other costs required for compliance with the rules**

A summary of the administrative effects of the rulemaking is given in the cost and benefit analysis in Section 2.

**c. A description of the methods that the agency may use to reduce the impact on small businesses**

The Department knows of no other methods to further reduce the impact on small businesses.

**d. The probable costs and benefits to private persons and consumers who are directly affected by the rules**

A summary of the effects of the rulemaking on private persons and consumers is given in the cost and benefit analysis.

**6. A statement of the probable effect on state revenues**

The rulemaking is not expected to have an effect on state revenues.

**7. A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking**

The Department has determined that there are no less intrusive or less costly alternatives for achieving the purpose of the rulemaking.

**8. A description of any data on which the rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data**

Not applicable

# TITLE 9. HEALTH SERVICES

## CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

Authority: A.R.S. §§ 36-132(A)(1), 36-136, 36-405, and 36-406

## ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

**R9-10-701. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:

"Emergency safety response" means physically holding a resident to manage the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual.

**R9-10-702. Supplemental Application and Documentation Submission Requirements**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a behavioral health residential facility shall include on the application:

1. Whether the applicant is planning to provide:
   a. Behavioral health services to individuals under 18 years of age, including the licensed capacity requested;
   b. Behavioral health services to individuals 18 years of age and older, including the licensed capacity requested; or
   c. Respite services;
2. Whether the applicant is requesting authorization to provide an outdoor behavioral health care program, including:
   a. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 12 to 17 years of age, and
   b. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 18 to 24 years of age;
3. Whether the applicant is requesting authorization to provide:
   a. Court-ordered evaluation,
   b. Court-ordered treatment,
   c. Behavioral health services to individuals 18 years of age or older whose behavioral health issue limits the individuals' ability to function independently, or
   d. Personal care services;
4. Whether the applicant is requesting authorization to provide recidivism reduction services as an adult residential care institution, including the requested licensed capacity for providing recidivism reduction services;
5. For a behavioral health residential facility requesting authorization to provide respite services, the requested number of individuals the behavioral health residential facility plans to admit for respite services who:
   a. Are included in the requested licensed capacities in subsections (A)(1)(a) and (b),
   b. Are under 18 years of age and who do not stay overnight in the behavioral health residential facility, and
   c. Are 18 years of age and older and who do not stay overnight in the behavioral health residential facility; and
6. For an outdoor behavioral health care program, a copy of the outdoor behavioral health care program's current accreditation report.

**B.** A licensee of an outdoor behavioral health care program shall submit a copy of the outdoor behavioral health care program's current accreditation report to the Department with the relevant fees required in R9-10-106(C).

**R9-10-703. Administration**

**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a behavioral health residential facility;
2. Establish, in writing:
   a. A behavioral health residential facility's scope of services, and
   b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-704;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
   a. Expected not to be present on the behavioral health residential facility's premises for more than 30 calendar days, or
   b. Not present on the behavioral health residential facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

**B.** An administrator:



Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

1. Is directly accountable to the governing authority of a behavioral health residential facility for the daily operation of the behavioral health residential facility and all services provided by or at the behavioral health residential facility;
2. Has the authority and responsibility to manage the behavioral health residential facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the behavioral health residential facility's premises and accountable for the behavioral health residential facility when the administrator is not present on the behavioral health residential facility's premises.

**C.** An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
   b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
   c. Include how a personnel member may submit a complaint relating to services provided to a resident;
   d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
   e. Cover cardiopulmonary resuscitation training including:
      i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
      ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
      iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
      iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
   f. Cover implementation of the requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;
   g. Cover implementation of the requirements in A.R.S. § 8-804, if applicable;
   h. Cover first aid training;
   i. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
   j. Cover resident rights, including assisting a resident who does not speak English or who has a physical or other disability to become aware of resident rights;
   k. Cover specific steps for:
      i. A resident to file a complaint, and
      ii. The behavioral health residential facility to respond to a resident complaint;
   l. Cover health care directives;
   m. Cover medical records, including electronic medical records;
   n. Cover a quality management program, including incident reports and supporting documentation;
   o. Cover contracted services; and
   p. Cover when an individual may visit a resident in a behavioral health residential facility;
2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover resident screening, admission, assessment, treatment plan, transport, transfer, discharge planning, and discharge;
   b. Cover the provision of behavioral health services and physical health services;
   c. Include when general consent and informed consent are required;
   d. Cover emergency safety responses;
   e. Cover a resident's personal funds account;
   f. Cover dispensing medication, administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
   g. Cover prescribing a controlled substance to minimize substance abuse by a resident;
   h. Cover respite services, including, as applicable, respite services for individuals who are admitted:
      i. To receive respite services for up to 30 calendar days as a resident of the behavioral health residential facility, and
      ii. For respite services and do not stay overnight in the behavioral health residential facility;
   i. Cover services provided by an outdoor behavioral health care program, if applicable;
   j. Cover infection control;
   k. Cover resident time-out;
   l. Cover resident outings;
   m. Cover environmental services that affect resident care;
   n. Cover whether pets and other animals are allowed on the premises, including procedures to ensure that any pets or other animals allowed on the premises do not endanger the health or safety of residents or the public;
   o. If animals are used as part of a therapeutic program, cover:
      i. Inoculation/vaccination requirements, and
      ii. Methods to minimize risks to a resident's health and safety;
   p. Cover the process for receiving a fee from a resident and refunding a fee to a resident;
   q. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks;
   r. Cover the security of a resident's possessions that are allowed on the premises;

s. Cover smoking and the use of tobacco products on the premises; and
t. Cover how the behavioral health residential facility will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;

3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
   a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
   b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health residential facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health residential facility.

**D.** If an applicant requests or a behavioral health residential facility has a licensed capacity of 10 or more residents, an administrator shall designate a clinical director who:
1. Provides direction for the behavioral health services provided by or at the behavioral health residential facility;
2. Is a behavioral health professional; and
3. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(2)(b) and (D)(1) and (2).

**E.** Except for respite services, an administrator shall ensure that medical services, nursing services, health-related services, or ancillary services provided by a behavioral health residential facility are only provided to a resident who is expected to be present in the behavioral health residential facility for more than 24 hours.

**F.** The administrator of a behavioral health residential facility providing services to children shall notify the Department within 30 calendar days after:
1. Beginning to contract exclusively with the federal government, and
2. Receiving only federal monies for services provided.

**G.** An administrator shall provide written notification to the Department of a resident's:
1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
2. Self-injury, within two working days after the resident inflicts a self-injury or has an accident that requires immediate intervention by an emergency medical services provider.

**H.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a behavioral health residential facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
2. For a resident under 18 years of age, according to A.R.S. § 13-3620.

**I.** If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a behavioral health residential facility's employee or personnel member, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the resident:
   a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
   b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (I)(1); and
   c. The report in subsection (I)(2);
4. Maintain the documentation in subsection (I)(3) for at least 12 months after the date of the report in subsection (I)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in (I)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (I)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

**J.** In addition to the notification requirements in subsections (F), (G), (H), and (I), an administrator of a behavioral health residential facility providing services to children that contracts exclusively with the federal government and receives only federal monies for services provided shall comply with A.R.S. § 36-418.

**K.** An administrator shall:
1. Establish and document requirements regarding residents, personnel members, employees, and other individuals entering and exiting the premises;
2. For a behavioral health residential facility licensed according to A.R.S. § 36-425.06 and in addition to the requirements in subsection (K)(1), establish and document requirements for a resident admitted according to A.R.S. § 36-550.09, consistent with R9-10-722(D);
3. Establish and document guidelines for meeting the needs of an individual residing at a behavioral health residential facility with a resident, such as a child accompanying a parent in treatment, if applicable;
4. If children under the age of 12, who are not admitted to a behavioral health residential facility, are residing at the behavioral health residential facility and being cared for by employees or personnel members, ensure that:
   a. An employee or personnel member caring for children has current cardiopulmonary resuscitation and first aid training specific to the ages of children being cared for; and
   b. The staff-to-children ratios in A.A.C. R9-5-404(A) are maintained, based on the age of the youngest child in the group;
5. Establish and document the process for responding to a resident's need for immediate and unscheduled behavioral health services or physical health services;
6. Establish and document the criteria for determining when a resident's absence is unauthorized, including criteria for a resident who:
   a. Was admitted under A.R.S. Title 36, Chapter 5, Articles 3, 4, 5, or 10;
   b. Is absent against medical advice; or
   c. Is under the age of 18;
7. If a resident's absence is unauthorized as determined according to the criteria in subsection (K)(5), within an hour after determining that the resident's absence is unauthorized, notify:
   a. For a resident who is under 18 years of age, the resident's parent or legal guardian; and
   b. For a resident who is under a court's jurisdiction, the appropriate court;
8. Maintain a written log of unauthorized absences for at least 12 months after the date of a resident's absence that includes the:
   a. Name of a resident absent without authorization,
   b. Name of the individual to whom the report required in subsection (K)(6) was submitted, and
   c. Date of the report; and
9. Evaluate and take action related to unauthorized absences under the quality management program in R9-10-704.

**L.** An administrator shall ensure that a personnel member who is able to read, write, understand, and communicate in English is on the premises of the behavioral health residential facility.

**M.** An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, employee, resident, or a resident's representative:
1. The behavioral health residential facility's current license,
2. The location at which inspection reports required in R9-10-720(C) are available for review or can be made available for review, and
3. The calendar days and times when a resident may accept visitors or make telephone calls.

**N.** An administrator shall ensure that:
1. Labor performed by a resident for the behavioral health residential facility is consistent with A.R.S. § 36-510;
2. A resident who is a child is only released to the child's custodial parent, guardian, or custodian or as authorized in writing by the child's custodial parent, guardian, or custodian;
3. The administrator obtains documentation of the identity of the parent, guardian, custodian, or family member authorized to act on behalf of a resident who is a child; and
4. A resident, who is an incapacitated person according to A.R.S. § 14-5101 or who is gravely disabled, is assisted in obtaining a resident's representative to act on the resident's behalf.

**O.** If an administrator determines that a resident is incapable of handling the resident's financial affairs, the administrator shall:
1. Notify the resident's representative or contact a public fiduciary or a trust officer to take responsibility of the resident's financial affairs, and
2. Maintain documentation of the notification required in subsection (O)(1) in the resident's medical record for at least 12 months after the date of the notification.

**P.** If an administrator manages a resident's money through a personal funds account, the administrator shall ensure that:
1. Policies and procedure are established, developed, and implemented for:
   a. Using resident's funds in a personal funds account,
   b. Protecting resident's funds in a personal funds account,
   c. Investigating a complaint about the use of resident's funds in a personal funds account and ensuring that the complaint is investigated by an individual who does not manage the personal funds account,
   d. Processing each deposit into and withdrawal from a personal funds account, and
   e. Maintaining a record for each deposit into and withdrawal from a personal funds account; and
2. The personal funds account is only initiated after receiving a written request that:
   a. Is provided:

i. Voluntarily by the resident,
ii. By the resident's representative, or
iii. By a court of competent jurisdiction;
b. May be withdrawn at any time; and
c. Is maintained in the resident's record.

**R9-10-704. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to residents;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to resident care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to resident care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**R9-10-705. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**R9-10-706. Personnel**

**A.** An administrator shall ensure that:
1. A personnel member, an employee, or a student is at least 18 years old; and
2. A volunteer is at least 21 years old.

**B.** An administrator shall ensure that:
1. The qualifications, skills, and knowledge required for each type of personnel member:
   a. Are based on:
      i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
      ii. The acuity of the residents receiving behavioral health services or physical health services from the personnel member according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description,
      ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description, and
      iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
   a. Before the personnel member provides physical health services or behavioral health services, and
   b. According to policies and procedures; and
3. Sufficient personnel members are present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to:
   a. Provide the services in the behavioral health residential facility's scope of services,
   b. Meet the needs of a resident, and
   c. Ensure the health and safety of a resident.

**C.** An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.

**D.** An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as a baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision, as defined in A.A.C. R4-6-101.

**E.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
2. A personnel member completes orientation before providing behavioral health services or physical health services;
3. An individual's orientation is documented, to include:
   a. The individual's name,
   b. The date of the orientation, and
   c. The subject or topics covered in the orientation;
4. A written plan is developed and implemented to provide in-service education specific to the duties of a personnel member; and
5. A personnel member's in-service education is documented, to include:
   a. The personnel member's name,
   b. The date of the training, and
   c. The subject or topics covered in the training.

**F.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and
2. As specified in R9-10-113.

**G.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
   a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
   b. The individual's education and experience applicable to the individual's job duties;
   c. The individual's completed orientation and in-service education as required by policies and procedures;
   d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
   e. The individual's compliance with requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;
   f. The individual's compliance with the requirements in A.R.S. § 8-804, if applicable;
   g. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
   h. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-703(C)(1)(e);
   i. First aid training, if required for the individual according to this Article or policies and procedures; and
   j. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).

**H.** An administrator shall ensure that personnel records are:
1. Maintained:
   a. Throughout an individual's period of providing services at or for the behavioral health residential facility, and
   b. For at least 24 months after the last date the individual provided services in or for the behavioral health residential facility; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the behavioral health residential facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.

**I.** An administrator shall ensure that a personnel member who is recidivism reduction staff at an adult residential care institution:
1. Submits an application for a fingerprint clearance card according to A.R.S. § 36-411; and
2. If the personnel member is denied a fingerprint clearance card, is evaluated to determine whether the personnel member:
   a. Has successfully completed treatment for recidivism reduction as shown by:
      i. Documentation of completion of treatment for recidivism reduction;
      ii. If applicable, continued negative results on random drug screening tests;
      iii. If applicable, continued participation in a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous, or a support group related to the personnel member's behavioral health issue; and
      iv. No arrests or convictions of the personnel member related to the reason for denial of the fingerprint clearance card within the previous two years; and
   b. Is not likely to be a threat to the health or safety of staff or residents through:
      i. Review of the reasons for denial of a fingerprint clearance card;
      ii. Assessment of the situations or circumstances that may have contributed to the reasons for denial of a fingerprint clearance card;
      iii. Review of the steps taken by the personnel member to address the situations or circumstances that may have contributed to the reasons for denial of a fingerprint clearance card;

iv. Observation of the personnel member's interactions with residents while under direct visual supervision, as defined in A.R.S. § 36-411, by personnel members having a valid fingerprint clearance card; and
v. Institution of any other methods, according to policies and procedures, specific to the:
(1) Behavioral health residential facility;
(2) Issues of the residents that place them at risk for a future threat of prosecution, diversion, or incarceration; and
(3) Recidivism reduction services that are expected to be provided by the personnel member.

**J.** An administrator shall ensure that the following personnel members have first-aid and cardiopulmonary resuscitation training specific to the populations served by the behavioral health residential facility:
1. At least one personnel member who is present at the behavioral health residential facility during hours of operation of the behavioral health residential facility, and
2. Each personnel member participating in an outing.

**K.** An administrator shall ensure that:
1. At least one personnel member is present and awake at the behavioral health residential facility when a resident is on the premises;
2. In addition to the personnel member in subsection (K)(1), at least one personnel member is on-call and available to come to the behavioral health residential facility if needed;
3. There is a daily staffing schedule that:
a. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;
b. Includes documentation of the employees who work each calendar day and the hours worked by each employee; and
c. Is maintained for at least 12 months after the last date on the documentation;
4. A behavioral health professional is present at the behavioral health residential facility or on-call;
5. A registered nurse is present at the behavioral health residential facility or on-call; and
6. If a resident requires services that the behavioral health residential facility is not authorized or not able to provide, a personnel member arranges for the resident to be transported to a hospital or another health care institution where the services can be provided.

**R9-10-707. Admission; Assessment**

**A.** An administrator shall ensure that:
1. A resident is admitted based upon:
a. The resident's primary condition for which the resident is admitted to the behavioral health residential facility being a behavioral health issue, and
b. The resident's behavioral health issue and treatment needs are within the behavioral health residential facility's scope of services;
2. A behavioral health professional, authorized by policies and procedures to admit a resident, is available;
3. Except as provided in subsection (A)(4), general consent is obtained from:
a. An adult resident or the resident's representative before or at the time of admission, or
b. A resident's representative, if the resident is not an adult;
4. General consent is not required from a patient receiving a court-ordered evaluation or court-ordered treatment;
5. The general consent obtained in subsection (A)(3) is documented in the resident's medical record;
6. Except as provided in subsection (E)(1)(a), a medical practitioner performs a medical history and physical examination or a registered nurse performs a nursing assessment on a resident within 30 calendar days before admission or within 72 hours after admission and documents the medical history and physical examination or nursing assessment in the resident's medical record within 72 hours after admission;
7. If a medical practitioner performs a medical history and physical examination or a nurse performs a nursing assessment on a resident before admission, the medical practitioner enters an interval note or the nurse enters a progress note in the resident's medical record within seven calendar days after admission;
8. If a behavioral health assessment is conducted by a:
a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the resident; or
b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, supervises the behavioral health paraprofessional during the completion of the assessment and signs the assessment to ensure that the assessment identifies the behavioral health services needed by the resident;
9. Except as provided in subsection (A)(10), a behavioral health assessment for a resident is completed before treatment for the resident is initiated;
10. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the behavioral health residential facility or if the behavioral health residential facility has a medical record for the

resident that contains a behavioral health assessment that was completed within 12 months before the date of the resident's current admission:

a. The resident's assessment information is reviewed before treatment for the resident is initiated and updated if additional information that affects the resident's assessment is identified, and

b. The review and update of the resident's assessment information is documented in the resident's medical record within 48 hours after the review is completed;

11. A behavioral health assessment:
    a. Documents a resident's:
        i. Presenting issue;
        ii. Substance abuse history;
        iii. Co-occurring disorder;
        iv. Legal history, including:
            (1) Custody,
            (2) Guardianship, and
            (3) Pending litigation;
        v. Criminal justice record;
        vi. Family history;
        vii. Behavioral health treatment history;
        viii. Symptoms reported by the resident; and
        ix. Referrals needed by the resident, if any;
    b. Includes:
        i. Recommendations for further assessment or examination of the resident's needs,
        ii. The physical health services or ancillary services that will be provided to the resident until the resident's treatment plan is completed, and
        iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
    c. Is documented in resident's medical record;
12. A resident is referred to a medical practitioner if a determination is made that the resident requires immediate physical health services or the resident's behavioral health issue may be related to the resident's medical condition; and
13. Except as provided in subsection (E)(1)(d), a resident provides evidence of freedom from infectious tuberculosis:
    a. Before or within seven calendar days after the resident's admission, and
    b. As specified in R9-10-113.

**B.** An administrator shall ensure that:
1. A request for participation in a resident's behavioral health assessment is made to the resident or the resident's representative,
2. An opportunity for participation in the resident's behavioral health assessment is provided to the resident or the resident's representative, and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.

**C.** An administrator shall ensure that a resident's behavioral health assessment information is documented in the medical record within 48 hours after completing the behavioral health assessment.

**D.** If information in subsection (A)(10) is obtained about a resident after the resident's behavioral health assessment is completed, an administrator shall ensure that an interval note, including the information, is documented in the resident's medical record within 24 hours after the information is obtained.

**E.** If a behavioral health residential facility is authorized to provide respite services, an administrator shall ensure that:
1. Upon admission of a resident for respite services:
    a. Except as provided in subsection (F), a medical history and physical examination of the resident:
        i. Is performed; or
        ii. If dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;
    b. A treatment plan that meets the requirements in R9-10-708:
        i. Is developed; or
        ii. If dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;
    c. If a treatment plan, dated within the previous 12 months, is available, the treatment plan is reviewed, updated, and documented in the resident's medical record; and
    d. The resident is not required to comply with the requirements in subsection (A)(13) if the resident is not expected to be present in the behavioral health residential facility:
        i. For more than seven consecutive days, or
        ii. For 10 days or more days in a 90-consecutive-day period;
2. The common area required in R9-10-722(B)(1)(b) provides at least 25 square feet for each resident, including residents who do not stay overnight; and

3. In addition to the requirements in R9-10-722(B)(3), toilets and hand-washing sinks are available to residents, including residents who do not stay overnight, as follows:
   a. There is at least one working toilet that flushes and has a seat and one sink with running water for every 10 residents,
   b. There are at least two working toilets that flush and have seats and two sinks with running water if there are 11 to 25 residents, and
   c. There is at least one additional working toilet that flushes and has a seat and one additional sink with running water for each additional 20 residents.

**F.** A medical history and physical examination is not required for a child who is admitted or expected to be admitted to a residential behavioral health facility for less than 10 days in a 90-consecutive-day period.

**R9-10-708. Treatment Plan**

**A.** An administrator shall ensure that a treatment plan is developed and implemented for each resident that:
1. Is based on the medical history and physical examination or nursing assessment required in R9-10-707(A)(6) or (E)(1)(a) and the behavioral health assessment required in R9-10-707(A)(9) or (10) and on-going changes to the behavioral health assessment of the resident;
2. Is completed:
   a. By a behavioral health professional or a behavioral health technician under the clinical oversight of a behavioral health professional, and
   b. Before the resident receives physical health services or behavioral health services or within 48 hours after the assessment is completed;
3. Is documented in the resident's medical record within 48 hours after the resident first receives physical health services or behavioral health services;
4. Includes:
   a. The resident's presenting issue;
   b. The physical health services or behavioral health services to be provided to the resident;
   c. The signature of the resident or the resident's representative and date signed, or documentation of the refusal to sign;
   d. The date when the resident's treatment plan will be reviewed;
   e. If a discharge date has been determined, the treatment needed after discharge; and
   f. The signature of the personnel member who developed the treatment plan and the date signed;
5. If the treatment plan was completed by a behavioral health technician, is reviewed and signed by a behavioral health professional within 24 hours after the completion of the treatment plan to ensure that the treatment plan is complete and accurate and meets the resident's treatment needs; and
6. Is reviewed and updated on an on-going basis:
   a. According to the review date specified in the treatment plan,
   b. When a treatment goal is accomplished or changed,
   c. When additional information that affects the resident's behavioral health assessment is identified, and
   d. When a resident has a significant change in condition or experiences an event that affects treatment.

**B.** An administrator shall ensure that:
1. A request for participation in developing a resident's treatment plan is made to the resident or the resident's representative,
2. An opportunity for participation in developing the resident's treatment plan is provided to the resident or the resident's representative, and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.

**R9-10-709. Discharge**

**A.** An administrator shall ensure that a discharge plan for a resident is:
1. Developed that:
   a. Identifies any specific needs of the resident after discharge,
   b. Is completed before discharge occurs, and
   c. Includes a description of the level of care that may meet the resident's assessed and anticipated needs after discharge;
2. Documented in the resident's medical record within 48 hours after the discharge plan is completed; and
3. Provided to the resident or the resident's representative before the discharge occurs.

**B.** An administrator shall ensure that:
1. A request for participation in developing a resident's discharge plan is made to the resident or the resident's representative,
2. An opportunity for participation in developing the resident's discharge plan is provided to the resident or the resident's representative, and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.

**C.** An administrator shall ensure that a resident is discharged from a behavioral health residential facility when the resident's treatment needs are not consistent with the services that the behavioral health residential facility is authorized and able to provide.

**D.** An administrator shall ensure that there is a documented discharge order by a medical practitioner or behavioral health professional before a resident is discharged unless the resident leaves the behavioral health residential facility against a medical practitioner's or behavioral health professional's advice.

**E.** An administrator shall ensure that, at the time of discharge, a resident receives a referral for treatment or ancillary services that the resident may need after discharge, if applicable.

**F.** If a resident is discharged to any location other than a health care institution, an administrator shall ensure that:
1. Discharge instructions are documented, and
2. The resident or the resident's representative is provided with a copy of the discharge instructions.

**G.** An administrator shall ensure that a discharge summary for a resident:
1. Is entered into the resident's medical record within 10 working days after a resident's discharge; and
2. Includes:
   a. The following information authenticated by a medical practitioner or behavioral health professional:
      i. The resident's presenting issue and other physical health and behavioral health issues identified in the resident's treatment plan;
      ii. A summary of the treatment provided to the resident;
      iii. The resident's progress in meeting treatment goals, including treatment goals that were and were not achieved; and
      iv. The name, dosage, and frequency of each medication ordered for the resident by a medical practitioner at the behavioral health residential facility at the time of the resident's discharge; and
   b. A description of the disposition of the resident's possessions, funds, or medications brought to the behavioral health residential facility by the resident.

**H.** An administrator shall ensure that a resident who is dependent upon a prescribed medication is offered a written referral to detoxification services or opioid treatment before the resident is discharged from the behavioral health residential facility if a medical practitioner for the behavioral health residential facility will not be prescribing the medication for the resident at or after discharge.

**R9-10-710. Transport; Transfer**

**A.** Except as provided in subsection (B), an administrator shall ensure that:
1. A personnel member coordinates the transport and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before and after the transport,
   b. Information from the resident's medical record is provided to a receiving health care institution, and
   c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transport;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the resident during a transport.

**B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a resident by the resident or the resident's representative,
3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
4. A transport to another licensed health care institution in an emergency.

**C.** Except for a transfer of a resident due to an emergency, an administrator shall ensure that:
1. A personnel member coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before the transfer;
   b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the personnel member accompanying the resident during a transfer.

**R9-10-711. Resident Rights**

**A.** An administrator shall ensure that:
1. The requirements in subsection (B) and the resident rights in subsection (E) are conspicuously posted on the premises;
2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (E); and
3. Policies and procedures include:
   a. How and when a resident or the resident's representative is informed of the resident rights in subsection (E), and

b. Where resident rights are posted as required in subsection (A)(1).

**B.** An administrator shall ensure that:
1. A resident is treated with dignity, respect, and consideration;
2. A resident is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity;
   k. Misappropriation of personal and private property by the behavioral health residential facility's personnel members, employees, volunteers, or students;
   l. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the resident's treatment needs, except as established in a fee agreement signed by the resident or the resident's representative; or
   m. Treatment that involves the denial of:
      i. Food,
      ii. The opportunity to sleep, or
      iii. The opportunity to use the toilet;
3. Except as provided in subsection (C) or (D), and unless restricted by the resident's representative, a resident is allowed to:
   a. Associate with individuals of the resident's choice, receive visitors, and make telephone calls during the hours established by the behavioral health residential facility;
   b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
   c. Unless restricted by a court order, send and receive uncensored and unopened mail; and
4. A resident or the resident's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated, unless the treatment is:
      i. Ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01;
      ii. Necessary to save the resident's life or physical health; or
      iii. Provided according to A.R.S. § 36-512;
   c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;
   d. Is informed of the following:
      i. The behavioral health residential facility's policy on health care directives, and
      ii. The resident complaint process; and
   e. Except as otherwise permitted by law, provides written consent to the release of information in the resident's:
      i. Medical record, or
      ii. Financial records.

**C.** For a behavioral health residential facility with licensed capacity of less than 10 residents, if a behavioral health professional determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the behavioral health professional shall:
1. Document a specific treatment purpose in the resident's medical record that justifies restricting the resident from the activity,
2. Inform the resident or resident's representative of the reason why the activity is being restricted, and
3. Inform the resident or resident's representative of the resident's right to file a complaint and the procedure for filing a complaint.

**D.** For a behavioral health residential facility with a licensed capacity of 10 or more residents, if a clinical director determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the clinical director shall comply with the requirements in subsections (C)(1) through (3).

**E.** A resident has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that:
   a. Supports and respects the resident's individuality, choices, strengths, and abilities;
   b. Supports the resident's personal liberty and only restricts the resident's personal liberty according to a court order, by the resident's or the resident's representative's general consent, or as permitted in this Chapter; and
   c. Is provided in the least restrictive environment that meets the resident's treatment needs;

3. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
   a. A resident may be photographed when admitted to a behavioral health residential facility for identification and administrative purposes;
   b. For a resident receiving treatment according to A.R.S. Title 36, Chapter 37; or
   c. For video recordings used for security purposes that are maintained only on a temporary basis;
4. Not to be prevented or impeded from exercising the resident's civil rights unless the resident has been adjudicated incompetent or a court of competent jurisdiction has found that the resident is not able to exercise a specific right or category of rights;
5. To review, upon written request, the resident's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
6. To be provided locked storage space for the resident's belongings while the resident receives treatment;
7. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
8. To be informed of the requirements necessary for the resident's discharge or transfer to a less restrictive physical environment;
9. To receive a referral to another health care institution if the behavioral health residential facility is not authorized or not able to provide physical health services or behavioral health services needed by the resident;
10. To participate or have the resident's representative participate in the development of a treatment plan or decisions concerning treatment;
11. To participate or refuse to participate in research or experimental treatment; and
12. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

**R9-10-712. Medical Records**

**A.** An administrator shall ensure that:
1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
   a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. An order is:
   a. Dated when the order is entered in the resident's medical record and includes the time of the order;
   b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
   c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A resident's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the resident's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
   c. As permitted by law;
6. Policies and procedures include the maximum time-frame to retrieve a resident's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
7. A resident's medical record is protected from loss, damage, or unauthorized use.

**B.** If a behavioral health residential facility maintains residents' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.

**C.** An administrator shall ensure that a resident's medical record contains:
1. Resident information that includes:
   a. The resident's name;
   b. The resident's address;
   c. The resident's date of birth; and
   d. Any known allergies, including medication allergies;
2. The name of the admitting medical practitioner or behavioral health professional;
3. An admitting diagnosis or presenting behavioral health issues;
4. The date of admission and, if applicable, date of discharge;
5. If applicable, the name and contact information of the resident's representative and:
   a. If the resident is 18 years of age or older or an emancipated minor, the document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
   b. If the resident's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or

ii. Is a legal guardian, a copy of the court order establishing guardianship;
6. If applicable, documented general consent and informed consent for treatment by the resident or the resident's representative;
7. Documentation of medical history and results of a physical examination;
8. A copy of resident's health care directive, if applicable;
9. Orders;
10. If applicable, documentation that evaluation or treatment was ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01;
11. Assessment;
12. Treatment plans;
13. Interval notes;
14. Progress notes;
15. Documentation of behavioral health services and physical health services provided to the resident;
16. If applicable, documentation of the use of an emergency safety response;
17. If applicable, documentation of time-out required in R9-10-714(6);
18. Except as allowed in R9-10-707(E)(1)(d), documentation of freedom from infectious tuberculosis required in R9-10-707(A)(13);
19. The disposition of the resident after discharge;
20. The discharge plan;
21. The discharge summary, if applicable;
22. If applicable:
    a. Laboratory reports,
    b. Radiologic reports,
    c. Diagnostic reports, and
    d. Consultation reports; and
23. Documentation of medication administered to the resident that includes:
    a. The date and time of administration;
    b. The name, strength, dosage, and route of administration;
    c. For a medication administered for pain, when administered initially or on a PRN basis:
        i. An assessment of the resident's pain before administering the medication, and
        ii. The effect of the medication administered;
    d. For a psychotropic medication, when administered initially or on a PRN basis:
        i. An assessment of the resident's behavior before administering the psychotropic medication, and
        ii. The effect of the psychotropic medication administered;
    e. The identification, signature, and professional designation of the individual administering or providing assistance in the self-administration of the medication; and
    f. Any adverse reaction a resident has to the medication.

**R9-10-713. Transportation; Resident Outings**

**A.** An administrator of a behavioral health residential facility that uses a vehicle owned or leased by the behavioral health residential facility to provide transportation to a resident shall ensure that:
1. The vehicle:
    a. Is safe and in good repair,
    b. Contains a first aid kit,
    c. Contains drinking water sufficient to meet the needs of each resident present in the vehicle, and
    d. Contains a working heating and air conditioning system;
2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle are maintained;
3. A driver of the vehicle:
    a. Is 21 years of age or older;
    b. Has a valid driver license;
    c. Operates the vehicle in a manner that does not endanger a resident in the vehicle;
    d. Does not leave in the vehicle an unattended:
        i. Child,
        ii. Resident who may be a threat to the health or safety of the resident or another individual, or
        iii. Resident who is incapable of independent exit from the vehicle; and
    e. Ensures the safe and hazard-free loading and unloading of residents; and
4. Transportation safety is maintained as follows:
    a. Each individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
    b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a resident's body.

**B.** An administrator shall ensure that:

1. An outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each resident participating in the outing;
2. At least two personnel members are present on an outing;
3. In addition to the personnel members required in subsection (B)(2), a sufficient number of personnel members are present to ensure each resident's health and safety on the outing;
4. Documentation is developed before an outing that includes:
   a. The name of each resident participating in the outing;
   b. A description of the outing;
   c. The date of the outing;
   d. The anticipated departure and return times;
   e. The name, address, and, if available, telephone number of the outing destination; and
   f. If applicable, the license plate number of each vehicle used to transport a resident;
5. The documentation described in subsection (B)(4) is updated to include the actual departure and return times and is maintained for at least 12 months after the date of the outing; and
6. Emergency information for each resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
   a. The resident's name;
   b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
   c. The resident's allergies; and
   d. The name and telephone number of a designated individual to notify in case of an emergency, who is present on the behavioral health residential facility's premises.

**R9-10-714. Resident Time-Out**

An administrator shall ensure that a time-out:

1. Is provided to a resident who voluntarily decides to go in a time-out;
2. Takes place in an area that is unlocked, lighted, quiet, and private;
3. Is time-limited and does not exceed the amount of time as determined by the resident;
4. Does not result in a resident missing a meal if the resident is in time-out at mealtime;
5. Includes monitoring of the resident by a personnel member at least once every 15 minutes to ensure the resident's health and safety and to discuss with the resident if the resident is ready to leave time-out; and
6. Is documented in the resident's medical record, to include:
   a. The date of the time-out,
   b. The reason for the time-out,
   c. The duration of the time-out, and
   d. The action planned and taken by the administrator to prevent the use of time-out in the future.

**R9-10-715. Physical Health Services**

An administrator of a behavioral health residential facility that is authorized to provide personal care services shall ensure that:

1. Personnel members who provide personal care services have documentation of completion of a caregiver training program that complies with A.A.C. R4-33-702(A)(5);
2. Residents receive personal care services according to the requirements in R9-10-814(A), (D), (E), and (F); and
3. A resident who has a stage 3 or stage 4 pressure sore is not admitted to the behavioral health residential facility.

**R9-10-716. Behavioral Health Services**

**A.** An administrator shall ensure that:

1. If a behavioral health residential facility is authorized to provide court-ordered evaluation or court-ordered treatment:
   a. Court-ordered evaluation is provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 4; and
   b. Court-ordered treatment is provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 5;
2. If a behavioral health residential facility is authorized to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently receives:
   a. Behavioral health services and personal care services as indicated in the resident's treatment plan, and
   b. Continuous protective oversight;
3. A resident admitted to the behavioral health residential facility who needs behavioral health services to maintain or enhance the resident's ability to function independently:
   a. Receives behavioral health services, and, if indicated in the resident's treatment plan, personal care services; and
   b. Is provided an opportunity to participate in activities designed to maintain or enhance the resident's ability to function independently while:
      i. The resident receives services to maintain the resident's health, safety, or personal hygiene; or
      ii. Homemaking functions are performed for the resident;

4. Behavioral health services are provided to meet the needs of a resident and are consistent with a behavioral health residential facility's scope of services;
5. Behavioral health services listed in the behavioral health residential facility's scope of services are provided on the premises;
6. Before a resident participates in behavioral health services provided in a setting or activity with more than one resident participating, the diagnoses, treatment needs, developmental levels, social skills, verbal skills, and personal histories, including any history of physical or sexual abuse, of the residents participating are reviewed to ensure that the:
   a. Health and safety of each resident is protected, and
   b. Treatment needs of each resident participating are being met; and
7. A resident does not:
   a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or
   b. Share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that may present a threat to the resident's health or safety, based on the other resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history.

**B.** An administrator shall ensure that counseling is:
1. Offered as described in the behavioral health residential facility's scope of services,
2. Provided according to the frequency and number of hours identified in the resident's treatment plan, and
3. Provided by a behavioral health professional or a behavioral health technician.

**C.** An administrator shall ensure that:
1. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
2. Each counseling session is documented in a resident's medical record to include:
   a. The date of the counseling session;
   b. The amount of time spent in the counseling session;
   c. Whether the counseling was individual counseling, family counseling, or group counseling;
   d. The treatment goals addressed in the counseling session; and
   e. The signature of the personnel member who provided the counseling and the date signed.

**D.** An administrator of a behavioral health residential facility authorized to provide behavioral health services to individuals under 18 years of age:
1. May continue to provide behavioral health services to a resident who is 18 years of age or older:
   a. If the resident:
      i. Was admitted to the behavioral health residential facility before the resident's 18th birthday;
      ii. Is not 21 years of age or older; and
      iii. Is:
         (1) Attending classes or completing coursework to obtain a high school or a high school equivalency diploma, or
         (2) Participating in a job training program; or
   b. Through the last calendar day of the month of the resident's 18th birthday; and
2. Shall ensure that:
   a. A resident does not receive the following from other residents at the behavioral health residential facility:
      i. Threats,
      ii. Ridicule,
      iii. Verbal harassment,
      iv. Punishment, or
      v. Abuse;
   b. The interior of the behavioral health residential facility has furnishings and decorations appropriate to the ages of the residents receiving services at the behavioral health residential facility;
   c. A resident older than three years of age does not sleep in a crib;
   d. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to residents on the premises in a quantity sufficient to meet each resident's needs and are appropriate to each resident's age, developmental level, and treatment needs; and
   e. A resident's educational needs are addressed according to A.R.S. Title 15, Chapter 7, Article 4 .

**E.** An administrator shall ensure that:
1. An emergency safety response is:
   a. Only used:
      i. By a personnel member trained to use an emergency safety response,
      ii. For the management of a resident's violent or self-destructive behavior, and
      iii. When less restrictive interventions have been determined to be ineffective; and

b. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;

2. Within 24 hours after an emergency safety response is used for a resident, the following information is entered into the resident medical record:
   a. The date and time the emergency safety response was used;
   b. The name of each personnel member who used an emergency safety response;
   c. The specific emergency safety response used;
   d. The personnel member or resident behavior, event, or environmental factor that caused the need for the emergency safety response; and
   e. Any injury that resulted from the use of the emergency safety response;
3. Within 10 working days after an emergency safety response is used for a resident, the administrator or clinical director reviews the information in subsection (E)(2); and
4. After the review required in subsection (E)(3), the following information is entered, according to policies and procedures, into the resident's medical record:
   a. Actions taken or planned actions to prevent the need for the use of an emergency safety response for the resident,
   b. A determination of whether the resident is appropriately placed at the behavioral health residential facility, and
   c. Whether the resident's treatment plan was reviewed or needs to be reviewed and amended to ensure that the resident's treatment plan is meeting the resident's treatment needs.

**F.** An administrator shall ensure that:
1. A personnel member whose job description includes the ability to use an emergency safety response:
   a. Completes training in crisis intervention that includes:
      i. Techniques to identify personnel member and resident behaviors, events, and environmental factors that may trigger the need for the use of an emergency safety response;
      ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods; and
      iii. The safe use of an emergency safety response including the ability to recognize and respond to signs of physical distress in a client who is receiving an emergency safety response; and
   b. Completes training required in subsection (F)(1)(a):
      i. Before providing behavioral health services, and
      ii. At least once every 12 months after the date the personnel member completed the initial training;
2. Documentation of the completed training in subsection (F)(1)(a) includes:
   a. The name and credentials of the individual providing the training,
   b. Date of the training, and
   c. Verification of a personnel member's ability to use the training; and
3. The materials used to provide the completed training in crisis intervention, including handbooks, electronic presentations, and skills verification worksheets, are maintained for at least 12 months after each personnel member who received training using the materials no longer provides services at the behavioral health residential facility.

**R9-10-717. Outdoor Behavioral Health Care Programs**

**A.** An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program shall ensure that:
1. Behavioral health services are provided to a resident participating in the outdoor behavioral health care program consistent with the age, developmental level, physical ability, medical condition, and treatment needs of the resident;
2. Continuous protective oversight is provided to a resident;
3. Transportation is provided to a resident from the behavioral health residential facility's administrative office for the outdoor behavioral health care program to the location where the outdoor behavioral health care program is provided and from the location where the outdoor behavioral health care program is provided to the behavioral health residential facility's administrative office for the outdoor behavioral health care program; and
4. Communication is available between the outdoor behavioral health care program personnel and:
   a. A behavioral health professional,
   b. A registered nurse,
   c. An emergency medical response team, and
   d. The behavioral health residential facility's administrative office for the outdoor behavioral health care program.

**B.** An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program shall ensure that:
1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a resident such as cut, chopped, ground, pureed, or thickened;
2. A food menu is prepared based on the number of calendar days scheduled for the behavioral health care program;
3. Meals and snacks provided by the behavioral health care program are served according to menus;
4. Meals and snacks for each day are planned using the applicable guidelines in http://www.health.gov/dietaryguidelines/2015;

5. A resident is provided:
   a. A diet that meets the resident's nutritional needs as specified in the resident's assessment or treatment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(5)(d);
   c. The option to have a daily evening snack or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if the resident agrees;
6. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan;
7. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
8. Food is protected from potential contamination; and
9. Food being maintained in coolers containing ice is not in direct contact with ice or water if water may enter the food because of the nature of the food's packaging, wrapping, or container or the positioning of the food in the ice or water.

**C.** An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program shall ensure that:
1. The location and, if applicable, equipment used by the outdoor behavioral health care program are sufficient to accommodate the activities, treatment, and ancillary services required by the residents participating in the behavioral health care program;
2. The location and equipment are maintained in a condition that allows the location and equipment to be used for the original purpose of the location and equipment;
3. Garbage and refuse are:
   a. Stored in plastic bags in covered containers, and
   b. Removed from the location used by the outdoor behavioral health care program at least once a week;
4. Common areas:
   a. Are lighted when in use to assure the safety of residents, and
   b. Have sufficient lighting to allow personnel members to monitor resident activity;
5. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
6. Soiled clothing is stored in closed containers away from food storage, medications, and eating areas;
7. Poisonous or toxic materials are maintained in labeled containers, secured, and separate from food preparation and storage, eating areas, and medications and inaccessible to residents;
8. Combustible or flammable liquids and hazardous materials are stored in the original labeled containers or safety containers, secured, and inaccessible to residents;
9. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
   a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
   b. If necessary, corrective action is taken to ensure the water is safe to drink; and
   c. Documentation of testing is retained for at least 12 months after the date of the test; and
10. Smoking or the use of tobacco products may be permitted away from the residents.

**R9-10-717.01. Recidivism Reduction Services**

An administrator of a behavioral health residential facility that is an adult residential care institution and is authorized to provide recidivism reduction services shall ensure that:
1. A personnel member who is recidivism reduction staff at the adult residential care institution does not provide:
   a. Behavioral health services other than recidivism reduction services; or
   b. Recidivism reduction services to a resident who has not been referred by a physician, behavioral health professional, or court of competent jurisdiction to receive recidivism reduction services;
2. The adult residential care institution accepts an individual as a resident only if the individual:
   a. Is at least 18 years of age; and
   b. Has documentation of a referral to receive recidivism reduction services that:
      i. Was made by a physician, behavioral health professional, or court of competent jurisdiction; and
      ii. Complies with the requirements in A.R.S. § 36-411.01(D);
3. The referral is included in the resident's medical record; and
4. The recidivism reduction services provided to a resident are:
   a. Consistent with the age, developmental level, physical ability, medical condition, and treatment needs of the resident; and
   b. Provided by recidivism reduction staff whose experience is compatible with the experience of the resident.

**R9-10-718. Medication Services**

**A.** An administrator shall ensure that policies and procedures for medication services:
1. Include:
   a. A process for providing information to a resident about medication prescribed for the resident including:
      i. The prescribed medication's anticipated results,
      ii. The prescribed medication's potential adverse reactions,

iii. The prescribed medication's potential side effects, and
iv. Potential adverse reactions that could result from not taking the medication as prescribed;
b. Procedures for preventing, responding to, and reporting any of the following:
i. A medication error,
ii. An adverse reaction to a medication, or
iii. A medication overdose;
c. Procedures to ensure that a resident's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
d. Procedures for documenting, as applicable, medication administration and assistance in the self-administration of medication;
e. A process for monitoring a resident who self-administers medication;
f. Procedures for assisting a resident in obtaining medication; and
g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. Specify a process for review through the quality management program of:
a. A medication administration error, and
b. An adverse reaction to a medication.

**B.** If a behavioral health residential facility provides medication administration, an administrator shall ensure that:
1. Policies and procedures for medication administration:
a. Are reviewed and approved by a medical practitioner;
b. Specify the individuals who may:
i. Order medication, and
ii. Administer medication;
c. Ensure that medication is administered to a resident only as ordered; and
d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a resident:
a. Is administered in compliance with an order, and
b. Is documented in the resident's medical record.

**C.** If a behavioral health residential facility provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A resident's medication is stored by the behavioral health residential facility;
2. The following assistance is provided to a resident:
a. A reminder when it is time to take the medication;
b. Opening the medication container for the resident;
c. Observing the resident while the resident removes the medication from the container;
d. Verifying that the medication is taken as prescribed by the resident's medical practitioner by confirming that:
i. The resident taking the medication is the individual stated on the medication container label,
ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
e. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
b. Includes:
i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a resident:
a. Is in compliance with an order, and
b. Is documented in the resident's medical record.

**D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;
2. A current toxicology reference guide is available for use by personnel members; and
3. If pharmaceutical services are provided on the premises:
   a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
      i. Develop a drug formulary,
      ii. Update the drug formulary at least once every 12 months,
      iii. Develop medication usage and medication substitution policies and procedures, and
      iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
   b. The pharmaceutical services are provided under the direction of a pharmacist;
   c. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
   d. A copy of the pharmacy license is provided to the Department upon request.

**E.** When medication is stored at a behavioral health residential facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.

**F.** An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the medical practitioner who ordered or prescribed the medication and, if applicable, the behavioral health residential facility's clinical director.

**R9-10-719. Food Services**

**A.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:
1. For a behavioral health residential facility that has a licensed capacity of more than 10 residents:
   a. The behavioral health residential facility obtains a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
   b. A copy of the behavioral health residential facility's food establishment license or permit is maintained;
2. If a behavioral health residential facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health residential facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health residential facility;
3. Food is stored, refrigerated, and reheated to meet the dietary needs of a resident;
4. A registered dietitian is employed full-time, part-time, or as a consultant; and
5. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to meet the nutritional needs of the residents.

**B.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, a registered dietitian or director of food services shall ensure that:
1. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
2. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
3. Meals and snacks provided by the behavioral health residential facility are served according to posted menus;
4. Meals and snacks for each day are planned using the applicable guidelines in http://www.health.gov/dietaryguidelines/2015;
5. A resident is provided:
   a. A diet that meets the resident's nutritional needs as specified in the resident's assessment or treatment plan;
   b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(5)(d);
   c. The option to have a daily evening snack identified in subsection (B)(5)(d)(ii) or other snack; and
   d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:

i. The resident agrees; and
ii. The resident is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;

6. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
7. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan.

**C.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that food is obtained, prepared, served, and stored as follows:

1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below; and
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
      i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
      ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
      iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
      v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
      vi. Leftovers are reheated to a temperature of at least 165° F;
4. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
5. Frozen foods are stored at a temperature of 0° F or below; and
6. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**R9-10-720. Emergency and Safety Standards**

**A.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that a behavioral health residential facility has:

1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and a sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that are in working order; or
2. An alternative method to ensure resident's safety that is documented and approved by the local jurisdiction.

**B.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
   a. When, how, and where residents will be relocated;
   b. How each resident's medical record will be available to individuals providing services to the resident during a disaster;
   c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
   d. A plan for obtaining food and water for individuals present in the behavioral health residential facility, under the care and supervision of personnel members, or in the behavioral health residential facility's relocation site during a disaster;
2. The disaster plan required in subsection (B)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (B)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
   a. The date and time of the disaster plan review;
   b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and residents on the premises is conducted at least once every six months on each shift;
6. Documentation of each evacuation drill is created, is maintained for 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for all employees and residents to evacuate the behavioral health residential facility;
   c. Names of employees participating in the evacuation drill;
   d. An identification of residents needing assistance for evacuation;
   e. Any problems encountered in conducting the evacuation drill; and
   f. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health residential facility.

**C.** An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

**R9-10-721. Environmental Standards**

**A.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:

1. The premises and equipment are:
   a. Maintained in a condition that allows the premises and equipment to be used for the original purpose of the premises and equipment;
   b. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
   c. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
4. Equipment used at the behavioral health residential facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
6. Garbage and refuse are:
   a. Stored in covered containers lined with plastic bags, and
   b. Removed from the premises at least once a week;
7. Heating and cooling systems maintain the behavioral health residential facility at a temperature between 70° F and 84° F;
8. A space heater is not used;
9. Common areas:
   a. Are lighted to assure the safety of residents, and
   b. Have lighting sufficient to allow personnel members to monitor resident activity;
10. Hot water temperatures are maintained between 95° F and 120° F in the areas of the behavioral health residential facility used by residents;
11. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
12. Soiled linen and soiled clothing stored by the behavioral health residential facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
13. Oxygen containers are secured in an upright position;
14. Poisonous or toxic materials stored by the behavioral health residential facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;
15. Combustible or flammable liquids and hazardous materials stored by a behavioral health residential facility are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
16. If pets or animals are allowed in the behavioral health residential facility, pets or animals are:
   a. Controlled to prevent endangering the residents and to maintain sanitation;
   b. Licensed consistent with local ordinances; and
   c. For a dog or cat, vaccinated against rabies;
17. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
   a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
   b. If necessary, corrective action is taken to ensure the water is safe to drink; and
   c. Documentation of testing is retained for at least 12 months after the date of the test; and
18. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

**B.** An administrator shall ensure that:

1. Smoking tobacco products is not permitted within a behavioral health residential facility; and
2. Smoking tobacco products may be permitted on the premises outside a behavioral health residential facility if:
   a. Signs designating smoking areas are conspicuously posted, and
   b. Smoking is prohibited in areas where combustible materials are stored or in use.

**C.** If a swimming pool is located on the premises, an administrator shall ensure that:

1. On each day that a resident uses the swimming pool, an employee:

a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
   i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
   ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
   iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
b. Records the results of the water quality tests in a log that includes each testing date and test result;

2. Documentation of the water quality test is maintained for at least 12 months after the date of the test;
3. A swimming pool is not used by a resident if a water quality test shows that the swimming pool water does not comply with subsection (C)(1)(a);
4. At least one personnel member, with cardiopulmonary resuscitation training that meets the requirements in R9-10-703(C)(1)(e), is present in the pool area when a resident is in the pool area; and
5. At least two personnel members are present in the pool area if two or more residents are in the pool area.

**R9-10-722. Physical Plant Standards**

**A.** Except for a behavioral health outdoor program, an administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services in the behavioral health residential facility's scope of services, and
2. An individual admitted as a resident by the behavioral health residential facility.

**B.** An administrator shall ensure that:
1. A behavioral health residential facility has a:
   a. Room that provides privacy for a resident to receive treatment or visitors; and
   b. Common area and a dining area that contain furniture and materials to accommodate the recreational and socialization needs of the residents and other individuals in the behavioral health residential facility;
2. At least one bathroom is accessible from a common area that:
   a. May be used by residents and visitors;
   b. Provides privacy when in use; and
   c. Contains the following:
      i. At least one working sink with running water,
      ii. At least one working toilet that flushes and has a seat,
      iii. Toilet tissue for each toilet,
      iv. Soap in a dispenser accessible from each sink,
      v. Paper towels in a dispenser or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A window that opens or another means of ventilation;
3. For every six residents who stay overnight at the behavioral health residential facility, there is at least one working toilet that flushes and has a seat, and one sink with running water;
4. For every eight residents who stay overnight at the behavioral health residential facility, there is at least one working bathtub or shower;
5. A resident bathroom provides privacy when in use and contains:
   a. A shatter-proof mirror, unless the resident's treatment plan allows for otherwise;
   b. A window that opens or another means of ventilation; and
   c. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
6. If a resident bathroom door locks from the inside, an employee has a key and access to the bathroom;
7. Each resident is provided a sleeping area that is in a bedroom; and
8. A resident bedroom complies with the following:
   a. Is not used as a common area;
   b. Is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of an individual occupying the bedroom;
   c. Contains a door that opens into a hallway, common area, or outdoors;
   d. Is constructed and furnished to provide unimpeded access to the door;
   e. Has window or door covers that provide resident privacy;
   f. Has floor to ceiling walls;
   g. Is a:
      i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
      ii. Shared bedroom that:
         (1) Is shared by no more than eight residents;
         (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and
         (3) Provides at least three feet of floor space between beds or bunk beds;
   h. Contains for each resident occupying the bedroom:

i. A bed that is at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and linens; and
ii. Individual storage space for personal effects and clothing such as shelves, a dresser, or chest of drawers;
i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
j. Has sufficient lighting for a resident occupying the bedroom to read; and
k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury.

**C.** A behavioral health residential facility that was licensed as a Level 4 transitional agency before October 1, 2013 may continue to use a shared bedroom that provides at least 40 square feet of floor space, not including a closet, for each individual occupying the shared bedroom. If there is a modification to the shared bedroom, the behavioral health residential facility shall comply with the requirement in subsection (B)(8)(g).

**D.** For a behavioral health residential facility licensed according to A.R.S. § 36-425.06, an administrator shall ensure that:
1. The premises are secure, as defined in A.R.S. § 36-425.06; and
2. There is a means of exiting the facility for a resident who does not have special knowledge for egress that meets one of the following:
   a. Provides access to an outside area that:
      i. Allows the resident to be at least 30 feet away from the facility, and
      ii. Controls or alerts employees of the egress of a resident from the facility;
   b. Provides access to an outside area:
      i. From which a resident may exit to a location at least 30 feet away from the facility, and
      ii. Controls or alerts employees of the egress of a resident from the facility; or
   c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the Uniform Building Code incorporated by reference in A.A.C. R9-10-104.01.

**E.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. The swimming pool is equipped with the following:
   a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
      i. A removable strainer,
      ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
      iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
   b. An operational vacuum cleaning system;
2. The swimming pool is enclosed by a wall or fence that:
   a. Is at least five feet in height as measured on the exterior of the wall or fence;
   b. Has no vertical openings greater than four inches across;
   c. Has no horizontal openings, except as described in subsection (E)(2)(e);
   d. Is not chain-link;
   e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
   f. Has a self-closing, self-latching gate that:
      i. Opens away from the swimming pool,
      ii. Has a latch located at least 54 inches from the ground, and
      iii. Is locked when the swimming pool is not in use; and
3. A life preserver or shepherd's crook is available and accessible in the pool area.

**F.** An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (E)(2) is covered and locked when not in use.

## ARTICLE 8. ASSISTED LIVING FACILITIES

**R9-10-801. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article, unless the context otherwise requires:
1. "Accept" or "acceptance" means:
   a. An individual begins living in and receiving assisted living services from an assisted living facility; or
   b. An individual begins receiving adult day health care services or respite care services from an assisted living facility.
2. "Assistant caregiver" means an employee or volunteer who helps a manager or caregiver provide supervisory care services, personal care services, or directed care services to a resident, and does not include a family member of the resident.
3. "Assisted living services" means supervisory care services, personal care services, directed care services, behavioral care, or ancillary services provided to a resident by or on behalf of an assisted living facility.

4. "Caregiver" means an individual who provides supervisory care services, personal care services, or directed care services to a resident, and does not include a family member of the resident.
5. "Manager" means an individual designated by a governing authority to act on behalf of the governing authority in the onsite management of the assisted living facility.
6. "Medication organizer" means a container that is designed to hold doses of medication and is divided according to date or time increments.
7. "Primary care provider" means a physician, a physician's assistant, or registered nurse practitioner who directs a resident's medical services.
8. "Residency agreement" means a document signed by a resident or the resident's representative and a manager, detailing the terms of residency.
9. "Service plan" means a written description of a resident's need for supervisory care services, personal care services, directed care services, ancillary services, or behavioral health services and the specific assisted living services to be provided to the resident.
10. "Termination of residency" or "terminate residency" means a resident is no longer living in and receiving assisted living services from an assisted living facility.

**R9-10-802. Supplemental Application Requirements; Exemption**

**A.** In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as an assisted living facility shall include in a Department-provided format:
1. Which of the following levels of assisted living services the applicant is requesting authorization to provide:
   a. Supervisory care services,
   b. Personal care services, or
   c. Directed care services; and
2. Whether the applicant is requesting authorization to provide:
   a. Adult day health care services, or
   b. Behavioral health services other than behavioral care.

**B.** The Arizona Pioneers' Home is exempt from:
1. Architectural plans and specifications for a health care institution specified in R9-10-104; and
2. Physical plant codes and standards for a health care institution specified in R9-10-105(A)(5)(a).

**R9-10-803. Administration**

**A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of an assisted living facility;
2. Establish, in writing, an assisted living facility's scope of services;
3. Designate, in writing, a manager who:
   a. Is 21 years of age or older; and
   b. Except for the manager of an adult foster care home, has either a:
      i. Certificate as an assisted living facility manager issued under A.R.S. § 36-446.04(C), or
      ii. A temporary certificate as an assisted living facility manager issued under A.R.S. § 36-446.06;
4. Adopt a quality management program that complies with R9-10-804;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting manager who has the qualifications established in subsection (A)(3), if the manager is:
   a. Expected not to be present on the assisted living facility's premises for more than 30 calendar days, or
   b. Not present on the assisted living facility's premises for more than 30 calendar days;
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the manager and identify the name and qualifications of the new manager;
8. Ensure that a manager or caregiver who is able to read, write, understand, and communicate in English is on an assisted living facility's premises; and
9. Ensure compliance with A.R.S. § 36-411.

**B.** A manager:
1. Is directly accountable to the governing authority of an assisted living facility for the daily operation of the assisted living facility and all services provided by or at the assisted living facility;
2. Has the authority and responsibility to manage the assisted living facility; and
3. Except as provided in subsection (A)(6), designates, in writing, a caregiver who is:
   a. At least 21 years of age, and
   b. Present on the assisted living facility's premises and accountable for the assisted living facility when the manager is not present on the assisted living facility premises.

**C.** A manager shall ensure that policies and procedures are:
1. Established, documented, and implemented to protect the health and safety of a resident that:
   a. Cover job descriptions, duties, and qualifications, including required skills and knowledge, education, and experience for employees and volunteers;
   b. Cover orientation and in-service education for employees and volunteers;

c. Include how an employee may submit a complaint related to resident care;
d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
e. Except as provided in subsection (M), cover cardiopulmonary resuscitation training for applicable employees and volunteers, including:
i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the employee's or volunteer's ability to perform cardiopulmonary resuscitation;
ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
iv. The documentation that verifies that the employee or volunteer has received cardiopulmonary resuscitation training;
f. Cover first aid training;
g. Cover how a caregiver will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
h. Cover staffing and recordkeeping;
i. Cover resident acceptance and resident rights;
j. Cover termination of residency, including:
i. Termination initiated by the manager of an assisted living facility, and
ii. Termination initiated by a resident or the resident's representative;
k. Cover the provision of assisted living services, including:
i. Coordinating the provision of assisted living services,
ii. Making vaccination for influenza and pneumonia available to residents according to A.R.S. § 36-406(1)(d), and
iii. Obtaining resident preferences for food and the provision of assisted living services;
l. Cover the provision of respite services or adult day health services, if applicable;
m. Cover methods by which the assisted living facility is aware of the general or specific whereabouts of a resident, based on the level of assisted living services provided to the resident and the assisted living services the assisted living facility is authorized to provide;
n. Cover resident medical records, including electronic medical records;
o. Cover personal funds accounts, if applicable;
p. Cover specific steps for:
i. A resident to file a complaint, and
ii. The assisted living facility to respond to a resident's complaint;
q. Cover health care directives;
r. Cover assistance in the self-administration of medication, and medication administration;
s. Cover food services;
t. Cover contracted services;
u. Cover equipment inspection and maintenance, if applicable;
v. Cover infection control; and
w. Cover a quality management program, including incident report and supporting documentation;
2. Available to employees and volunteers of the assisted living facility; and
3. Reviewed at least once every three years and updated as needed.

**D.** A manager shall ensure that the following are conspicuously posted:
1. A list of resident rights;
2. The assisted living facility's license;
3. Current phone numbers of:
a. The unit in the Department responsible for licensing and monitoring the assisted living facility,
b. Adult Protective Services in the Department of Economic Security,
c. The State Long-Term Care Ombudsman, and
d. The Arizona Center for Disability Law; and
4. The location at which a copy of the most recent Department inspection report and any plan of correction resulting from the Department inspection may be viewed.

**E.** A manager shall ensure that, unless otherwise stated:
1. Documentation required by this Article is provided to the Department within two hours after a Department request; and
2. When documentation or information is required by this Chapter to be submitted on behalf of an assisted living facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the assisted living facility.

**F.** If a requirement in this Article states that a manager shall ensure an action or condition or sign a document:
1. A governing authority or licensee may ensure the action or condition or sign the document and retain the responsibility to ensure compliance with the requirement in this Article;

2. The manager may delegate ensuring the action or condition or signing the document to another individual, but the manager retains the responsibility to ensure compliance with the requirement in the Article; and
3. If the manager delegates ensuring an action or condition or signing a document, the delegation is documented and the documentation includes the name of the individual to whom the action, condition, or signing is delegated and the effective date of the delegation.

**G.** A manager shall:
1. Not act as a resident's representative and not allow an employee or a family member of an employee to act as a resident's representative for a resident who is not a family member of the employee;
2. If the assisted living facility administers personal funds accounts for residents and is authorized in writing by a resident or the resident's representative to administer a personal funds account for the resident:
   a. Ensure that the resident's personal funds account does not exceed $2,000;
   b. Maintain a separate record for each resident's personal funds account, including receipts and expenditures;
   c. Maintain the resident's personal funds account separate from any account of the assisted living facility; and
   d. Provide a copy of the record of the resident's personal funds account to the resident or the resident's representative at least once every three months;
3. Notify the resident's representative, family member, public fiduciary, or trust officer if the manager determines that a resident is incapable of handling financial affairs; and
4. Except when a resident's need for assisted living services changes, as documented in the resident's service plan, ensure that a resident receives at least 30 calendar days written notice before any increase in a fee or charge.

**H.** A manager shall permit the Department to interview an employee, a volunteer, or a resident as part of a compliance survey or a complaint investigation.

**I.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was accepted or while the resident is not on the premises and not receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall report the alleged or suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454.

**J.** If a manager has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect or exploitation has occurred on the premises or while a resident is receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454;
3. Document:
   a. The suspected abuse, neglect, or exploitation;
   b. Any action taken according to subsection (J)(1); and
   c. The report in subsection (J)(2);
4. Maintain the documentation in subsection (J)(3) for at least 12 months after the date of the report in subsection(J)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (J)(2):
   a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
   b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
   c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
   d. The actions taken by the manager to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (J)(5) for at least 12 months after the date the investigation was initiated.

**K.** A manager shall provide written notification to the Department of a resident's:
1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency services provider.

**L.** If a resident is receiving services from a home health agency or hospice service agency, a manager shall ensure that:
1. The resident's medical record contains:
   a. The name, address, and contact individual, including contact information, of the home health agency or hospice service agency;
   b. Any information provided by the home health agency or hospice service agency; and
   c. A copy of resident follow-up instructions provided to the resident by the home health agency or hospice service agency; and
2. Any care instructions for a resident provided to the assisted living facility by the home health agency or hospice service agency are:
   a. Within the assisted living facility's scope of services,
   b. Communicated to a caregiver, and
   c. Documented in the resident's service plan.

**M.** A manager of an assisted living home may establish, in policies and procedures, requirements that a caregiver obtains and provides documentation of cardiopulmonary resuscitation training specific to adults, which includes a demonstration of the caregiver's ability to perform cardiopulmonary resuscitation, from one of the following organizations:
1. American Red Cross,
2. American Heart Association, or
3. National Safety Council.

**R9-10-804. Quality Management**

A manager shall ensure that:
1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to residents;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to resident care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to resident care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

**R9-10-805. Contracted Services**

A manager shall ensure that:
1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

**R9-10-806. Personnel**

**A.** A manager shall ensure that:
1. A caregiver:
   a. Is 18 years of age or older; and
   b. Provides documentation of:
      i. Completion of a caregiver training program approved by the Department or the Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers;
      ii. For supervisory care services, employment as a manager or caregiver of a supervisory care home before November 1, 1998;
      iii. For supervisory care services or personal care services, employment as a manager or caregiver of a supportive residential living center before November 1, 1998; or
      iv. For supervisory care services, personal care services, or directed services, one of the following:
         (1) A nursing care institution administrator's license issued by the Board of Examiners;
         (2) A nurse's license issued to the individual under A.R.S. Title 32, Chapter 15;
         (3) Documentation of employment as a manager or caregiver of an unclassified residential care institution before November 1, 1998; or
         (4) Documentation of sponsorship of or employment as a caregiver in an adult foster care home before November 1, 1998;
2. An assistant caregiver:
   a. Is 16 years of age or older, and
   b. Interacts with residents under the supervision of a manager or caregiver;
3. The qualifications, skills, and knowledge required for a caregiver or assistant caregiver:
   a. Are based on:
      i. The type of assisted living services, behavioral health services, or behavioral care expected to be provided by the caregiver or assistant caregiver according to the established job description; and
      ii. The acuity of the residents receiving assisted living services, behavioral health services, or behavioral care from the caregiver or assistant caregiver according to the established job description; and
   b. Include:
      i. The specific skills and knowledge necessary for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description;

ii. The type and duration of education that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description; and
iii. The type and duration of experience that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services or behavioral care listed in the established job description;

4. A caregiver's or assistant caregiver's skills and knowledge are verified and documented:
   a. Before the caregiver or assistant caregiver provides physical health services or behavioral health services, and
   b. According to policies and procedures;
5. An assisted living facility has a manager, caregivers, and assistant caregivers with the qualifications, experience, skills, and knowledge necessary to:
   a. Provide the assisted living services, behavioral health services, behavioral care, and ancillary services in the assisted living facility's scope of services;
   b. Meet the needs of a resident; and
   c. Ensure the health and safety of a resident;
6. At least one manager or caregiver is present and awake at an assisted living center when a resident is on the premises;
7. Documentation is maintained for at least 12 months after the last date on the documentation of the caregivers and assistant caregivers working each day, including the hours worked by each;
8. A manager, a caregiver, and an assistant caregiver, or an employee or a volunteer who has or is expected to have more than eight hours per week of direct interaction with residents, provides evidence of freedom from infectious tuberculosis:
   a. On or before the date the individual begins providing services at or on behalf of the assisted living facility, and
   b. As specified in R9-10-113;
9. Before providing assisted living services to a resident, a caregiver or an assistant caregiver receives orientation that is specific to the duties to be performed by the caregiver or assistant caregiver; and
10. Before providing assisted living services to a resident, a manager or caregiver provides current documentation of first aid training and cardiopulmonary resuscitation training certification specific to adults.

**B.** A manager of an assisted living home shall ensure that:
1. An individual residing in an assisted living home, who is not a resident, a manager, a caregiver, or an assistant caregiver:
   a. Either:
      i. Complies with the fingerprinting requirements in A.R.S. § 36-411, or
      ii. Interacts with residents only under the supervision of an individual who has a valid fingerprint clearance card; and
   b. If the individual is 12 years of age or older, provides evidence of freedom from infectious tuberculosis as specified in R9-10-113;
2. Documentation of compliance with the requirements in subsection (B)(1)(a) and evidence of freedom from infectious tuberculosis, if required under subsection (B)(1)(b), is maintained for an individual residing in the assisted living home who is not a resident, a manager, a caregiver, or an assistant caregiver;
3. As part of the policies and procedures required in R9-10-803(C)(1)(h), a plan is established, documented, and implemented to ensure that the manager or a caregiver is available as back-up to provide assisted living services to a resident if the manager or a caregiver assigned to work is not available or not able to provide the required assisted living services; and
4. At least the manager or a caregiver is present at an assisted living home when a resident is present in the assisted living home and:
   a. Except for nighttime hours, the manager or caregiver is awake; and
   b. If the manager or caregiver is not awake during nighttime hours:
      i. The manager or caregiver can hear and respond to a resident needing assistance; and
      ii. If the assisted living home is authorized to provide directed care services, policies and procedures are developed, documented, and implemented to establish a process for checking on a resident receiving directed care services during nighttime hours to ensure the resident's health and safety.

**C.** A manager shall ensure that a personnel record for each employee or volunteer:
1. Includes:
   a. The individual's name, date of birth, and contact telephone number;
   b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
   c. Documentation of:
      i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
      ii. The individual's education and experience applicable to the individual's job duties;
      iii. The individual's completed orientation and in-service education required by policies and procedures;
      iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or in policies and procedures;
      v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
      vi. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(8);
      vii. Cardiopulmonary resuscitation training, if required for the individual in this Article or policies and procedures;

viii First aid training, if required for the individual in this Article or policies and procedures; and
ix. Documentation of compliance with the requirements in A.R.S. § 36-411(A) and (C);
2. Is maintained:
a. Throughout the individual's period of providing services in or for the assisted living facility, and
b. For at least 24 months after the last date the individual provided services in or for the assisted living facility; and
3. For a manager, a caregiver, or an assistant caregiver who has not provided physical health services or behavioral health services at or for the assisted living facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.

**R9-10-807. Residency and Residency Agreements**

**A.** Except as provided in R9-10-808(B)(2), a manager shall ensure that a resident provides evidence of freedom from infectious tuberculosis:
1. Before or within seven calendar days after the resident's date of occupancy, and
2. As specified in R9-10-113.

**B.** A manager shall ensure that before or at the time of acceptance of an individual, the individual submits documentation that is dated within 90 calendar days before the individual is accepted by an assisted living facility and:
1. If an individual is requesting or is expected to receive supervisory care services, personal care services, or directed care services:
a. Includes whether the individual requires:
i. Continuous medical services,
ii. Continuous or intermittent nursing services, or
iii. Restraints; and
b. Is dated and signed by a:
i. Physician,
ii. Registered nurse practitioner,
iii. Registered nurse, or
iv. Physician assistant; and
2. If an individual is requesting or is expected to receive behavioral health services, other than behavioral care, in addition to supervisory care services, personal care services, or directed care services from an assisted living facility:
a. Includes whether the individual requires continuous behavioral health services, and
b. Is signed and dated by a behavioral health professional.

**C.** A manager shall not accept or retain an individual if:
1. The individual requires continuous:
a. Medical services;
b. Nursing services, unless the assisted living facility complies with A.R.S. § 36-401(C); or
c. Behavioral health services;
2. The primary condition for which the individual needs assisted living services is a behavioral health issue;
3. The services needed by the individual are not within the assisted living facility's scope of services and a home health agency or hospice service agency is not involved in the care of the individual;
4. The assisted living facility does not have the ability to provide the assisted living services needed by the individual; or
5. The individual requires restraints, including the use of bedrails.

**D.** Before or at the time of an individual's acceptance by an assisted living facility, a manager shall ensure that there is a documented residency agreement with the assisted living facility that includes:
1. The individual's name;
2. Terms of occupancy, including:
a. Date of occupancy or expected date of occupancy,
b. Resident responsibilities, and
c. Responsibilities of the assisted living facility;
3. A list of the services to be provided by the assisted living facility to the resident;
4. A list of the services available from the assisted living facility at an additional fee or charge;
5. For an assisted living home, whether the manager or a caregiver is awake during nighttime hours;
6. The policy for refunding fees, charges, or deposits;
7. The policy and procedure for a resident to terminate residency, including terminating residency because services were not provided to the resident according to the resident's service plan;
8. The policy and procedure for an assisted living facility to terminate residency;
9. The complaint process; and
10. The manager's signature and date signed.

**E.** Before or within five working days after a resident's acceptance by an assisted living facility, a manager shall obtain on the documented agreement, required in subsection (D), the signature of one of the following individuals:
1. The resident,

2. The resident's representative,
3. The resident's legal guardian, or
4. Another individual who has been designated by the individual under A.R.S. § 36-3221 to make health care decisions on the individual's behalf.

**F.** A manager shall:
1. Before or at the time of an individual's acceptance by an assisted living facility, provide to the resident or resident's representative a copy of:
   a. The residency agreement in subsection (D),
   b. Resident's rights, and
   c. The policy and procedure on health care directives; and
2. Maintain the original of the residency agreement in subsection (D) in the resident's medical record.

**G.** A manager may terminate residency of a resident as follows:
1. Without notice, if the resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in an assisted living facility;
2. With a 14-calendar-day written notice of termination of residency:
   a. For nonpayment of fees, charges, or deposit; or
   b. Under any of the conditions in subsection (C); or
3. With a 30-calendar-day written notice of termination of residency, for any other reason.

**H.** A manager shall ensure that the written notice of termination of residency in subsection (G) includes:
1. The date of notice;
2. The reason for termination;
3. The policy for refunding fees, charges, or deposits;
4. The deposition of a resident's fees, charges, and deposits; and
5. Contact information for the State Long-Term Care Ombudsman.

**I.** A manager shall provide the following to a resident when the manager provides the written notice of termination of residency in subsection (G):
1. A copy of the resident's current service plan, and
2. Documentation of the resident's freedom from infectious tuberculosis.

**J.** If an assisted living facility issues a written notice of termination of residency as provided in subsection (G) to a resident or the resident's representative because the resident needs services the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide, a manager shall ensure that the written notice of termination of residency includes a description of the specific services that the resident needs that the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide.

**R9-10-808. Service Plans**

**A.** Except as required in subsection (B), a manager shall ensure that a resident has a written service plan that:
1. Is completed no later than 14 calendar days after the resident's date of acceptance;
2. Is developed with assistance and review from:
   a. The resident or resident's representative,
   b. The manager, and
   c. Any individual requested by the resident or the resident's representative;
3. Includes the following:
   a. A description of the resident's medical or health problems, including physical, behavioral, cognitive, or functional conditions or impairments;
   b. The level of service the resident is expected to receive;
   c. The amount, type, and frequency of assisted living services being provided to the resident, including medication administration or assistance in the self-administration of medication;
   d. For a resident who requires intermittent nursing services or medication administration, review by a nurse or medical practitioner;
   e. For a resident who requires behavioral care:
      i. Any of the following that is necessary to provide assistance with the resident's psychosocial interactions to manage the resident's behavior:
         (1) The psychosocial interactions or behaviors for which the resident requires assistance,
         (2) Psychotropic medications ordered for the resident,
         (3) Planned strategies and actions for changing the resident's psychosocial interactions or behaviors, and
         (4) Goals for changes in the resident's psychosocial interactions or behaviors; and
      ii. Review by a medical practitioner or behavioral health professional; and
   f. For a resident who will be storing medication in the resident's bedroom or residential unit, how the medication will be stored and controlled;
4. Is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f):

a. No later than 14 calendar days after a significant change in the resident's physical, cognitive, or functional condition; and
b. As follows:
i. At least once every 12 months for a resident receiving supervisory care services,
ii. At least once every six months for a resident receiving personal care services, and
iii. At least once every three months for a resident receiving directed care services; and

5. When initially developed and when updated, is signed and dated by:
a. The resident or resident's representative;
b. The manager;
c. If a review is required in subsection (A)(3)(d), the nurse or medical practitioner who reviewed the service plan; and
d. If a review is required in subsection (A)(3)(e)(ii), the medical practitioner or behavioral health professional who reviewed the service plan.

**B.** For a resident receiving respite care services, a manager shall ensure that:
1. A written service plan is:
a. Based on a determination of the resident's current needs and:
i. Is completed no later than three working days after the resident's date of acceptance; or
ii. If the resident has a service plan in the resident's medical record that was developed within the previous 12 months, is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f) within three working days after the resident's date of acceptance; and
b. If a significant change in the resident's physical, cognitive, or functional condition occurs while the resident is receiving respite care services, updated based on changes in the requirements in subsections (A)(3)(a) through (f) within three working days after the significant change occurs; and
2. If the resident is not expected to be present in the assisted living facility for more than seven calendar days, the resident is not required to comply with the requirements in R9-10-807(A).

**C.** A manager shall ensure that:
1. A caregiver or an assistant caregiver:
a. Provides a resident with the assisted living services in the resident's service plan;
b. Is only assigned to provide the assisted living services the caregiver or assistant caregiver has the documented skills and knowledge to perform;
c. Provides assistance with activities of daily living according to the resident's service plan;
d. If applicable, suggests techniques a resident may use to maintain or improve the resident's independence in performing activities of daily living;
e. Provides assistance with, supervises, or directs a resident's personal hygiene according to the resident's service plan;
f. Encourages a resident to participate in activities planned according to subsection (E); and
g. Documents the services provided in the resident's medical record; and
2. A volunteer or an assistant caregiver who is 16 or 17 years of age does not provide:
a. Assistance to a resident for:
i. Bathing,
ii. Toileting, or
iii. Moving the resident's body from one surface to another surface;
b. Assistance in the self-administration of medication;
c. Medication administration; or
d. Nursing services.

**D.** A manager of an assisted living facility that is authorized to provide adult day health services shall ensure that the adult day health care services are provided as specified in R9-10-1113.

**E.** A manager shall ensure that:
1. Daily social, recreational, or rehabilitative activities are planned according to residents' preferences, needs, and abilities;
2. A calendar of planned activities is:
a. Prepared at least one week in advance of the date the activity is provided,
b. Posted in a location that is easily seen by residents,
c. Updated as necessary to reflect substitutions in the activities provided, and
d. Maintained for at least 12 months after the last scheduled activity;
3. Equipment and supplies are available and accessible to accommodate a resident who chooses to participate in a planned activity; and
4. Multiple media sources, such as daily newspapers, current magazines, internet sources, and a variety of reading materials, are available and accessible to a resident to maintain the resident's continued awareness of current news, social events, and other noteworthy information.

**F.** If a resident is not receiving assistance with the resident's psychosocial interactions under the direction of a behavioral health professional or any other behavioral health services at an assisted living facility, the resident is not considered to be receiving behavioral care or behavioral health services from the assisted living facility if the resident:
1. Is prescribed a psychotropic medication, or
2. Is receiving directed care services and has a primary diagnosis of:
   a. Dementia,
   b. Alzheimer's disease-related dementia, or
   c. Traumatic brain injury.

**R9-10-809. Transport; Transfer**

**A.** Except as provided in subsection (B), a manager shall ensure that:
1. A caregiver or employee coordinates the transport and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before and after the transport, and
   b. Information from the resident's medical record is provided to a receiving health care institution; and
3. Documentation includes:
   a. If applicable, any communication with an individual at a receiving health care institution;
   b. The date and time of the transport; and
   c. If applicable, the name of the caregiver accompanying the resident during a transport.

**B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,
2. Transportation provided for a resident by the resident or the resident's representative,
3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
4. A transport to another licensed health care institution in an emergency.

**C.** Except for a transfer of a resident due to an emergency, a manager shall ensure that:
1. A caregiver coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
   a. An evaluation of the resident is conducted before the transfer;
   b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
   c. A caregiver explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
   a. Communication with an individual at a receiving health care institution;
   b. The date and time of the transfer;
   c. The mode of transportation; and
   d. If applicable, the name of the caregiver accompanying the resident during a transfer.

**R9-10-810. Resident Rights**

**A.** A manager shall ensure that, at the time of acceptance, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C).

**B.** A manager shall ensure that:
1. A resident is treated with dignity, respect, and consideration;
2. A resident is not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Seclusion;
   i. Restraint;
   j. Retaliation for submitting a complaint to the Department or another entity; or
   k. Misappropriation of personal and private property by the assisted living facility's manager, caregivers, assistant caregivers, employees, or volunteers; and
3. A resident or the resident's representative:
   a. Is informed of the following:
      i. The policy on health care directives, and
      ii. The resident complaint process;
   b. Consents to photographs of the resident before the resident is photographed, except that a resident may be photographed when accepted as a resident by an assisted living facility for identification and administrative purposes;

c. Except as otherwise permitted by law, provides written consent before the release of information in the resident's:
   i. Medical record, or
   ii. Financial records;
d. May:
   i. Request or consent to relocation within the assisted living facility; and
   ii. Except when relocation is necessary based on a change in the resident's condition as documented in the resident's service plan, refuse relocation within the assisted living facility;
e. Has access to the resident's records during normal business hours or at a time agreed upon by the resident or resident's representative and the manager; and
f. Is informed of:
   i. The rates and charges for services before the services are initiated;
   ii. A change in rates or charges at least 30 calendar days before the change is implemented, unless the change in rates or charges results from a change in services; and
   iii. A change in services at least 30 calendar days before the change is implemented, unless the resident's service plan changes.

**C.** A resident has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive assisted living services that support and respect the resident's individuality, choices, strengths, and abilities;
3. To receive privacy in:
   a. Care for personal needs;
   b. Correspondence, communications, and visitation; and
   c. Financial and personal affairs;
4. To maintain, use, and display personal items unless the personal items constitute a hazard;
5. To choose to participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities;
6. To review, upon written request, the resident's own medical record;
7. To receive a referral to another health care institution if the assisted living facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
8. To choose to access services from a health care provider, health care institution, or pharmacy other than the assisted living facility where the resident is residing and receiving services or a health care provider, health care institution, or pharmacy recommended by the assisted living facility;
9. To participate or have the resident's representative participate in the development of, or decisions concerning, the resident's service plan; and
10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

**R9-10-811. Medical Records**

**A.** A manager shall ensure that:
1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:
   a. Only recorded by an individual authorized by policies and procedures to make the entry;
   b. Dated, legible, and authenticated; and
   c. Not changed to make the initial entry illegible;
3. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
4. A resident's medical record is available to an individual:
   a. Authorized according to policies and procedures to access the resident's medical record;
   b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
   c. As permitted by law; and
5. A resident's medical record is protected from loss, damage, or unauthorized use.

**B.** If an assisted living facility maintains residents' medical records electronically, a manager shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.

**C.** A manager shall ensure that a resident's medical record contains:
1. Resident information that includes:
   a. The resident's name, and
   b. The resident's date of birth;

2. The names, addresses, and telephone numbers of:
   a. The resident's primary care provider;
   b. Other persons, such as a home health agency or hospice service agency, involved in the care of the resident; and
   c. An individual to be contacted in the event of emergency, significant change in the resident's condition, or termination of residency;
3. If applicable, the name and contact information of the resident's representative and:
   a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
   b. If the resident's representative:
      i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
      ii. Is a legal guardian, a copy of the court order establishing guardianship;
4. The date of acceptance and, if applicable, date of termination of residency;
5. Documentation of the resident's needs required in R9-10-807(B);
6. Documentation of general consent and informed consent, if applicable;
7. Except as allowed in R9-10-808(B)(2), documentation of freedom from infectious tuberculosis as required in R9-10-807(A);
8. A copy of resident's health care directive, if applicable;
9. The resident's signed residency agreement and any amendments;
10. Resident's service plan and updates;
11. Documentation of assisted living services provided to the resident;
12. A medication order from a medical practitioner for each medication that is administered to the resident or for which the resident receives assistance in the self-administration of the medication;
13. Documentation of medication administered to the resident or for which the resident received assistance in the self-administration of medication that includes:
    a. The date and time of administration or assistance;
    b. The name, strength, dosage, and route of administration;
    c. The name and signature of the individual administering or providing assistance in the self-administration of medication; and
    d. An unexpected reaction the resident has to the medication;
14. Documentation of the resident's refusal of a medication, if applicable;
15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
16. If applicable, documentation of a determination by a medical practitioner that evacuation from the assisted living facility during an evacuation drill would cause harm to the resident;
17. Documentation of notification of the resident of the availability of vaccination for influenza and pneumonia, according to A.R.S. § 36-406(1)(d);
18. Documentation of the resident's orientation to exits from the assisted living facility required in R9-10-818(B);
19. If a resident is receiving behavioral health services other than behavioral care, documentation of the determination in R9-10-813(3);
20. If a resident is receiving behavioral care, documentation of the determination in R9-10-812(3);
21. If applicable, for a resident who is unable to direct self-care, the information required in R9-10-815(F);
22. Documentation of any significant change in a resident's behavior, physical, cognitive, or functional condition and the action taken by a manager or caregiver to address the resident's changing needs;
23. Documentation of the notification required in R9-10-803(G) if the resident is incapable of handling financial affairs; and
24. If the resident no longer resides and receives assisted living services from the assisted living facility:
    a. A written notice of termination of residency; or
    b. If the resident terminated residency, the date the resident terminated residency.

**R9-10-812. Behavioral Care**

A manager shall ensure that for a resident who requests or receives behavioral care from the assisted living facility, a behavioral health professional or medical practitioner:

1. Evaluates the resident:
   a. Within 30 calendar days before acceptance of the resident or before the resident begins receiving behavioral care, and
   b. At least once every six months throughout the duration of the resident's need for behavioral care;
2. Reviews the assisted living facility's scope of services; and
3. Signs and dates a determination stating that the resident's need for behavioral care can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

**R9-10-813. Behavioral Health Services**

If an assisted living facility is authorized to provide behavioral health services other than behavioral care, a manager shall ensure that:

1. Policies and procedures are established, documented, and implemented that cover when general consent and informed consent are required and by whom general consent and informed consent may be given;
2. The behavioral health services:

a. Are provided under the direction of a behavioral health professional; and
b. Comply with the requirements:
i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
ii. For an assessment, in R9-10-1011(B); and
3. For a resident who requests or receives behavioral health services from the assisted living facility, a behavioral health professional:
a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for behavioral health services;
b. Reviews the assisted living facility's scope of services; and
c. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

**R9-10-814. Personal Care Services**

**A.** A manager of an assisted living facility authorized to provide personal care services shall not accept or retain a resident who:
1. Is unable to direct self-care;
2. Except as specified in subsection (B), is confined to a bed or chair because of an inability to ambulate even with assistance; or
3. Except as specified in subsection (C), has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.

**B.** A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who is confined to a bed or chair because of an inability to ambulate even with assistance if:
1. The condition is a result of a short-term illness or injury; or
2. The following requirements are met at the onset of the condition or when the resident is accepted by the assisted living facility:
a. The resident or resident's representative requests that the resident be accepted by or remain in the assisted living facility;
b. The resident's primary care provider or other medical practitioner:
i. Examines the resident at the onset of the condition, or within 30 calendar days before acceptance, and at least once every six months throughout the duration of the resident's condition;
ii. Reviews the assisted living facility's scope of services; and
iii. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility; and
c. The resident's service plan includes the resident's increased need for personal care services.

**C.** A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner, if the requirements in subsection (B)(2) are met.

**D.** A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who:
1. Is receiving nursing services from a home health agency or a hospice service agency; or
2. Requires intermittent nursing services if:
a. The resident's condition for which nursing services are required is a result of a short-term illness or injury, and
b. The requirements of subsection (B)(2) are met.

**E.** A manager shall ensure that a bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available and accessible in a bedroom or residential unit being used by a resident receiving personal care services.

**F.** In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving personal care services includes:
1. Skin maintenance to prevent and treat bruises, injuries, pressure sores, and infections;
2. Offering sufficient fluids to maintain hydration;
3. Incontinence care that ensures that a resident maintains the highest practicable level of independence when toileting; and
4. If applicable, the determination in subsection (B)(2)(b)(iii).

**G.** A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving personal care services unless the resident has an order from the resident's primary care provider or another medical practitioner for the non-prescription medication.

**R9-10-815. Directed Care Services**

**A.** A manager shall ensure that a resident's representative is designated for a resident who is unable to direct self-care.

**B.** A manager of an assisted living facility authorized to provide directed care services shall not accept or retain a resident who, except as provided in R9-10-814(B)(2):
1. Is confined to a bed or chair because of an inability to ambulate even with assistance; or
2. Has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.

**C.** In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving directed care services includes:
1. The requirements in R9-10-814(F)(1) through (3);
2. If applicable, the determination in R9-10-814(B)(2)(b)(iii);

3. Cognitive stimulation and activities to maximize functioning;
4. Strategies to ensure a resident's personal safety;
5. Encouragement to eat meals and snacks;
6. Documentation:
   a. Of the resident's weight, or
   b. From a medical practitioner stating that weighing the resident is contraindicated; and
7. Coordination of communications with the resident's representative, family members, and, if applicable, other individuals identified in the resident's service plan.

**D.** A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving directed care services unless the resident has an order from a medical practitioner for the non-prescription medication.

**E.** A manager shall ensure that:
1. A bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available in a bedroom being used by a resident receiving directed care services; or
2. An assisted living facility has implemented another means to alert a caregiver or assistant caregiver to a resident's needs or emergencies.

**F.** A manager of an assisted living facility authorized to provide directed care services shall ensure that:
1. Policies and procedures are established, documented, and implemented that ensure the safety of a resident who may wander;
2. There is a means of exiting the facility for a resident who does not have a key, special knowledge for egress, or the ability to expend increased physical effort that meets one of the following:
   a. Provides access to an outside area that:
      i. Allows the resident to be at least 30 feet away from the facility, and
      ii. Controls or alerts employees of the egress of a resident from the facility;
   b. Provides access to an outside area:
      i. From which a resident may exit to a location at least 30 feet away from the facility, and
      ii. Controls or alerts employees of the egress of a resident from the facility; or
   c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the International Building Code incorporated by reference in R9-10-104.01; and
3. A caregiver or an assistant caregiver complies with the requirements for incidents in R9-10-804 when a resident who is unable to direct self-care wanders into an area not designated by the governing authority for use by the resident.

**R9-10-816. Medication Services**

**A.** A manager shall ensure that:
1. Policies and procedures for medication services include:
   a. Procedures for preventing, responding to, and reporting a medication error;
   b. Procedures for responding to and reporting an unexpected reaction to a medication;
   c. Procedures to ensure that a resident's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
   d. Procedures for:
      i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
      ii. Monitoring a resident who self-administers medication;
   e. Procedures for assisting a resident in procuring medication; and
   f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
2. If a verbal order for a resident's medication is received from a medical practitioner by the assisted living facility:
   a. The manager or a caregiver takes the verbal order from the medical practitioner,
   b. The verbal order is documented in the resident's medical record, and
   c. A written order verifying the verbal order is obtained from the medical practitioner within 14 calendar days after receiving the verbal order.

**B.** If an assisted living facility provides medication administration, a manager shall ensure that:
1. Medication is stored by the assisted living facility;
2. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;
   b. Include a process for documenting an individual, authorized, according to the definition of "administer" in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;
   c. Ensure that medication is administered to a resident only as prescribed; and
   d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record; and
3. A medication administered to a resident:
   a. Is administered by an individual under direction of a medical practitioner,
   b. Is administered in compliance with a medication order, and
   c. Is documented in the resident's medical record.

**C.** If an assisted living facility provides assistance in the self-administration of medication, a manager shall ensure that:
1. A resident's medication is stored by the assisted living facility;
2. The following assistance is provided to a resident:
   a. A reminder when it is time to take the medication;
   b. Opening the medication container or medication organizer for the resident;
   c. Observing the resident while the resident removes the medication from the container or medication organizer;
   d. Except when a resident uses a medication organizer, verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:
      i. The resident taking the medication is the individual stated on the medication container label,
      ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
      iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label;
   e. For a resident using a medication organizer, verifying that the resident is taking the medication in the medication organizer according to the schedule specified on the medical practitioner's order; or
   f. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or nurse; and
4. Assistance in the self-administration of medication provided to a resident:
   a. Is in compliance with an order, and
   b. Is documented in the resident's medical record.

**D.** A manager shall ensure that:
1. A current drug reference guide is available for use by personnel members, and
2. A current toxicology reference guide is available for use by personnel members.

**E.** A manager shall ensure that a resident's medication organizer is only filled by:
1. The resident;
2. The resident's representative;
3. A family member of the resident;
4. A personnel member of a home health agency or hospice service agency; or
5. The manager or a caregiver who has been designated and is under the direction of a medical practitioner, according to subsection (B)(2)(b).

**F.** When medication is stored by an assisted living facility, a manager shall ensure that:
1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.

**G.** A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.

**H.** If medication is stored by a resident in the resident's bedroom or residential unit, a manager shall ensure that:
1. The medication is stored according to the resident's service plan; or
2. If the medication is not being stored according to the resident's service plan, the resident's service plan is updated to include how the medication is being stored by the resident.

**R9-10-817. Food Services**

**A.** A manager shall ensure that:
1. A food menu:
   a. Is prepared at least one week in advance,
   b. Includes the foods to be served each day,
   c. Is conspicuously posted at least one calendar day before the first meal on the food menu is served,
   d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
   e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the assisted living facility are served according to posted menus;

3. If the assisted living facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the assisted living facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the assisted living facility;
4. The assisted living facility is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
5. Meals and snacks for each day are planned using the applicable guidelines in http://www.health.gov/dietaryguidelines/2015;
6. A resident is provided a diet that meets the resident's nutritional needs as specified in the resident's service plan;
7. Water is available and accessible to residents at all times, unless otherwise stated in a medical practitioner's order; and
8. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the provision of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the resident.

**B.** If the assisted living facility offers therapeutic diets, a manager shall ensure that:
1. A current therapeutic diet manual is available for use by employees, and
2. The therapeutic diet is provided to a resident according to a written order from the resident's primary care provider or another medical practitioner.

**C.** A manager shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Food is prepared:
   a. Using methods that conserve nutritional value, flavor, and appearance; and
   b. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
4. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below; and
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
      i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
      ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
      iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155 °F;
      v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
      vi. Leftovers are reheated to a temperature of at least 165° F;
5. A refrigerator used by an assisted living facility to store food or medication contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
6. Frozen foods are stored at a temperature of 0° F or below; and
7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**D.** A manager of an assisted living center shall ensure that:
1. The assisted living center has a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
2. A copy of the assisted living center's food establishment license or permit is maintained.

**R9-10-818. Emergency and Safety Standards**

**A.** A manager shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to caregivers and assistant caregivers, and, if necessary, implemented that includes:
   a. When, how, and where residents will be relocated;
   b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
   c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
   d. A plan for obtaining food and water for individuals present in the assisted living facility or the assisted living facility's relocation site during a disaster;
2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
3. Documentation of the disaster plan review required in subsection (A)(2) includes:
   a. The date and time of the disaster plan review;
   b. The name of each employee or volunteer participating in the disaster plan review;
   c. A critique of the disaster plan review; and
   d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and residents:
   a. Is conducted at least once every six months; and
   b. Includes all individuals on the premises except for:

i. A resident whose medical record contains documentation that evacuation from the assisted living facility would cause harm to the resident, and
ii. Sufficient caregivers to ensure the health and safety of residents not evacuated according to subsection (A)(5)(b)(i);

6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
   a. The date and time of the evacuation drill;
   b. The amount of time taken for employees and residents to evacuate the assisted living facility;
   c. If applicable:
      i. An identification of residents needing assistance for evacuation, and
      ii. An identification of residents who were not evacuated;
   d. Any problems encountered in conducting the evacuation drill; and
   e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted in each hallway of each floor of the assisted living facility.

**B.** A manager shall ensure that:
1. A resident receives orientation to the exits from the assisted living facility and the route to be used when evacuating the assisted living facility within 24 hours after the resident's acceptance by the assisted living facility, and
2. The resident's orientation is documented.

**C.** A manager shall ensure that a first-aid kit is maintained in the assisted living facility in a location accessible to caregivers and assistant caregivers.

**D.** When a resident has an accident, emergency, or injury that results in the resident needing medical services, a manager shall ensure that a caregiver or an assistant caregiver:
1. Immediately notifies the resident's emergency contact and primary care provider; and
2. Documents the following:
   a. The date and time of the accident, emergency, or injury;
   b. A description of the accident, emergency, or injury;
   c. The names of individuals who observed the accident, emergency, or injury;
   d. The actions taken by the caregiver or assistant caregiver;
   e. The individuals notified by the caregiver or assistant caregiver; and
   f. Any action taken to prevent the accident, emergency, or injury from occurring in the future.

**E.** A manager of an assisted living center shall ensure that:
1. Unless the assisted living center has documentation of having received an exception from the Department before October 1, 2013, in the areas of the assisted living center providing personal care services or directed care services:
   a. A fire alarm system is installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and is in working order; and
   b. A sprinkler system is installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, and is in working order;
2. For the areas of the assisted living center providing only supervisory care services:
   a. A fire alarm system and a sprinkler system meeting the requirements in subsection (E)(1) are installed and in working order, or
   b. The assisted living center complies with the requirements in subsection (F);
3. A fire inspection is conducted by a local fire department or the State Fire Marshal before licensing and according to the time-frame established by the local fire department or the State Fire Marshal;
4. Any repairs or corrections stated on the fire inspection report are made; and
5. Documentation of a current fire inspection is maintained.

**F.** A manager of an assisted living home shall ensure that:
1. A fire extinguisher that is labeled as rated at least 2A-10-BC by the Underwriters Laboratories is mounted and maintained in the assisted living home;
2. A disposable fire extinguisher is replaced when its indicator reaches the red zone;
3. A rechargeable fire extinguisher:
   a. Is serviced at least once every 12 months, and
   b. Has a tag attached to the fire extinguisher that specifies the date of the last servicing and the identification of the person who serviced the fire extinguisher;
4. Except as provided in subsection (G):
   a. A smoke detector is:
      i. Installed in each bedroom, hallway that adjoins a bedroom, storage room, laundry room, attached garage, and room or hallway adjacent to the kitchen, and other places recommended by the manufacturer;
      ii. Either battery operated or, if hard-wired into the electrical system of the assisted living home, has a back-up battery;
      iii. In working order; and

iv. Tested at least once a month; and
b. Documentation of the test required in subsection (F)(4)(a)(iv) is maintained for at least 12 months after the date of the test;
5. An appliance, light, or other device with a frayed or spliced electrical cord is not used at the assisted living home; and
6. An electrical cord, including an extension cord, is not run under a rug or carpeting, over a nail, or from one room to another at the assisted living home.

**G.** A manager of an assisted living home may use a fire alarm system and a sprinkler system to ensure the safety of residents if the fire alarm system and sprinkler system:
1. Are installed and in working order, and
2. Meet the requirements in subsection (E)(1).

**R9-10-819. Environmental Standards**

**A.** A manager shall ensure that:
1. The premises and equipment used at the assisted living facility are:
   a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
   b. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Garbage and refuse are:
   a. Stored in covered containers lined with plastic bags, and
   b. Removed from the premises at least once a week;
4. Heating and cooling systems maintain the assisted living facility at a temperature between 70° F and 84° F at all times, unless individually controlled by a resident;
5. Common areas:
   a. Are lighted to ensure the safety of residents, and
   b. Have lighting sufficient to allow caregivers and assistant caregivers to monitor resident activity;
6. Hot water temperatures are maintained between 95º F and 120º F in areas of an assisted living facility used by residents;
7. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
8. A resident has access to a laundry service or a washing machine and dryer in the assisted living facility;
9. Soiled linen and soiled clothing stored by the assisted living facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
10. Oxygen containers are secured in an upright position;
11. Poisonous or toxic materials stored by the assisted living facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;
12. Combustible or flammable liquids and hazardous materials stored by the assisted living facility are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
13. Equipment used at the assisted living facility is:
   a. Maintained in working order;
   b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
   c. Used according to the manufacturer's recommendations;
14. If pets or animals are allowed in the assisted living facility, pets or animals are:
   a. Controlled to prevent endangering the residents and to maintain sanitation;
   b. Licensed consistent with local ordinances; and
   c. For a dog or cat, vaccinated against rabies;
15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
   a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
   b. If necessary, corrective action is taken to ensure the water is safe to drink; and
   c. Documentation of testing is retained for at least 12 months after the date of the test; and
16. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to applicable state laws and rules.

**B.** If a swimming pool is located on the premises, a manager shall ensure that:
1. On a day that a resident uses the swimming pool, an employee:
   a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
      i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
      ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
      iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
   b. Records the results of the water quality tests in a log that includes the date tested and test result;
2. Documentation of the water quality test is maintained for at least 12 months after the date of the test; and

3. A swimming pool is not used by a resident if a water quality test shows that the swimming pool water does not comply with subsection (B)(1)(a).

**R9-10-820. Physical Plant Standards**

**A.** A manager shall ensure that an assisted living center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that:
1. Are applicable to the level of services planned to be provided or being provided; and
2. Were in effect on the date the assisted living facility submitted architectural plans and specifications to the Department for approval, according to R9-10-104.

**B.** A manager shall ensure that:
1. The premises and equipment are sufficient to accommodate:
   a. The services stated in the assisted living facility's scope of services, and
   b. An individual accepted as a resident by the assisted living facility;
2. A common area for use by residents is provided that has sufficient space and furniture to accommodate the recreational and socialization needs of residents;
3. A dining area has sufficient space and tables and chairs to accommodate the needs of the residents;
4. At least one bathroom is accessible from a common area and:
   a. May be used by residents and visitors;
   b. Provides privacy when in use; and
   c. Contains the following:
      i. At least one working sink with running water,
      ii. At least one working toilet that flushes and has a seat,
      iii. Toilet tissue for each toilet,
      iv. Soap in a dispenser accessible from each sink,
      v. Paper towels in a dispenser or a mechanical air hand dryer,
      vi. Lighting, and
      vii. A window that opens or another means of ventilation;
5. An outside activity space is provided and available that:
   a. Is on the premises,
   b. Has a hard-surfaced section for wheelchairs, and
   c. Has an available shaded area;
6. Exterior doors are equipped with ramps or other devices to allow use by a resident using a wheelchair or other assistive device; and
7. The key to the door of a lockable bathroom, bedroom, or residential unit is available to a manager, caregiver, and assistant caregiver.

**C.** A manager shall ensure that:
1. For every eight residents there is at least one working toilet that flushes and has a seat and one sink with running water;
2. For every eight residents there is at least one working bathtub or shower; and
3. A resident bathroom provides privacy when in use and contains:
   a. A mirror;
   b. Toilet tissue for each toilet;
   c. Soap accessible from each sink;
   d. Paper towels in a dispenser or a mechanical air hand dryer for a bathroom that is not in a residential unit and used by more than one resident;
   e. A window that opens or another means of ventilation;
   f. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
   g. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers.

**D.** A manager shall ensure that:
1. Each resident is provided with a sleeping area in a residential unit or a bedroom;
2. For an assisted living home, a resident's sleeping area is on the ground floor of the assisted living home unless:
   a. The resident is able to direct self-care;
   b. The resident is ambulatory without assistance; and
   c. There are at least two unobstructed, usable exits to the outside from the sleeping area that the resident is capable of using;
3. Except as provided in subsection (E), no more than two individuals reside in a residential unit or bedroom;
4. A resident's sleeping area:
   a. Is not used as a common area;
   b. Is not used as a passageway to a common area, another sleeping area, or common bathroom unless the resident's sleeping area:

i. Was used as a passageway to a common area, another sleeping area, or common bathroom before October 1, 2013; and
ii. Written consent is obtained from the resident or the resident's representative;
c. Is constructed and furnished to provide unimpeded access to the door;
d. Has floor-to-ceiling walls with at least one door;
e. Has access to natural light through a window or a glass door to the outside; and
f. Has a window or door that can be used for direct egress to outside the building;

5. If a resident's sleeping area is in a bedroom, the bedroom has:
a. For a private bedroom, at least 80 square feet of floor space, not including a closet or bathroom;
b. For a shared bedroom, at least 60 square feet of floor space for each individual occupying the shared bedroom, not including a closet or bathroom; and
c. A door that opens into a hallway, common area, or outdoors;

6. If a resident's sleeping area is in a residential unit, the residential unit has:
a. Except as provided in subsection (E)(2), at least 220 square feet of floor space, not including a closet or bathroom, for one individual residing in the residential unit and an additional 100 square feet of floor space, not including a closet or bathroom, for each additional individual residing in the residential unit;
b. An individually keyed entry door;
c. A bathroom that provides privacy when in use and contains:
i. A working toilet that flushes and has a seat;
ii. A working sink with running water;
iii. A working bathtub or shower;
iv. Lighting;
v. A mirror;
vi. A window that opens or another means of ventilation;
vii. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
viii. Nonporous surfaces for shower enclosures and slip-resistant surfaces in bathtubs and showers;
d. A resident-controlled thermostat for heating and cooling;
e. A kitchen area equipped with:
i. A working sink and refrigerator,
ii. A cooking appliance that can be removed or disconnected,
iii. Space for food preparation, and
iv. Storage for utensils and supplies; and
f. If not furnished by a resident:
i. An armchair, and
ii. A table where a resident may eat a meal; and

7. If not furnished by a resident, each sleeping area has:
a. A bed, at least 36 inches in width and 72 inches in length, consisting of at least a frame and mattress that is clean and in good repair;
b. Clean linen, including a mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, a bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for the resident;
c. Sufficient light for reading;
d. Storage space for clothing;
e. Individual storage space for personal effects; and
f. Adjustable window covers that provide resident privacy.

**E.** A manager may allow more than two individuals to reside in a residential unit or bedroom if:
1. There is at least 60 square feet for each individual living in the bedroom;
2. There is at least 100 square feet for each individual living in the residential unit; and
3. The manager has documentation that the assisted living facility has been operating since before November 1, 1998, with more than two individuals living in the residential unit or bedroom.

**F.** If there is a swimming pool on the premises of the assisted living facility, a manager shall ensure that:
1. Unless the assisted living facility has documentation of having received an exception from the Department before October 1, 2013, the swimming pool is enclosed by a wall or fence that:
a. Is at least five feet in height as measured on the exterior of the wall or fence;
b. Has no vertical openings greater that four inches across;
c. Has no horizontal openings, except as described in subsection (F)(1)(e);
d. Is not chain-link;
e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
f. Has a self-closing, self-latching gate that:
i. Opens away from the swimming pool,
ii. Has a latch located at least 54 inches from the ground, and

iii. Is locked when the swimming pool is not in use;

2. A life preserver or shepherd's crook is available and accessible in the swimming pool area; and
3. Pool safety requirements are conspicuously posted in the swimming pool area.

**G.** A manager shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (F)(1) is covered and locked when not in use.

## 36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.

2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.

3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.

4. Operate sanitariums, hospitals or other facilities assigned to the department by law or by the governor.

5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information to promote good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of educating children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.

6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.

7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.

8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.

9. Encourage and aid in coordinating local programs concerning nutrition of the people of this state.

10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.

11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.

12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.

13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.

14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in enforcing the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).

15. Recruit and train personnel for state, local and district health departments.

16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.

17. License and regulate health care institutions according to chapter 4 of this title.

18. Issue or direct the issuance of licenses and permits required by law.

19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:

(a) Screening in early pregnancy for detecting high-risk conditions.

(b) Comprehensive prenatal health care.

(c) Maternity, delivery and postpartum care.

(d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.

(e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes and behavioral-supported group homes for persons with developmental disabilities. The department shall issue a license to an

accredited facility for a period of the accreditation, except that a licensing period shall not be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. Powers and duties of director; compensation of personnel; rules; definitions

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.

4. Administer and enforce the laws relating to health and sanitation and the rules of the department.

5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.

6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop,

tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health department, environmental department or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of

performance. If in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any monies that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for not longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases that are reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases that are transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meatpacking plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fundraising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is prepared in a kitchen of a private home for commercial purposes consistent with chapter 8, article 2 of this title.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

(j) Spirituous liquor produced on the premises licensed by the department of liquor licenses and control. This exemption includes both of the following:

(i) The area in which production and manufacturing of spirituous liquor occurs, as defined in an active basic permit on file with the United States alcohol and tobacco tax and trade bureau.

(ii) The area licensed by the department of liquor licenses and control as a microbrewery, farm winery or craft distiller that is open to the public and serves spirituous liquor and commercially prepackaged food, crackers or pretzels for consumption on the premises. A producer of spirituous liquor may not provide, allow or expose for common use any cup, glass or other receptacle used for drinking purposes. For the purposes of this item, "common use" means the use of a drinking receptacle for drinking purposes by or for more than one person without the receptacle being thoroughly cleansed and sanitized between consecutive uses by methods prescribed by or acceptable to the department.

(k) Spirituous liquor produced by a producer that is licensed by the department of liquor licenses and control or spirituous liquor imported and sold by wholesalers that is licensed by the department of liquor licenses and control. This exemption includes all commercially prepackaged spirituous liquor and all spirituous liquor poured at a licensed special event, festival or fair in this state.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for

sanitary facilities to be used in identifying, storing, handling and selling all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for submitting samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for preserving or storing food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparing food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these

premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. Confidential information may not be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection and chapter 8, article 2 of this title. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout this state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction if the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of

this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (j) of this section, spirituous liquor and commercially prepackaged food, crackers or pretzels that meet the requirements of subsection I, paragraph 4, subdivision (j) of this section are exempt from the rules prescribed in subsection I of this section.

R. For the purposes of this section:

1. "Cottage food product" has the same meaning prescribed in section 36-931.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

## 36-405. Powers and duties of the director

A. The director shall adopt rules to establish minimum standards and requirements for constructing, modifying and licensing health care institutions necessary to ensure the public health, safety and welfare. The standards and requirements shall relate to the construction, equipment, sanitation, staffing for medical, nursing and personal care services, and recordkeeping pertaining to administering medical, nursing, behavioral health and personal care services, in accordance with generally accepted practices of health care. The standards shall require that a physician who is licensed pursuant to title 32, chapter 13 or 17 medically discharge patients from surgery and shall allow an outpatient surgical center to require that either an anesthesia provider who is licensed pursuant to title 32, chapter 13, 15 or 17 or a physician who is licensed pursuant to title 32, chapter 13 or 17 remain present on the premises until all patients are discharged from the recovery room. Except as otherwise provided in this subsection, the director shall use the current standards adopted by the joint commission on accreditation of hospitals and the commission on accreditation of the American osteopathic association or those adopted by any recognized accreditation organization approved by the department as guidelines in prescribing minimum standards and requirements under this section.

B. The director, by rule, may:

1. Classify and subclassify health care institutions according to character, size, range of services provided, medical or dental specialty offered, duration of care and standard of patient care required for the purposes of licensure. Classes of health care institutions may include hospitals, infirmaries, outpatient treatment centers, health screening services centers and residential care facilities. Whenever the director reasonably deems distinctions in rules and standards to be appropriate among different classes or subclasses of health care institutions, the director may make such distinctions.

2. Prescribe standards for determining a health care institution's substantial compliance with licensure requirements.

3. Prescribe the criteria for the licensure inspection process.

4. Prescribe standards for selecting health care-related demonstration projects.

5. Establish nonrefundable application and licensing fees for health care institutions, including a grace period and a fee for the late payment of licensing fees.

6. Establish a process for the department to notify a licensee of the licensee's licensing fee due date.

7. Establish a process for a licensee to request a different licensing fee due date, including any limits on the number of requests by the licensee.

C. The director, by rule, shall adopt licensing provisions that facilitate the colocation and integration of outpatient treatment centers that provide medical, nursing and health-related services with behavioral health services consistent with article 3.1 of this chapter.

D. The director shall establish a model in rule for the department to monitor health care institutions on-site that are found to not be in substantial compliance with the applicable licensure requirements. The director shall establish on-site monitoring fees for health care institutions that are subject to the on-site monitoring requirements. The department may not charge a fee pursuant to this subsection for a complaint or compliance-related survey or inspection if a health care institution is in substantial compliance.

E. The department may provide in-service training to health care institutions that request in-service training relating to regulatory compliance outside of the survey process. The director shall establish in rule in-service training fees for health care institutions that request in-service training from the department.

F. Ninety percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the health services licensing fund established by section 36-414 and ten percent of the fees collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the state general fund.

G. Subsection B, paragraph 5 of this section does not apply to a health care institution operated by a state agency pursuant to state or federal law or to adult foster care residential settings.

36-406. Powers and duties of the department

In addition to its other powers and duties:

1. The department shall:

(a) Administer and enforce this chapter and the rules, regulations and standards adopted pursuant thereto.

(b) Review, and may approve, plans and specifications for construction or modification or additions to health care institutions regulated by this chapter.

(c) Have access to books, records, accounts and any other information of any health care institution reasonably necessary for the purposes of this chapter.

(d) Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe the manner by which the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.

2. The department may:

(a) Make or cause to be made inspections consistent with standard medical practice of every part of the premises of health care institutions which are subject to the provisions of this chapter as well as those which apply for or hold a license required by this chapter.

(b) Make studies and investigations of conditions and problems in health care institutions, or any class or subclass thereof, as they relate to compliance with this chapter and rules, regulations and standards adopted pursuant thereto.

(c) Develop manuals and guides relating to any of the several aspects of physical facilities and operations of health care institutions or any class or subclass thereof for distribution to the governing authorities of health care institutions and to the general public.

36-407. Prohibited acts; required acts

A. A person shall not establish, conduct or maintain in this state a health care institution or any class or subclass of health care institution unless that person holds a current and valid license issued by the department specifying the class or subclass of health care institution the person is establishing, conducting or maintaining. The license is valid only for the establishment, operation and maintenance of the class or subclass of health care institution, the type of services and, except for emergency admissions as prescribed by the director by rule, the licensed capacity specified by the license.

B. The licensee shall not imply by advertising, directory listing or otherwise that the licensee is authorized to perform services more specialized or of a higher degree of care than is authorized by this chapter and the underlying rules for the particular class or subclass of health care institution within which the licensee is licensed.

C. The licensee may not transfer or assign the license. A license is valid only for the premises occupied by the institution at the time of its issuance.

D. The licensee shall not personally or through an agent offer or imply an offer of rebate or fee splitting to any person regulated by title 32 or chapter 17 of this title.

E. The licensee shall submit an itemized statement of charges to each patient.

F. A health care institution shall refer a patient who is discharged after receiving emergency services for a drug-related overdose to a behavioral health services provider.

36-407.02. Health care institutions; clergy visitation; health and safety precautions; immunity; civil action; definitions

A. If a health care institution's visitation policy allows in-person visitation of any kind, the health care institution must allow a clergy member to visit a resident who requests an in-person visit or consents to be visited in person for religious purposes by the clergy member, including during a declared state of emergency. If a resident is unable, due to dementia or a similar cognitive impairment, to request an in-person visit or to consent to be visited in person by a clergy member for religious purposes, the request or consent must be made or given by the resident's legal representative.

B. Notwithstanding any other provision in this chapter, when a resident's death is imminent, a health care institution must allow a clergy member to visit the resident in person for religious purposes if either of the following applies:

1. The resident requests or consents to be visited by the clergy member.

2. The resident's legal representative requests that the resident be visited by the clergy member.

C. A health care institution may require clergy to comply with reasonable health and safety precautions, including undergoing health screenings and wearing personal protective equipment, that are imposed by the health care institution in connection with in-person visitation for preventing the spread of communicable diseases. If such a requirement would substantially burden the clergy member's free exercise of religion while carrying out the religious purpose for which the clergy member is visiting while with the resident in the resident's room or visiting area designated by the health care institution, the health care institution may require compliance with such precautions only if compliance in that instance furthers a compelling interest and the health care institution imposes the least restrictive burden on the clergy member's exercise of religion. Notwithstanding any other provision of this chapter, a health care institution may restrict visits of a clergy member who fails a health screening measure or tests positive for a communicable disease.

D. A health care institution and its employees and contractors are not liable to a person visiting a resident or to a resident of the health care institution for civil damages for injury or death due to actual or alleged exposure to a communicable disease resulting from or related to a visitation in compliance with this section unless it is proven by clear and convincing evidence that the health care institution failed to substantially comply with the health care institution's applicable health and safety precautions. The immunity prescribed in this subsection does not apply to any act or omission unless there is clear and convincing evidence that the act or omission constitutes gross negligence or wilful or wanton misconduct.

E. A person or religious organization may bring a civil action against a health care institution alleging a violation of this section. Any person that successfully asserts a claim or defense under this section may recover declaratory relief, injunctive relief, reasonable attorney fees and costs and any other appropriate relief.

F. For the purposes of this section:

1. "Health care institution" has the same meaning prescribed in section 36-420.

2. "Resident" means a person living at or receiving inpatient services from a health care institution.

36-502.01. Powers and duties of director of the department of health services; rules; expenditure limitation

A. The director of the department shall make rules that include standards for the state hospital when providing services as an evaluation agency or mental health agency and shall prescribe forms as may be necessary for the proper administration and enforcement of those responsibilities. The rules shall be applicable to patients admitted to, evaluated by or treated in the state hospital as set forth in this chapter and shall provide for periodic inspections of the state hospital.

B. The director of the department shall make rules concerning the admission of patients to the state hospital and the transfer of patients between the state hospital and other mental health treatment agencies. A patient undergoing court-ordered treatment may be transferred between the state hospital and another mental health treatment agency in accordance with the rules of the director of the department, subject to the approval of the court. The director of the department shall consult with the director of the administration on rules relating to transfers to and from the state hospital and other mental health treatment agencies.

C. The director of the department may make rules concerning leaves, visits and absences of patients from the state hospital.

D. The total amount of state monies that may be spent in any fiscal year by the department for mental health services pursuant to this chapter may not exceed the amount appropriated or authorized by section 35-173 for that purpose. This chapter does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

32-1909. Donated medicine; donors; authorized recipients; requirements; immunity; definitions

A. A donor may donate medicine to an authorized recipient, and an authorized recipient may receive donated medicine from donors. Before a donor may make its first donation to an authorized recipient, the authorized recipient must verify and record all the following:

1. That the donor is legally authorized to possess the medicine.

2. The donor's name, address and telephone number and permit or license number, if applicable.

3. That the donor will remove or redact any patient names and prescription numbers on donated medicine or will otherwise maintain patient confidentiality by executing a confidentiality agreement with the authorized recipient.

B. Notwithstanding any other law, an authorized recipient may transfer donated medicine to another authorized recipient or to an entity participating in a drug donation program operated by another state. Medicine transferred pursuant to this section may be transferred only once.

C. An authorized recipient may accept into inventory only donated medicine that meets all of the following:

1. Is in unopened, tamper-evident packaging or that has been repackaged under this section.

2. Is not adulterated or misbranded.

3. Has been maintained in accordance and in compliance with the United States food and drug administration risk evaluation and mitigation strategies pursuant to 21 United States Code section 355-1, if applicable.

4. Is accompanied by an attestation from the donor stating that the medicine being donated has been kept in a temperature-controlled environment and has not been adulterated.

D. An authorized recipient may accept into inventory a donated biologic only if the donated biologic meets the requirements of subsection C of this section and is donated by a health care professional or an entity legally authorized to posses the biologic.

E. Donated medicine that does not meet the requirements of subsection C of this section must be disposed of by returning it to the donor, destroying it in an incinerator, medical waste hauler or other lawful method or transferring it to a returns processor. A record of disposed medicine shall contain a description of the disposal method, the date of disposal and the name, strength and quantity of each medicine disposed of. No other record of disposal is required.

F. A drug manufacturer, repackager, dispenser or wholesaler, other than a returns processor, that participates in this program shall comply with the requirements of 21 United States Code sections 360eee-1 through 360eee-4 relating to drug supply chain security.

G. All donated medicine received by an authorized recipient but not yet accepted into inventory shall be kept in a separate designated area. Before or when accepting a donation or transfer into inventory, the authorized recipient shall maintain a written or electronic inventory of the donation consisting of the name, strength and quantity of each accepted medicine and the name, address and telephone number of the donor. This record is not required if the donor and authorized recipient are under common ownership or common control. No other record of donation is required.

H. An authorized recipient must store and maintain donated medicine physically or electronically separated from other inventory and in a secure and temperature-controlled environment that meets the drug manufacturers' recommendations and United States pharmacopeia standards.

I. Repackaged medicine shall be labeled with the drug's name, strength and expiration date and shall be kept in a separate designated area until inspected and initialed by a health care professional. If multiple packaged donated medicines with varied expiration dates are repackaged together, the earliest expiration date shall be used.

J. An authorized recipient may administer or dispense only donated medicine that meets all of the following:

1. Meets the requirements of subsection C of this section based on an inspection by a health care professional.

2. If dispensed to an eligible patient, is repackaged into a new container or has all previous patient information on the donated container redacted or removed.

3. Is properly labeled in accordance with board rules.

4. Has an expiration or beyond-use date brought forward from the donated medicine that will not expire before the medicine is completely used by the eligible patient based on the prescribing practitioner's directions for use or, for over-the-counter medicine, on the package's label.

K. An authorized recipient may dispense or administer donated medicine to an eligible patient only if otherwise allowed by law. Donated medicine may be dispensed or administered only to eligible patients pursuant to a valid prescription order and must have patient-specific written or electronic records maintained in accordance with board rules.

L. Donated medicine may not be dispensed or administered to an eligible patient if the prescriber writes or clearly displays on the face of the prescription form "DAW", "dispense as written" or any other language that indicates a substitution is not allowed.

M. The donation, transfer, receipt or facilitation of donated medicine pursuant to this section is not considered wholesale distribution and does not require licensing as a wholesale distributor.

N. Medicine donated under this section may not be resold and is considered nonsaleable. Charging a handling, dispensing or administrative fee under this section is not reselling a donated medicine. The board shall prescribe in rule the limits on the fees that an authorized recipient may charge under this section considering the medicine's retail cost for a monthly supply.

O. When performing any action under this section or otherwise processing donated medicine for tax, manufacturer or other credit, an authorized recipient is considered to be acting as a returns processor and shall comply with all recordkeeping requirements for nonsaleable returns under federal law.

P. An authorized recipient shall retain all records required by this section in a physical or electronic format for a period of at least seven years. A donor and authorized recipient may contract with each other or a third party to create or maintain records on each other's behalf. An identifier, such as a serial number or barcode, may be used in place of any information required to be in a record or on a label pursuant to this section if the identifier allows for such information to be readily retrievable. On request by the board, the identifier used for requested records shall be replaced with the original information. An identifier may not be used on patient labels when dispensing or administering a donated medicine.

Q. A donation or other transfer of possession or control is not a change of ownership unless it is specified as such by the authorized recipient. If a record of the donation's transaction information or history is required, the history must begin with the donor of the medicine and include all prior donations and, if the medicine was previously dispensed, must include only drug information required to be on the patient label in accordance with board rules.

R. A donor or authorized recipient shall make all records available for audit by the board within five business days after the request.

S. The following are not subject to civil liability, criminal liability or professional disciplinary action if acting in good faith under this section:

1. A person involved in the supply chain of donated medicine, including a donor, authorized recipient, manufacturer, repackager, wholesaler or pharmacy.

2. A person, including any employee, officer, volunteer, owner, partner, member, director, contractor or other person or entity associated with the person, that in compliance with this section prescribes, donates, receives, dispenses, administers, transfers, replenishes or repackages medicine, or facilitates any of the above pursuant to this section.

T. This section does not prohibit otherwise legal activities related to nonprescription drugs.

U. For the purposes of this section:

1. "Authorized recipient" means any entity that has a license or permit in good standing in this state and that is legally authorized to possess medicine, including a wholesaler, distributor, reverse distributor, repackager, hospital, pharmacy or health care institution.

2. "Donor":

(a) Means any person, any individual member of the public or any entity legally authorized to possess medicine, including a manufacturer, wholesaler, distributor, third-party logistic provider, pharmacy, dispenser, clinic, surgical center, health center, detention and rehabilitation center, laboratory, medical school, pharmacy school, health care professional or health care facility.

(b) Includes government agencies and entities that are federally authorized to possess medicine, including drug manufacturers, repackagers, relabelers, outsourcing facilities, prisons and importers authorized by the United States food and drug administration.

3. "Eligible patient" means an individual who is indigent, uninsured, underinsured or enrolled in a public health benefits program.

4. "Health care professional" means a health care provider who is licensed or certified pursuant to this title and authorized to dispense or administer prescription drugs.

5. "Medicine" means both prescription and nonprescription drugs, including drugs approved by the United States food and drug administration and labeled for investigational use.

6. "Returns processor" has the same meaning prescribed in 21 United States Code section 360eee and includes a reverse distributor.

7. "Unopened, tamper-evident packaging" has the same meaning as United States pharmacopeia packaging and storage requirements, including unopened unit-dose, multiple-dose and immediate, secondary and tertiary packaging.

**DEPARTMENT OF AGRICULTURE**
Title 3, Chapter 2, Articles 2, 7, 8

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **DEPARTMENT OF AGRICULTURE**
Title 3, Chapter 2, Articles 2, 7, 8

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**Summary**

This One-Year Review Report (1YRR) from the Department of Agriculture (Department) relates to three (3) rules in Title 3, Chapter 2, Articles 2, 7, and 8 regarding Meat and Poultry Inspection, Livestock Inspection, and Dairy and Diary Products Control, respectively. Specifically, beginning in fiscal year (FY) 2011, the Legislature authorized the Department to temporarily increase the livestock inspection service charge and various fees for licenses required to slaughter livestock, sell meat and poultry, and sell dairy products.

Each year, since FY 2011, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorized the fees to continue in FY 2023-2024. This was last completed by exempt rulemaking which became effective October 30, 2023. However, during the 2024 Legislative Session, the continuation of these fee increases were no longer extended and fees reverted to statutory amounts on July 1, 2024.

Pursuant to A.R.S. § 41-1095, "for an agency that the legislature has granted a one-time rulemaking exemption, within one year after a rule has been adopted the agency shall review the rule adopted under the rulemaking exemption to determine whether any rule adopted under the rulemaking exemption should be amended or repealed." Furthermore, "the agency shall prepare

and obtain council approval of a written report summarizing its findings, its supporting reasons and any proposed course of action." *Id.* The Department submits this 1YRR for the Council's consideration in compliance with A.R.S. § 41-1095

**Proposed Action**

The Department intends to submit a request to the Governor's Office in July 2025 to request approval to conduct rulemaking for rules R3-2-203, R3-2-701, and R3-2-810, pursuant to A.R.S. § 41-1039(A). Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office Policy Advisor, the Department will file a proposed rulemaking with the Secretary of State's Office to remove the references to the fees for FY 2024 for services provided in FY 2024 if the fee increase is not reintroduced in the 2025 legislative session.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific authorizing statutes for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Department, because this rule was adopted by exempt rulemaking, a formal economic, small business, and consumer impact comparison was not prepared.

The Department increased the livestock inspection service charge from $3 per request, pursuant to A.R.S. § 3-1337, to $10 (R3-2-701(E)). The Department increased the fees to obtain a license to slaughter livestock, sheep, goats or swine from $5, $15 and $80, pursuant to A.R.S. § 3-2003, to $250, $300 and $450, (R3-2-203(D)). The Department increased the fees to obtain a meat license from $10, pursuant to A.R.S. § 3-2081, to fees ranging from $150 to $500, depending on the type of licenses (R3-2-203(E)). The Department increased the fees to obtain a dairy license from between $25 and $50 pursuant to A.R.S. 3-607(E), to fees ranging between $25 and $300, depending on the operation. Plus an additional $2,500 for pasteurizers (R3-2-810). The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations. The Department receives approximately $218,000 per year as a result of these fee increases. The revenues generated from these fees are used to support the functions of the Department to provide the mandated oversight of these operations, including inspections of these facilities. Without the income generated, the Department would not be able to provide these services and the regulated community would not be able to conduct business, decreasing the overall impact to the State's economy.

Each year, since FY 2011, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorized the fees to continue in FY 2023-2024. The Department will be filed an exempt rulemaking with the Secretary of

State's Office to continue these fees in FY 2023-2024 on October 12, 2024. During the 2024 Legislative Session, the continuation of these fee increases were no longer extended and fee reverted to statutory amounts.

Stakeholders include the Department; recipients of the livestock inspection service charge; and individuals that require licenses related to slaughtering livestock and selling or exchanging meat or poultry, or selling dairy and dairy products.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department has determined that the benefits of the rules R3-2-203, R3-2-701, R3-2-810 outweigh the costs imposed by the regulatory community, and are the least burdensome and cost effective

**4. Has the agency received any written criticisms of the rules since the rule was adopted?**

The Department has not received any written criticisms regarding these rules.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rules are not currently enforced as written. As indicated above, during the 2024 Legislative Session, the continuation of these fee increases were no longer extended and fees reverted to statutory amounts on July 1, 2024.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates the rules are not more stringent than federal law.

**10. Has the agency completed any additional process required by law?**

The Department was not required to complete any additional processes.

**11. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Pursuant to A.R.S. § 41-1037(A), if an agency proposes an amendment to an existing rule that requires the issuance of a regulatory permit, license, or agency authorization, the agency shall use a general permit, as defined by A.R.S. § 41-1001(12), if the facilities, activities or practices in the class are substantially similar in nature unless certain exceptions apply.

A.R.S. § 41-1001(12) defines "general permit" to mean "a regulatory permit, license or agency authorization that is for facilities, activities or practices in a class that are substantially similar in nature and that is issued or granted by an agency to a qualified applicant to conduct identified operations or activities if the applicant meets the applicable requirements of the general permit, that requires less information than an individual or traditional permit, license or authorization and that does not require a public hearing."

The Department indicates R3-2-203 requires a license to conduct certain activities. R3-2-701 does not require a permit, and R3-2-810 sets out fees for certain licenses but does not itself require or establish any permits or licenses. The Department indicates it does not use a general permit for R3-2-203 because that would increase the cost for licensees by requiring them to pay the licensing fee for activities that the licensees do not engage in. As such, the issuance of a general permit is not technically feasible or would not meet the applicable statutory requirements and would result in additional regulatory requirements or costs being placed on the permit applicant. *See* A.R.S. § 41-1037(A)(3) and (4). Council staff believes the Board is in compliance with A.R.S. § 41-1037.

**12. Conclusion**

This 1YRR from the Department relates to three (3) rules in Title 3, Chapter 2, Articles 2, 7, and 8 regarding Meat and Poultry Inspection, Livestock Inspection, and Dairy and Diary Products Control, respectively. Specifically, beginning in fiscal year (FY) 2011, the Legislature authorized the Department to temporarily increase the livestock inspection service charge and various fees for licenses required to slaughter livestock, sell meat and poultry, and sell dairy products. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorized the fees to continue in FY 2023-2024. This was last completed by exempt rulemaking which became effective October 30, 2023. However, during the 2024 Legislative Session, the continuation of these fee increases were no longer extended and fees reverted to statutory amounts on July 1, 2024.

The Department intends to submit a request to the Governor's Office in July 2025 to request approval to conduct rulemaking for rules R3-2-203, R3-2-701, and R3-2-810, pursuant to A.R.S. § 41-1039(A). Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office Policy Advisor, the Department will file a proposed rulemaking with the

Secretary of State's Office to remove the references to the fees for FY 2024 for services provided in FY 2024 if the fee increase is not reintroduced in the 2025 legislative session.

Council staff recommends approval of this report.

KATIE HOBBS
Governor

PAUL E. BRIERLEY
Director

# Arizona Department of Agriculture

Physical Address: 1110 W. Washington Street, Suite 450 Phoenix, AZ 85007
Mailing Address: 1802 W. Jackson Street, #78 Phoenix, AZ 85007

February 27, 2025

grrc@azdoa.gov
Jessica Klein, Chair
Governor's Regulatory Review Council
100 N. 15th Avenue, Suite 302
Phoenix, Arizona 85007

**RE: One-Year Review Report for A.A.C. Title 3, Chapter 2, Articles 2, 7 and 8**

Dear Ms. Klein:

Enclosed please find the Arizona Department of Agriculture's (Department) one-year review report for A.A.C. Title 3, Chapter 2, R3-2-203, R3-2-701 and R3-2-810 which is due on February 27, 2025. This rule has been reviewed, and there is no intention for this rule to expire under § 41-1056(J). However, this rule sets fees for fiscal year 2023-2024 pursuant to Laws 2023, 1st Reg. Sess., Ch. 138, § 9. Since the provisions were not extended to fiscal year 2024-2025, the Department intends to file a rulemaking within six months to amend the prescribed fees and revert to fees prescribed in statute (A.R.S. §§ 3-607; 3-619(A); 3-1337; 3-2003; and 3-2081). Enclosed are copies of the draft rule changes and the authorizing statutes.

The Department certifies, in accordance with A.R.S. § 41-1056(A), that it is in compliance with A.R.S. § 41-1091.

Please contact Rob Smook at (602) 542-7186 or rsmook@azda.gov with any questions about this report.

Sincerely,

Paul E. Brierley
Director

Enclosures:
One-Year Review Report
2023 Session Law
Current Rules w/ proposed changes
Authorizing Statutes

**ARIZONA DEPARTMENT OF AGRICULTURE**

**1 YEAR REVIEW REPORT**

**Title 3, Chapter 2, Articles 2, 7, 8**

**February 27, 2025**

**1. Authorization of the rule by existing statutes**

Authorizing Statute: A.R.S. § 3-107(A)(1); Laws 2023, 1st Reg. Sess., Ch. 138, § 9.

Implementing Statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § § 3-607; 3-619(A); 3-1337; 3-2003; 3-2081.

Statute or session law authorizing the exemption; Laws 2023, 1st Reg. Sess., Ch. 138, § 9.

**2. The objective of each rule:**

| Rule | Objective |
|---|---|
| R3-2-203 | Sets out temporary fee increases as authorized by 2023 session law for the required licenses related to slaughtering livestock and selling or exchanging meat or poultry. |
| R3-2-701 | Sets out temporary fee increase as authorized for 2023 session law for the livestock inspection service charge of $10. |
| R3-2-810 | Sets out temporary fee increases as authorized by 2023 session law for the required licenses related to selling dairy and dairy products. |

**3. Are the rules effective in achieving their objectives?** **Yes x No ___**

R3-2-203, R3-2-701, R3-2-810 are effective in achieving their objectives.

**4. Are the rules consistent with other rules and statutes?** **Yes x No ___**

R3-2-203, R3-2-701, R3-2-810 are consistent with other rules and statutes.

**5. Are the rules enforced as written?** **Yes ___ No X**

R3-2-203, R3-2-701, R3-2-810 are enforced as written.

**6. Are the rules clear, concise, and understandable?** **Yes x No ___**

R3-2-203, R3-2-701, R3-2-810 are clear, concise and understandable.

**7. Has the agency received written criticisms of the rules within the last five years?** **Yes ___ No x**

The Department has not received written criticisms of the rules within the last five years.

**8. Economic, small business, and consumer impact comparison:**

Because this rule was adopted by exempt rulemaking, a formal economic, small business, and consumer impact comparison was not prepared.

Beginning in fiscal year (FY) 2011, the Legislature authorized the Department to temporarily increase the livestock inspection service charge and various fees for licenses required to slaughter livestock, sell meat and poultry, and sell dairy products. The Department increased the livestock inspection service charge from $3 per request, pursuant to A.R.S. § 3-1337, to $10 (R3-2-701(E)). The Department increased the fees to obtain a license to slaughter livestock, sheep, goats or swine from $5, $15 and $80, pursuant to A.R.S. § 3-2003, to $250, 300 and $450, (R3-2-203(D)). The Department increased the fees to obtain a meat license from $10, pursuant to A.R.S. § 3-2081, to fees ranging from $150 to $500, depending on the type of licenses (R3-2-203(E)). The Department increased the fees to obtain a dairy license from between $25 and $50 pursuant to A.R.S. 3-607(E), to fees ranging between $25 and $300, depending on the operation. Plus an additional $2,500 for pasteurizers (R3-2-810). The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations. The Department receives approximately $218,000 per year as a result of these fee increases. The revenues generated from these fees are used to support the functions of the Department to provide the mandated oversight of these operations, including inspections of these facilities. Without the income generated, the Department would not be able to provide these services and the regulated community would not be able to conduct business, decreasing the overall impact to the State's economy. The legislature appropriates general funds to the Department based on projected revenues from these fees, and then when these fees are collected, they are returned to the general fund. In essence, the legislature advances the funds anticipated to be collected during the year from these fees with the exception that the Department will return what is actually collected. By continuing these fee increases, the Department anticipates it will be able to collect an a amount similar to that appropriated by the legislature for this purpose. Each year, since FY 2011, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. Laws 2023, 1st Reg. Sess., Ch. 138, **§** 9 authorized the fees to continue in FY 2023-2024. The Department will be filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2023-2024 on October 12, 2024. During the 2024 Legislative Session, the continuation of these fee increases were no longer extended and fee reverted to statutory amounts.

**9. Has the agency received any business competitiveness analyses of the rules? Yes____ No x__**

No business competitive analysis has been received.

**10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

The agency completed the course of action from the previous one-year rule review report by filing an exempt rulemaking to continue these fees from fiscal year 2023 to fiscal year 2024 for services provided in fiscal year 2024. However, this fee extension was not continued for fiscal year 2025 and reverted to fee prescribed in statute on July 1, 2024.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department has determined that the benefits of the rules R3-2-203, R3-2-701, R3-2-810 outweigh the costs imposed by the regulatory community, and are the least burdensome and cost effective.

**12. Are the rules more stringent than corresponding federal laws? Yes____ No x__**

R3-2-203, R3-2-701 and R3-2-810 are not more stringent than Federal law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

R3-2-203 requires a license to conduct certain activities. R3-2-701 does not require a permit, and R3-2-810 sets out fees for certain licenses but does not itself require or establish any permits or licenses. The Department does not use a general permit for R3-2-203 because that would increase the cost for licensees by requiring them to pay the licensing fee for activities that the licensees do not engage in. Additionally, any duplication of information provided by an applicant to obtain multiple licenses would be minimal.

**14. Proposed course of action**

The Department intends to submit a request to the Governor's Office Policy Advisor in July, 2025 to request approval to conduct rulemaking for rules R3-2-203, 701, and 810, pursuant to A.R.S. § 41-1039(A). Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office Policy Advisor, the Department will file a proposed rulemaking with the Secretary of State's Office remove the references to the fees for fiscal year 2024 for services provided in fiscal year 2024 if the fee increase is not reintroduced in the 2025 legislative session.

# NOTICES OF EXEMPT RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Exempt Rulemaking.

It is common for an agency to be exempt from all steps outlined in the rulemaking process as specified in Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10, otherwise known as the Arizona Administrative Procedure Act (APA).

An agency's exemption is either written in law - under the APA, or by the Arizona State Legislature in statute, or under a referendum or initiative passed into law by Arizona voters; or a court has determined that an agency, board, or commission is exempt from the rulemaking process.

The Office makes a distinction when publishing certain exempt rulemakings, as provided in these laws, on a case-by-case basis, as determined by an agency's exemption. Other rule exemption types are published elsewhere in the *Register*.

Exempt rulemakings, as published, were promulgated with no special conditions or restrictions; no public input; no public hearing; and no filing of a Proposed Exempt Rulemaking.

## NOTICE OF EXEMPT RULEMAKING

### TITLE 3. AGRICULTURE

### CHAPTER 2. DEPARTMENT OF AGRICULTURE
### ANIMAL SERVICES DIVISION

[R23-212]

### PREAMBLE

**1. Article, Part, or Section Affected (as applicable)** | **Rulemaking Action**

| | |
|---|---|
| R3-2-203 | Amend |
| R3-2-701 | Amend |
| R3-2-810 | Amend |

**2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**

Authorizing statute: A.R.S. § 3-107(A)(1); Laws 2023, 1st Reg. Sess., Ch. 138, § 9

Implementing statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. §§ 3-607; 3-619(A); 3-1337; 3-2003; 3-2081

Statute or session law authorizing the exemption: Laws 2023, 1st Reg. Sess., Ch. 138, § 9

**3. The effective date of the rule and the agency's reason it selected the effective date:**

October 30, 2023

The effective date of the rules is based on the effective date of the law authorizing the rulemaking.

**4. A list of all notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:**

None

**5. The agency's contact person who can answer questions about the rulemaking:**

| | |
|---|---|
| Name: | Jerome Rosa, Associate Director |
| Address: | Arizona Department of Agriculture<br>1110 W. Washington St., Suite 450<br>Phoenix, AZ 85007 |
| Mailing Address: | Arizona Department of Agriculture<br>1802 W. Jackson St., #78<br>Phoenix, AZ 85007 |
| Telephone: | (602) 542-7186 |
| Fax: | (602) 542-4290 |
| Email: | jrosa@azda.gov |

**6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**

This rulemaking continues certain fees increased in fiscal years 2011 through 2023 for fiscal year 2024 for services provided in fiscal year 2024. See Notice of Exempt Rulemaking: 28 A.A.R. 2017, August 12,2022; 27 A.A.R. 1264, August 20, 2021; 26 A.A.R. 1471, July 24, 2020; 25 A.A.R. 2081, August 16, 2019; 24 A.A.R. 2219, August 3, 2018; 23 A.A.R. 1937, July 21, 2017; 21 A.A.R. 2404, October 16, 2015; 20 A.A.R. 2449, Sept. 5, 2014; 19 A.A.R. 3127, Oct. 11, 2013; 18 A.A.R. 2060, Aug. 24, 2012; 17 A.A.R. 1756, Sept. 2, 2011; & 16 A.A.R. 1331, July 23, 2010. The legislature appropriates general funds to the Department based on projected revenues from these fees, and then when these fees are collected, they will be returned to the general fund. In essence, the legislature advances the funds anticipated to be collected during the year from these fees with the expectation that the Department will return what is actually collected. By continuing these fee increases, the Department anticipates it will be able to collect an amount similar to that appropriated by the legislature for this purpose.

**7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
None

**8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable

**9. The summary of the economic, small business, and consumer impact, if applicable:**
Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorizes an exemption from the rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purpose of establishing fees pursuant to those sections until July 1, 2024. As a result, this rulemaking is exempt from the requirements of the Administrative Procedures Act and no economic, small business, and consumer impact statement is required.

**10. A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):**
Not applicable

**11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:**
None received

**12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**
The Department of Agriculture Advisory Council voted on June 29, 2023 on the fees set out in this rulemaking through fiscal year 2024.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
R3-2-203 requires a license to conduct certain activities. R3-2-701 does not require a permit, and R3-2-810 sets out fees for certain licenses but does not itself require or establish any permits or licenses. The Department does not use a general permit for R3-2-203 because that would increase the cost for licensees by requiring them to pay the licensing fee for activities that the licensees do not engage in. Additionally, any duplication of information provided by an applicant to obtain multiple licenses would be minimal.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**
Not applicable

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**
Not applicable

**13. A list of any incorporated by reference material and its location in the rule:**
None

**14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:**
Not applicable

**15. The full text of the rules follows:**

## TITLE 3. AGRICULTURE

### CHAPTER 2. DEPARTMENT OF AGRICULTURE
### ANIMAL SERVICES DIVISION

### ARTICLE 2. MEAT AND POULTRY INSPECTION

Section
R3-2-203. Licenses; Registration; Records

### ARTICLE 7. LIVESTOCK INSPECTION

Section
R3-2-701. Department Livestock Inspection

### ARTICLE 8. DAIRY AND DAIRY PRODUCTS CONTROL

Section
R3-2-810. License Fees

### ARTICLE 2. MEAT AND POULTRY INSPECTION

**R3-2-203. Licenses; Registration; Records**

**A.** No change
1. No change
a. No change

b. No change
i. No change
ii. No change
2. No change
a. No change
b. No change
c. No change
d. No change
e. No change
f. No change
g. No change

**B.** No change
1. No change
2. No change
3. No change

**C.** No change

**D.** During fiscal year ~~2023~~ 2024, the fee to obtain or renew a license to slaughter is:
1. Not to exceed 45 head of cattle, and not to exceed 55 head of sheep, goats or swine in one calendar year: $250.
2. For more than 45 and not to exceed 150 head of cattle and more than 45 and not to exceed 160 head of sheep, goats or swine in one calendar year: $300.
3. For more than 150 head of cattle and more than 160 head of sheep, goats or swine in any one calendar year: $450.

**E.** During fiscal year ~~2023~~ 2024, the fee to obtain or renew a meat license is:
1. For a broker, $450.
2. For exempt processing, $300.
3. For a distributor, $500 for a large distributor (more than $100,000 in sales per calendar year) and $150 for a small distributor (not to exceed $100,000 in sales per calendar year).
4. For a jobber, $450.
5. For a pet food manufacturer, $300.
6. For a processor, $300.
7. For meat storage, $450.
8. For transportation, $300.

## ARTICLE 7. LIVESTOCK INSPECTION

**R3-2-701. Department Livestock Inspection**

**A.** No change
1. No change
2. No change
3. No change

**B.** No change

**C.** No change

**D.** No change

**E.** During fiscal year ~~2023~~ 2024, livestock officers and inspectors shall collect from the person in charge of cattle, dairy cattle, or sheep inspected a service charge of $10 plus the per head inspection fee set out in A.R.S. § 3-1337 for making inspections for the transfer of ownership, sale, slaughter or transportation of the animals.

## ARTICLE 8. DAIRY AND DAIRY PRODUCTS CONTROL

**R3-2-810. License Fees**

During fiscal year ~~2023~~ 2024, an applicant shall pay the following fee to obtain or renew a dairy license:
1. For a license to operate a milk distributing plant or business: $300 plus $2,500 per pasteurizer.
2. For a license to operate a manufacturing milk processing plant: $100.
3. For a license to engage in the business of producer-distributor as an interstate milk shipper listed facility: $150 plus $2,500 per pasteurizer.
4. For a license to engage in the business of producer-distributor: $150.
5. For a license to engage in the business of producer-manufacturer: $25.
6. For a license to engage in the manufacture of trade products: $100.
7. For a license to engage in the business of selling at wholesale milk or dairy products, or both: $100.
8. For a license to sample milk or cream: an initial fee of $50 and a renewal fee of $30.

# 3-607. Annual licenses; inspections; revocation; fees; exceptions

A. A person shall not operate a milk distributing plant or a manufacturing milk processing plant, engage in the business of producer-distributor or producer-manufacturer, or engage in the business of selling at wholesale milk or dairy products, or both, without a license. This section does not require:

1. An Arizona dairy farm producing raw milk for sale to be processed to secure a license to operate.

2. A retailer or wholesaler to secure a license from the division to convert a pasteurized mix into frozen dessert.

3. A food establishment regulated by the department of health services to secure a license from the division to manufacture frozen desserts using pasteurized milk or pasteurized milk-based products if the frozen dessert is manufactured and sold at the same food establishment for consumption on the premises and the food establishment has submitted a plan for approval to the regulatory authority under title 36 demonstrating that the manufacturing process complies with the rules adopted pursuant to section 36-136, subsection I, including pasteurization as defined in rule. The division or the regulatory authority under title 36 may require a food establishment that manufactures frozen desserts using pasteurized milk or pasteurized milk-based products to provide samples of the frozen dessert to verify that the frozen dessert is pasteurized.

B. An application for a license shall be in writing in the form the associate director prescribes and shall be accompanied by the required filing fee. On receipt of an application, the associate director or an authorized representative shall examine the premises in which the applicant proposes to do business, and if it appears that the applicant has complied with all provisions of law, the license shall be issued.

C. After issuance of the first annual license, a license may be issued on inspection of the premises and payment not later than February 1 of each year of the required fee. The inspection shall be made by the associate director or an authorized representative to determine whether the premises are maintained in compliance with law. A written report of the inspection shall be filed in the division office. An annual license is valid for the period beginning January 1 and ending December 31 of each year, and a license that is not renewed on or before February 1 of each year is void.

D. An application for a license to produce grade A milk for human consumption shall be made in the manner prescribed by subsections A and B of this section. The license shall be valid until revoked for failure to comply with the provisions of this article relating to the production of milk. The associate director may suspend a license pending correction of deficiencies that violate this article. If the identified deficiencies are not corrected within a reasonable time after the licensee is notified, the associate director may proceed to revoke the license. Notice of a pending revocation shall be in writing, stating the cause, and setting a time during which the licensee may correct the cause for revocation. If the cause for revocation is not corrected within the time specified, the associate director, after a hearing and three days' notice of intention, may revoke the license. The director shall review the associate director's action on request of any person adversely affected by the action. A person holding a permit issued by a governmental agency operating outside of this state whose requirements are substantially the same as the requirements of this state shall be deemed to have a license meeting the requirements of this article, provided the facilities have first been inspected and approved also by a resident Arizona inspector, if in the opinion of the associate director such an inspection should be made. Any expense incurred for such an inspection shall be at the expense of the licensee.

E. Fees shall be paid as follows:

1. For a license or renewal of a license to operate a milk distributing plant or business, $50.

2. For a license or renewal of a license to operate a manufacturing milk processing plant, $50.

3. For a license or renewal of a license to engage in the business of producer-distributor or producer-manufacturer, $25.

4. For a license or renewal of a license to engage in the business of selling at wholesale milk or dairy products, or both, $25.

F. The associate director or dairy inspectors are authorized to inspect premises affected by this article and located outside of this state, and they shall receive subsistence and travel expenses in the amount provided for state officers, which shall be paid to the inspector by the owner of the premises inspected.

G. This section does not apply to a producer of raw milk.

# 3-619. Qualification of sampler; license; certificate of proficiency; revocation

A. No person shall sample milk or cream for the purpose of determining the amount of milk fat contained therein where the result of the test is used as a basis for payment for the milk or cream, or for official inspection or public record, unless licensed by the division. An applicant for a license shall give proof satisfactory to the associate director of his ability to perform his duties and shall pay a license fee of five dollars. The license shall be valid for the calendar year in which issued and upon payment of a renewal fee of one dollar fifty cents shall be renewed for each year in which the licensee desires to operate. A license not renewed prior to February 1 is void.

B. No person shall test milk or cream for the purpose of determining the butterfat content thereof, when the result of the test is used to determine the purchase sales value or the legal standard of the product, unless the tester has a tester's license. A tester's license may be obtained from the division by presenting a certificate of proficiency, and payment of a license fee of five dollars. The license shall be valid for the calendar year in which issued, and upon payment of a renewal fee of one dollar fifty cents shall be renewed for each year in which the tester desires to operate. A license not renewed prior to February 1 is void.

C. A certificate of proficiency may be obtained only from the department of dairy husbandry of the university of Arizona. The applicant therefor shall appear before the department of dairy husbandry or an official representative thereof and submit to such written examination and conduct such demonstration of laboratory technique as the department of dairy husbandry or its representative may require. Upon successfully completing the examination the department of dairy husbandry shall issue the certificate to an applicant displaying required proficiency. A tester's license issued by a state other than this state shall be accepted from the person named thereon in lieu of the certificate of proficiency, but the tester shall have been actively engaged in testing under the license for a period of not less than ninety days and shall furnish proof thereof. Each license shall be kept at the place in which the licensee is employed and shall be open to inspection.

D. A license may be revoked by the associate director, after a hearing upon due notice to the licensee, for a false statement in the application, dishonesty, incompetency or inaccuracy, or for violating any provision of this article. On request, the director shall review any action taken by the associate director under this subsection.

# 3-1337. Service charge and inspection fee; self-inspection

A. Livestock officers and inspectors shall collect from the person in charge of cattle inspected a service charge of three dollars plus an inspection fee of twenty-five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of cattle.

B. Livestock officers and inspectors shall collect from the person in charge of sheep inspected a service charge of three dollars plus an inspection fee of five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of sheep.

C. Livestock officers and inspectors shall collect from the person in charge of dairy cattle inspected a service charge of three dollars plus an inspection fee of twenty-five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of dairy cattle.

D. The division may approve self-inspection by movers of livestock and feedlots and dairies pursuant to section 3-1203, subsection D. Movement shall be documented on simple and concise self-inspection forms that are provided by the department and that include only the following information:

1. The certificate number.

2. The department contact information.

3. For out-of-state shipments, official identification.

4. For dairy cattle, back tag numbers.

5. The amount collected pursuant to section 3-1236.

6. The number and description of livestock.

7. The livestock owner's or agent's name, signature and address.

8. The transporter's name.

9. The location of the place and date of shipment.

10. The destination or buyer's name and address.

11. For branded animals, the animal's registered brand, including brand number, location and expiration date.

E. Movers of livestock and feedlots and dairies that utilize self-inspection shall purchase the self-inspection book from the department. The director, in consultation with the department of agriculture advisory council established pursuant to section 3-104, may establish a fee for the self-inspection book.

F. Any fees collected by the livestock officers and inspectors and by movers of livestock and feedlots and dairies utilizing self-inspection shall be remitted to the division. Any fees incurred by movers of livestock and feedlots and dairies shall be remitted to the department within ten days after the end of the month in which the livestock were inspected.

# 3-2003. Grant of licenses; fees; expiration date

A. The division may grant a license to slaughter livestock, sheep, goats or swine as set forth in the license issued on payment of the fees.

B. The fees shall be as follows:

1. For not to exceed forty-five head of livestock, and not to exceed fifty-five head of sheep, goats or swine in one calendar year, $5.

2. For more than forty-five and not to exceed one hundred fifty head of livestock and more than forty-five and not to exceed one hundred sixty head of sheep, goats or swine in one calendar year, $15.

3. For more than one hundred fifty head of livestock and more than one hundred sixty head of sheep, goats or swine in any one calendar year, $80.

C. Licenses issued under this section expire on December 31 of the year in which they are issued.

# 3-2081. Licenses for sale or exchange of meat or poultry; fee; records kept by licensee; expiration of license; violation; classification

A. A person, firm or corporation that engages in the business of meat or poultry processing, wholesaling, storing in or for intrastate commerce, transporting in intrastate commerce, distributing, jobbing or brokering other than canned meat or poultry or canned meat or poultry products, except a home consumer, shall, before offering such meat or poultry or meat or poultry food products for sale or exchange, after complying with the minimum requirements of the director, procure a license from the division, for which he shall pay an annual license fee of ten dollars for each place of business, store, stand, market or vehicle in or from which the meat is to be sold or exchanged and shall keep a record of the name and address of each person from whom the licensee obtained such meat or meat food products, the date of purchase, quantity and kind of meat purchased and time and place of purchase. Upon request by an inspector or peace officer, the licensee shall exhibit the record to him. The record shall be retained for one year.

B. All licenses issued under the provisions of this article shall expire on December 31 of the year in which issued.

C. The following persons, firms and corporations shall keep such records as will fully and correctly disclose all transactions involved in their businesses and all persons, firms and corporations subject to such requirements shall at all reasonable times upon notice by a duly authorized representative of the department afford such representative access to their places of business and opportunity to examine the facilities and inventory and to take reasonable samples of their inventory upon payment of the fair market value:

1. Any persons, firms or corporations that engage in the business of slaughtering any cattle, sheep, swine, goats, horses, mules or other equines or preparing, freezing, packaging or labeling any carcasses or parts or products of carcasses of any such animals for use as human food or animal food.

2. Any persons, firms or corporations that engage in the business of buying or selling as meat brokers, wholesalers or otherwise or transporting or storing or importing any carcasses or parts or products of carcasses of any such animals.

3. Any persons, firms or corporations that engage in business as renderers or engage in the business of buying, selling, transporting or importing any dead, dying, disabled or diseased cattle, sheep, swine, goats, horses, mules or other equines or parts of the carcasses of any such animals that died otherwise than by slaughter.

D. Any record required to be maintained by this section shall be maintained for such period of time as the director may by rules prescribe.

E. A person violating any provision of this section is guilty of a class 2 misdemeanor.

# 3-217. Nursery or nursery stock certification; fee; denial, revocation or suspension; hearing

A. The associate director shall:

1. Establish a nursery certification program.

2. By rule, set and collect a variable fee for each nursery or nursery stock certification inspection based on a schedule of costs for services as may be appropriate to recover the actual direct costs incurred by the division, but not more than fifty dollars for each inspection.

B. If the state agricultural laboratory performs tests under a nursery certification program, the laboratory may collect fees prescribed by rule for the tests established as follows:

1. The associate director shall establish by rule the extent and type of testing required for the Arizona certified nursery program including only tests that the department would not otherwise have performed to determine if the nursery or nursery stock is infested or infected with a crop pest or disease.

2. The extent and type of testing required for the export criteria program shall be established according to the requirements of another state, country or commonwealth.

C. The associate director may issue, refuse to issue, revoke or suspend a nursery certificate under the nursery certification program.

D. A person who is aggrieved by any action under the nursery certification program may request a hearing pursuant to title 41, chapter 6, article 10.

## 3-109.02. Office of commodity development and promotion; fees; commodity promotion fund; definition

A. The office of commodity development and promotion shall provide for programs to stimulate, educate, encourage and foster the production and consumption of Arizona agricultural products domestically and abroad.

B. The office may provide authorized or contracted administrative functions for councils and commissions established by law.

C. The director may collect a fee, which the director shall establish by rule, for the issuance of certificates of free sale. The amount of the fee shall not exceed the actual cost of preparing the certificate of free sale. All monies collected from the fees shall be deposited, pursuant to sections 35-146 and 35-147, in the commodity promotion fund.

D. The commodity promotion fund is established. The fund consists of all monies collected pursuant to any promotional service provided to industry under this section and not supported by general fund appropriation, and monies received pursuant to section 3-107, subsection B, paragraph 8. The director shall administer the fund. On notice from the director, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are:

1. Continuously appropriated to the department for the purposes of this section.

2. Exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. For the purposes of this section, "certificate of free sale" means a document that authenticates a commodity that is generally and freely sold in domestic channels of trade.

State of Arizona
Senate
Fifty-sixth Legislature
First Regular Session
2023

# CHAPTER 138

# SENATE BILL 1725

AN ACT

AMENDING TITLE 26, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 26-107; REPEALING SECTION 26-107, ARIZONA REVISED STATUTES; APPROPRIATING MONIES; RELATING TO THE ENVIRONMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 26, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 26-107, to read:

26-107. Hazard mitigation revolving fund

THE HAZARD MITIGATION REVOLVING FUND IS ESTABLISHED CONSISTING OF MONIES APPROPRIATED BY THE LEGISLATURE AND MONIES RECEIVED FROM THE FEDERAL GOVERNMENT. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED. THE DEPARTMENT OF EMERGENCY AND MILITARY AFFAIRS SHALL ADMINISTER THE FUND. MONIES IN THE FUND MAY BE USED IN FISCAL YEARS 2023-2024, 2024-2025, 2025-2026, 2026-2027 AND 2027-2028 IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED PURSUANT TO THE SAFEGUARDING TOMORROW THROUGH ONGOING RISK MITIGATION ACT (P.L. 116-284; 134 STAT. 4869).

Sec. 2. Delayed repeal

Section 26-107, Arizona Revised Statutes, as added by this act, is repealed from and after June 30, 2028.

Sec. 3. Fire incident management fund

A. The fire incident management fund is established for fiscal year 2023-2024 consisting of legislative appropriations. The department of administration shall administer the fund. Not more than $200,000 of monies appropriated to the fund may be used by the department of administration to administer the fund. Monies in the fund are continuously appropriated and shall be used to provide grants to municipal fire departments and fire districts for hardware and software that:

1. Enables the statewide deployment of a secure incident management platform to fire and law enforcement agencies.

2. Provides a standardized incident command and management platform based on federal emergency management agency standards that enable diverse incident management and support entities to work together and ensure the following:

(a) A clearly defined chain of command.

(b) The use of common terminology.

(c) The safety of first responders and others.

(d) The achievement of response objectives.

(e) The efficient use of resources.

3. Provides a collaboration and communications solution that does the following:

(a) Identifies the location, status and assignment of assigned resources.

(b) Allows status updates, tracking and management of an incident.

(c) Allows secure messaging and file sharing to all users involved in an incident.

(d) Allows the sharing of collaborative maps, building floor plans and images between public safety agencies.

(e) Allows collaboration and information sharing between disparate agencies during a mass casualty incident.

(f) Defines a federal emergency management agency or national incident management systems-based organizational structure for the management of incidents.

(g) Provides the ability to print standard integrated computer solutions forms for tracking and cost reimbursement.

(h) Provides enhanced telemetry-based firefighter safety monitoring.

(i) Works in areas without internet access in a disconnected mode.

(j) Provides a seamless and connected platform for notification, response and rostering.

(k) Provides cross-platform functionality.

(l) Provides a smartphone-based application for notification, accountability and situational awareness.

B. Each municipal fire department or fire district in this state may submit a grant request to the department of administration for the costs of the secure incident management system that meets all of the criteria described in subsection A of this section.

C. The department of administration shall award grants on a first-come, first-served basis. Grants that are awarded shall fully fund the costs of the secure incident management system for each municipal fire department or fire district for three years.

Sec. 4. Arizona water protection fund; use of monies

Notwithstanding section 45-2114, Arizona Revised Statutes, in fiscal year 2023-2024, the Arizona water protection fund commission may grant to the department of water resources up to $336,000 of the unobligated balance in the Arizona water protection fund established by section 45-2111, Arizona Revised Statutes, to pay for administrative costs of the department in fiscal year 2023-2024.

Sec. 5. Underground storage tank revolving fund; use of monies

Notwithstanding any other law, in fiscal year 2023-2024, the department of environmental quality may use up to $6,531,000 from the underground storage tank revolving fund established by section 49-1015, Arizona Revised Statutes, in fiscal year 2023-2024 for:

1. Administrative costs of the department.

2. Remediating sewage discharge issues in Naco, Arizona and other border areas of this state.

Sec. 6. Arizona water banking fund; use of monies

In addition to the purposes provided in section 45-2425, Arizona Revised Statutes, monies appropriated to the Arizona navigable stream adjudication commission from the Arizona water banking fund established by section 45-2425, Arizona Revised Statutes, may be used in fiscal year 2023-2024 to pay legal fees.

Sec. 7. Appropriation limit; water quality assurance revolving fund

Notwithstanding section 49-282, Arizona Revised Statutes, the appropriation from the state general fund to the water quality assurance revolving fund established by section 49-282, Arizona Revised Statutes, for fiscal year 2023-2024 may not exceed $15,000,000.

Sec. 8. Department of environmental quality; vehicle emissions testing fees; exemption from rulemaking

A. Notwithstanding any other law, the director of environmental quality shall charge fees in fiscal year 2023-2024 that are not more than the fees that were charged in fiscal year 2022-2023 for tests conducted in Area A, as defined in section 49-541, Arizona Revised Statutes.

B. The department of environmental quality is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2024 for the purpose of establishing fees pursuant to this section.

Sec. 9. Agricultural fees; continuation; intent; exemption from rulemaking

A. Notwithstanding any other law, the director of the Arizona department of agriculture, with the assistance of the department of agriculture advisory council, may continue to increase or lower existing fees from fiscal years 2021-2022 and 2022-2023 in fiscal year 2023-2024 for services provided in fiscal year 2023-2024.

B. The legislature intends that the additional revenue generated by the fees prescribed in subsection A of this section not exceed $218,000 to the state general fund, $113,000 to the pesticide trust fund established by section 3-350, Arizona Revised Statutes, and $26,000 to the dangerous plants, pests and diseases trust fund established by section 3-214.01, Arizona Revised Statutes, in fiscal year 2023-2024.

C. The Arizona department of agriculture is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2024 for the purpose of establishing fees pursuant to this section.

APPROVED BY THE GOVERNOR MAY 11, 2023.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 12, 2023.

State of Arizona
House of Representatives
Fifty-sixth Legislature
Second Regular Session
2024

# CHAPTER 214

# HOUSE BILL 2902

AN ACT

AMENDING SECTIONS 3-109.03, 26-305, 41-511.24 AND 49-1333, ARIZONA REVISED STATUTES; AMENDING LAWS 2023, CHAPTER 138, SECTION 3; APPROPRIATING MONIES; RELATING TO THE ENVIRONMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 3-109.03, Arizona Revised Statutes, is amended to read:

3-109.03. Livestock operator fire and flood assistance grant program; requirements; fund; exemption; definition

A. The livestock operator fire and flood assistance grant program is established under the department to provide grant monies to landowners and lessees of a livestock operation of more than forty animals under normal operating conditions for infrastructure projects that are required as a result of a wildfire ~~and~~ OR associated flooding and that are either:

1. Not eligible for funding from another federal or state program.

2. Partially funded by another federal or state program.

B. The department shall:

1. Develop guidelines and criteria to implement the program, including an application process that includes a description of the intended use for the grant monies.

2. Award all grants pursuant to title 41, chapter 24.

3. Not grant more than fifty percent of the monies in the livestock operator fire and flood assistance fund for infrastructure projects on land in one county in any fiscal year.

4. Ensure that grants from the livestock operator fire and flood assistance GRANT program do not exceed more than:

(a) Fifty percent of the total costs of any infrastructure project.

(b) An aggregate of $250,000 per livestock operation for infrastructure projects that are required as a result of a single wildfire and that wildfire's associated flooding.

5. Require each grantee to submit to the department, within twelve months after receiving the grant, a written report detailing how the grant monies were used to achieve the infrastructure project described in the application. If the infrastructure project takes longer than one year to complete, the grantee shall submit a written report to the department annually until the infrastructure project is complete.

6. On or before December 31 of each year, submit a report of the disposition of monies appropriated to the livestock operator fire and flood assistance fund each fiscal year to the governor, the president of the senate and the speaker of the house of representatives and shall provide a copy of this report to the secretary of state and to any person who requests a copy.

C. The department is exempt from title 41, chapter 6 with respect to adopting rules for the purposes of this section, except that the department shall provide for public notice and sixty days for public comment on the annual grant guidelines and criteria, including public hearings.

D. The livestock operator fire and flood assistance fund is established consisting of federal monies, legislative appropriations from the state general fund, public and private grants and private donations received for the purpose of providing grant monies to landowners and lessees of a livestock operation OF MORE THAN FORTY ANIMALS UNDER NORMAL OPERATING CONDITIONS for infrastructure projects pursuant to this section. The department shall administer the fund. Monies in the fund are continuously appropriated. On notice from the department, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. The department may use up to five percent of the monies appropriated to the livestock operator fire and flood assistance fund in any fiscal year for the purposes of administering the program.

F. For the purposes of this section, "infrastructure" includes wells, buildings, fences, pipelines, spring and water developments, corrals and other essential components to a livestock operation.

Sec. 2. Section 26-305, Arizona Revised Statutes, is amended to read:

26-305. Division of emergency management; duties; director; term; qualifications; compensation; emergency management training revolving fund

A. There is established in the department of emergency and military affairs the division of emergency management, which is administered by the department under the authority of the adjutant general, subject to powers vested in the governor as provided by law.

B. The division shall prepare for and coordinate those emergency management activities that may be required to reduce the impact of disaster on persons or property.

C. Through the powers vested in the governor, the division shall coordinate the cooperative effort of all governmental agencies including the federal government, this state and its political subdivisions to alleviate suffering and loss resulting from disaster.

D. The adjutant general shall appoint the director who serves at the pleasure of the adjutant general. The adjutant general shall select the director on the basis of demonstrated ability in governmental functions or business administration and general knowledge of contingency planning and disaster preparedness.

E. The director is eligible to receive compensation pursuant to section 38-611.

F. The emergency management training REVOLVING fund is established consisting of ~~monies received from~~ LEGISLATIVE APPROPRIATIONS, REIMBURSEMENTS RECEIVED AND fees collected by the division for coordinating ~~symposiums, training~~ conferences ~~and seminars~~, TRAININGS AND

EXERCISES relating to ~~its~~ THE DIVISION'S powers and duties. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS. The director of the division shall deposit all fees collected for these activities in the fund, which shall be used only for expenses of the activities. ~~All monies collected from each event that are in excess of the expenses of the event shall revert to the state general fund by the end of the fiscal year.~~

Sec. 3. Section 41-511.24, Arizona Revised Statutes, is amended to read:

41-511.24. Arizona state parks store fund

A. The Arizona state parks store fund is established consisting of monies deposited pursuant to a fee schedule for goods and services determined by the Arizona state parks board. The board shall administer the fund. Monies in the fund are subject to legislative appropriation and shall be used by the board to operate and maintain gift shops.

B. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations. All monies in the fund exceeding ~~$1,250,000~~ $1,750,000 at the end of a fiscal year are transferred to the state parks revenue fund established by section 41-511.21.

Sec. 4. Section 49-1333, Arizona Revised Statutes, is amended to read:

49-1333. Water conservation grant fund; procedures

A. In compliance with any applicable requirements, an eligible entity as defined in section 49-1301 may apply to the authority for and accept grants from the water conservation grant fund for a water conservation program or project that complies with the requirements of sections 49-1332 and 49-1334. A nongovernment organization that focuses on water conservation or environmental protection may apply to the authority for and accept grants from the water conservation grant fund for a water conservation program or project if it partners with an eligible entity as defined in section 49-1301. AN ELIGIBLE ENTITY MAY APPLY TO THE AUTHORITY FOR AND ACCEPT GRANTS FROM THE WATER CONSERVATION GRANT FUND TO DISTRIBUTE REBATES FOR THE INSTALLATION OF GRAY WATER SYSTEMS.

B. The authority shall:

1. Prescribe a simplified form and procedure to apply for and approve assistance.

2. Establish by rule criteria that are consistent with this article by which assistance will be awarded.

3. Determine the order and priority of water conservation programs or projects assisted under this section based on the merits of the application with respect to the requirements of sections 49-1332 and 49-1334.

4. Provide that a single water conservation program grant may not exceed $3,000,000, a single water conservation project grant may not

exceed $250,000 and at least a twenty-five percent match is required for each water conservation program or project. Monies from any other source may satisfy the match requirement.

Sec. 5. Laws 2023, chapter 138, section 3 is amended to read:

Sec. 3. Fire incident management fund; exemption; delayed repeal; transfer of monies

A. The fire incident management fund is established ~~for fiscal year 2023-2024~~ consisting of legislative appropriations. The department of administration shall administer the fund. Not more than $200,000 of monies appropriated to the fund may be used by the department of administration to administer the fund. Monies in the fund are continuously appropriated and ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190, ARIZONA REVISED STATUTES, RELATING TO LAPSING OF APPROPRIATIONS. THE DEPARTMENT OF ADMINISTRATION shall ~~be used~~ DISTRIBUTE MONIES FROM THE FUND to provide grants to municipal fire departments and fire districts for hardware and software that:

1. Enables the statewide deployment of a secure incident management platform to fire and law enforcement agencies.

2. Provides a standardized incident command and management platform based on federal emergency management agency standards that enable diverse incident management and support entities to work together and ensure the following:

(a) A clearly defined chain of command.

(b) The use of common terminology.

(c) The safety of first responders and others.

(d) The achievement of response objectives.

(e) The efficient use of resources.

3. Provides a collaboration and communications solution that does the following:

(a) Identifies the location, status and assignment of assigned resources.

(b) Allows status updates, tracking and management of an incident.

(c) Allows secure messaging and file sharing to all users involved in an incident.

(d) Allows the sharing of collaborative maps, building floor plans and images between public safety agencies.

(e) Allows collaboration and information sharing between disparate agencies during a mass casualty incident.

(f) Defines a federal emergency management agency or national incident management systems-based organizational structure for the management of incidents.

(g) Provides the ability to print standard integrated computer solutions forms for tracking and cost reimbursement.

(h) Provides enhanced telemetry-based firefighter safety monitoring.

(i) Works in areas without internet access in a disconnected mode.

(j) Provides a seamless and connected platform for notification, response and rostering.

(k) Provides cross-platform functionality.

(l) Provides a smartphone-based application for notification, accountability and situational awareness.

B. Each municipal fire department or fire district in this state may submit a grant request to the department of administration for the costs of the secure incident management system that meets all of the criteria described in subsection A of this section.

C. The department of administration shall award grants on a first-come, first-served basis. Grants that are awarded shall fully fund the costs of the secure incident management system for each municipal fire department or fire district for three years.

D. FROM AND AFTER JUNE 30, 2025, THIS SECTION IS REPEALED AND ALL UNEXPENDED AND UNENCUMBERED MONIES IN THE FIRE INCIDENT MANAGEMENT FUND ESTABLISHED BY THIS SECTION REVERT TO THE STATE GENERAL FUND.

Sec. 6. Arizona water protection fund; use of monies

Notwithstanding section 45-2114, Arizona Revised Statutes, in fiscal year 2024-2025, the Arizona water protection fund commission may grant to the department of water resources up to $336,000 of the unobligated balance in the Arizona water protection fund established by section 45-2111, Arizona Revised Statutes, to pay for administrative costs of the department in fiscal year 2024-2025.

Sec. 7. Underground storage tank revolving fund; use of monies

Notwithstanding any other law, in fiscal year 2024-2025, the department of environmental quality may use up to $6,531,000 from the underground storage tank revolving fund established by section 49-1015, Arizona Revised Statutes, in fiscal year 2024-2025 for:

1. Administrative costs of the department.

2. Remediating sewage discharge issues in Naco, Arizona and other border areas of this state.

Sec. 8. Arizona water banking fund; use of monies

In addition to the purposes provided in section 45-2425, Arizona Revised Statutes, monies appropriated to the Arizona navigable stream adjudication commission from the Arizona water banking fund established by section 45-2425, Arizona Revised Statutes, may be used in fiscal year 2024-2025 to pay legal fees.

Sec. 9. Appropriation limit; water quality assurance revolving fund

Notwithstanding section 49-282, Arizona Revised Statutes, the appropriation from the state general fund to the water quality assurance revolving fund established by section 49-282, Arizona Revised Statutes, for fiscal year 2024-2025 may not exceed $15,000,000.

Sec. 10. Department of environmental quality; vehicle emissions testing fees; exemption from rulemaking

A. Notwithstanding any other law, in fiscal year 2024-2025, the director of the department of environmental quality shall reduce fees for tests conducted in area A so that vehicle emissions testing fee revenues collected from area A are reduced by five percent of fiscal year 2023-2024 area A collections. For the purposes of this subsection, "area A" has the same meaning prescribed in section 49-541, Arizona Revised Statutes.

B. The department of environmental quality is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2025 for the purpose of establishing fees pursuant to this section.

Sec. 11. Agricultural fees; emergency rulemaking

A. For fiscal year 2024-2025, notwithstanding any other law, the director of the Arizona department of agriculture, subject to the review of the department of agriculture advisory council, may lower existing fees for any funds held in trust by the department.

B. The Arizona department of agriculture shall adopt emergency rules pursuant to title 41, chapter 6, Arizona Revised Statutes, through July 1, 2025, in conjunction with the industry, to modify fees deposited in the dangerous plants, pests and diseases trust fund established by section 3-214.01, Arizona Revised Statutes. These rules must be reviewed by the department of agriculture advisory council.

Sec. 12. Authorization for liabilities and expenses; fiscal year 2024-2025

Notwithstanding section 35-192, Arizona Revised Statutes, in fiscal year 2024-2025, the governor may allocate $500,000 to the emergency management assistance compact and Arizona mutual aid compact revolving fund established by section 26-403, Arizona Revised Statutes, and $300,000 to the emergency management training revolving fund established by section 26-305, Arizona Revised Statutes, as amended by this act. Each allocation the governor makes pursuant to this section counts toward the $4,000,000 aggregate amount allowed in fiscal year 2024-2025 as prescribed by section 35-192, subsection F, Arizona Revised Statutes.

APPROVED BY THE GOVERNOR JUNE 18, 2024.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 18, 2024.

**DEPARTMENT OF AGRICULTURE**
Title 3, Chapter 4, Article 3

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **DEPARTMENT OF AGRICULTURE**
Title 3, Chapter 4, Article 3

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**Summary**

This One-Year Review Report (1YRR) from the Department of Agriculture (Department) relates to one (1) rule in Title 3, Chapter 4, Article 3 regarding Nursery Certification Program. Specifically, rule R3-4-301 sets out temporary fee increases as authorized by 2023 session law for the nursery certification program, which includes general and special nursery stock inspection certifications and fees.

Many Arizona nursery stock producers/exporters participate in the voluntary Arizona Certified Nursery Program to receive a General Nursery Stock Certification that meets or exceeds the National Plant Board standards of pest freedom and generally satisfies most domestic entry requirements. Beginning in fiscal year (FY) 2011, the Legislature authorized the Department to increase the fee for general nursery stock certification (A.R.S. § 3-217) from $50 to $250 and increase the single shipment certification fee from $50 to $50 plus $10 for each additional lot inspected. The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations.

Each year since that time, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. The current fee increase will end at the end of FY 2025. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorizes these fees to continue in FY

2024-2025. The Department filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2024-2025, which became effective October 30, 2023. The exempt rulemaking was superseded by an emergency rulemaking filed with the Arizona Attorney General's Office to continue the fee increase through FY 2024-2025 for services provided in FY 2024-2025 as authorized under Laws 2024, 2nd Reg. Sess., Ch 214 § 11(B).

**Proposed Action**

The Department proposes to maintain the rule as is. The Department intends to submit a request to the Governor's Office in July 2025 to request approval to conduct rulemaking for rule R3-4-301 pursuant to A.R.S. § 41-1039(A) and/or laws established during Legislative Session 2025, 1st Reg. Sess. Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office, the Department will file a rulemaking to continue nursery certification fees from FY 2024 in FY 2025, or amend the rule to remove the fee increase related to FY 2024-2025.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific authorizing statutes for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Department, because this rule was adopted by exempt rulemaking, a formal economic, small business, and consumer impact comparison was not prepared.

Beginning in fiscal year (FY) 2011, the Legislature authorized the Department to increase the fee for general nursery stock certification (A.R.S. § 3-217) from $50 to $250 and increase the single shipment certification fee from $50 to $50 plus $10 for each additional lot inspected. The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations. The Department receives approximately $26,000 per year as a result of these fee increases. The revenue generated is used to offset the cost of providing the inspection service to the regulated community. Without the income generated, the Department would not be able to provide these services and the regulated community would not be able to export regulated nursery products out of the state, decreasing the overall impact to the State's economy. The rule does not directly affect employment, consumers or state revenues.

Each year, since that time, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. The current fee increase will end at the end of the fiscal year. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorizes these fees to continue in FY 2024-2025. The Department filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2024-2025. The exempt rulemaking was superseded by an Emergency Rulemaking filed with the Arizona Attorney General's Office to continue the fee increase

through FY 2024-2025 for services provided in FY 2024-2025 as authorized under Laws 2024, 2nd Reg. Sess., Ch 214 § 11(B).

Stakeholders include the Department and Arizona nursery stock producers/exporters that participate in the Arizona Certified Nursery Program.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes R3-4-301 outweighs the costs imposed by the regulatory community, and are the least burdensome and cost effective.

**4. Has the agency received any written criticisms of the rules since the rule was adopted?**

The Department has not received any written criticisms regarding these rules.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates there is no corresponding federal law.

**10. Has the agency completed any additional process required by law?**

The Department was not required to complete any additional processes.

**11. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates rule R3-4-301 does not require a permit and the nursery certification program is voluntary.

**12. Conclusion**

This 1YRR from the Department relates to one (1) rule in Title 3, Chapter 4, Article 3 regarding Nursery Certification Program. Specifically, rule R3-4-301 sets out temporary fee increases as authorized by 2023 session law for the nursery certification program, which includes general and special nursery stock inspection certifications and fees. The Department proposes to maintain the rule as is. The Department intends to submit a request to the Governor's Office in July, 2025 to request approval to conduct rulemaking for rule R3-4-301 pursuant to A.R.S. § 41-1039(A) and/or laws established during Legislative Session 2025, 1st Reg. Sess. Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office Policy Advisor, the Department will file a rulemaking to continue nursery certification fees from FY 2024 in FY 2025, or amend the rule to remove the fee increase related to FY 2024-2025.

Council staff recommends approval of this report.

KATIE HOBBS
Governor

PAUL E. BRIERLEY
Director

# Arizona Department of Agriculture

Physical Address: 1110 W. Washington Street, Suite 450 Phoenix, AZ 85007
Mailing Address: 1802 W. Jackson Street, #78 Phoenix, AZ 85007

February 27, 2025

grrc@azdoa.gov
Jessica Klein, Chair
Governor's Regulatory Review Council
100 N. 15th Avenue, Suite 302
Phoenix, Arizona 85007

**RE: One-Year Review Report for A.A.C. Title 3, Chapter 4, R3-4-301**

Dear Ms. Klein:

Enclosed please find the Arizona Department of Agriculture's (Department) one-year review report for A.A.C. Title 3, Chapter 4, R3-4-301 which is due on February 27, 2025. This rule has been reviewed, and there is no intention for this rule to expire under § 41-1056(J). However, Laws 2023, 1st Reg. Sess., Ch. 138, § 9 set fees for fiscal year 2024, and were filed under an exempt rulemaking on October 12, 2023. The Department filed an emergency rulemaking in accordance with Laws 2024, 2nd Reg. Sess., Ch. 214, Section 11 to modify fees deposited in the dangerous plants, pests, and disease trust fund in order to continue these fees in fiscal year 2025. Also enclosed are copies of the 2024 session law, rule and the authorizing statutes.

The Department certifies, in accordance with A.R.S. § 41-1056(A), that it is in compliance with A.R.S. § 41-1091.

Please contact Brian McGrew at (602) 542-3228 or bmcgrew@azda.gov with any questions about this report.

Sincerely,

Paul E. Brierley
Director

Enclosures:
One-Year Review Report
2023 Session Law
2024 Session Law
Current Rule
Authorizing Statutes

**ARIZONA DEPARTMENT OF AGRICULTURE**

**1 YEAR REVIEW REPORT**

**Title 3, Chapter 4, Article 3**

**February 27, 2025**

**1. Authorization of the rule by existing statutes**

Authorizing Statute: A.R.S. § 3-107(A)(1); Laws 2023, 1st Reg. Sess., Ch. 138, § 9.

Implementing Statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § § 3-201.01 (A)(5); 3-217.

Statute or session law authorizing the exemption: Laws 2023, 1st Reg. Sess., Ch. 138, § 9.

**2. The objective of each rule:**

| Rule | Objective |
|---|---|
| R3-4-301 | Sets out temporary fee increases as authorized by 2023 session law for the nursery certification program, which includes general and special nursery stock inspection certifications and fees. |

**3. Are the rules effective in achieving their objectives?** **Yes x No ___**

R3-4-301 is effective in achieving its objective.

**4. Are the rules consistent with other rules and statutes?** **Yes x No ___**

R3-4-301 is consistent with other rules and statutes.

List of rules and statutes used in determining consistency:
A.R.S. § 3-201 et seq.

**5. Are the rules enforced as written?** **Yes x No ___**

R3-4-301 is enforced as written.

**6. Are the rules clear, concise, and understandable?** **Yes x No ___**

R3-4-301 is clear, concise and understandable.

**7. Has the agency received written criticisms of the rules within the last five years?** **Yes ___ No** x

The Department has not received written criticisms of the rule within the last five years.

**8. Economic, small business, and consumer impact comparison:**

Because this rule was adopted by exempt rulemaking, a formal economic, small business, and consumer impact comparison was not prepared.

Many Arizona nursery stock producers/exporters participate in the voluntary Arizona Certified Nursery Program to receive a General Nursery Stock Certification that meets or exceeds the National Plant Board standards of pest freedom and generally satisfies most domestic entry requirements. Beginning in fiscal year (FY) 2011, the Legislature authorized the Department to increase the fee for general nursery stock certification (A.R.S. § 3-217) from $50 to $250 and increase the single shipment certification fee from $50 to $50 plus $10 for each additional lot inspected. The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations. The Department receives approximately $26,000 per year as a result of these fee increases. The revenue generated is used to offset the cost of providing the inspection service to the regulated community. Without the income generated, the Department would not be able to provide these services and the regulated community would not be able to export regulated nursery products out of the state, decreasing the overall impact to the State's economy. The rule does not directly affect employment, consumers or state revenues.

Each year, since that time, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. The current fee increase will end at the end of the fiscal year. Laws 2023, 1st Reg. Sess., Ch. 138, **§** 9 authorizes these fees to continue in FY 2024-2025. The Department filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2024-2025. The exempt rulemaking was superseded by an Emergency Rulemaking filed with the Arizona Attorney General's Office to continue the fee increase through FY 2024-2025 for services provided in FY 2024-2025 as authorized under Laws 2024, 2nd Reg. Sess., Ch 214 § 11(B)

**9. Has the agency received any business competitiveness analyses of the rules? Yes____ No x___**

No business competitive analysis has been received.

**10. Has the agency completed the course of action indicated in the agency's previous one-year-review report?**

The Department completed the course of action in the previous one-year-review report by filing a notice of exempt rulemaking on October 12, 2024.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department believes R3-4-301 outweighs the costs imposed by the regulatory community, and are the least burdensome and cost effective.

**12. Are the rules more stringent than corresponding federal laws? Yes____ No x___**

R3-4-301 has no corresponding federal law and is therefore not more stringent than a corresponding Federal law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

R3-4-301 does not require a permit. The nursery certification program is voluntary.

**14. Proposed course of action**

The Department proposes to maintain the rule as is. The Department intends to submit a request to the Governor's Office Policy Advisor in July, 2025 to request approval to conduct rulemaking for rule R3-4-301 pursuant to A.R.S. § 41-1039(A) and/or laws established during Legislative Session 2025, 1st Reg. Sess. Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office Policy Advisor, the Department will file a rulemaking to continue nursery certification fees from fiscal year 2024 in fiscal year 2025, or amend the rule to remove the fee increase related to FY 2024-2025.

# NOTICE OF EXEMPT RULEMAKING

## TITLE 3. AGRICULTURE

## CHAPTER 4. DEPARTMENT OF AGRICULTURE
## PLANT SERVICES DIVISION

[R23-213]

## PREAMBLE

**1. Article, Part, or Section Affected (as applicable)** **Rulemaking Action**
R3-4-301 Amend

**2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**
Authorizing statute: A.R.S. § 3-107(A)(1); Laws 2023, 1st Reg. Sess., Ch. 138, § 9
Implementing statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. §§ 3-201.01(A)(5); 3-217
Statute or session law authorizing the exemption: Laws 2023, 1st Reg. Sess., Ch. 138, § 9

**3. The effective date of the rule and the agency's reason it selected the effective date:**
October 30, 2023
The effective date of the rule is based on the effective date of the law authorizing the rulemaking.

**4. A list of all notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:**
None

**5. The agency's contact person who can answer questions about the rulemaking:**

| | |
|---|---|
| Name: | Jack Peterson, Associate Director |
| Address: | Arizona Department of Agriculture<br>1110 W. Washington St., Suite 450<br>Phoenix, AZ 85007 |
| Mailing Address: | Arizona Department of Agriculture<br>1802 W. Jackson St., #78<br>Phoenix, AZ 85007 |
| Telephone: | (602) 542-3575 |
| Fax: | (602) 542-1004 |
| Email: | jpeterson@azda.gov |

**6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**
This rulemaking continues nursery certification fees from fiscal years 2011 through 2023 in fiscal year 2024 for services provided in fiscal year 2024 in order to make up for decreases in general fund appropriations. See Notice of Exempt Rulemaking: 28 A.A.R. 2020, August 12, 2022; 27 A.A.R. 1266, August 20,2021; 26 A.A.R. 1473, July 24, 2020; 25 A.A.R. 2085, August 16, 2019; 24 A.A.R. 2223, August 3, 2018; 23 A.A.R. 1941, July 21, 2017; 21 A.A.R. 2410, Oct. 16, 2015; 20 A.A.R. 2449, Sept. 5, 2014; 19 A.A.R. 3143, Oct. 11, 2013; 18 A.A.R. 2063, Aug. 24, 2012; 17 A.A.R. 1761, Sept. 2, 2011; & 16 A.A.R. 1336, July 23, 2010. Continuing these fees is necessary to implement the budget for the plant services division for fiscal year 2024.

**7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
None

**8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable

**9. The summary of the economic, small business, and consumer impact, if applicable:**
Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorizes an exemption from the rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purpose of establishing fees pursuant to those sections until July 1, 2024. As a result, this rulemaking is exempt from the requirements of the Administrative Procedures Act and no economic, small business, and consumer impact statement is required.

**10. A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):**
Not applicable

**11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:**
None received

**12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**
The Department of Agriculture Advisory Council voted on June 29, 2023 in favor of continuing the fees set out in this rulemaking

through fiscal year 2024.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
The rule does not require a permit. The nursery certification program is voluntary.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**
Not applicable

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**
Not applicable

**13. A list of any incorporated by reference material and its location in the rule:**
None

**14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:**
Not applicable

**15. The full text of the rules follows:**

## TITLE 3. AGRICULTURE

## CHAPTER 4. DEPARTMENT OF AGRICULTURE
## PLANT SERVICES DIVISION

## ARTICLE 3. NURSERY CERTIFICATION PROGRAM

Section
R3-4-301. Nursery Certification

## ARTICLE 3. NURSERY CERTIFICATION PROGRAM

**R3-4-301. Nursery Certification**

**A.** Definitions. The following terms apply to this Section.

| | |
|---|---|
| "Associate Director" | No change |
| "Certificate" | No change |
| "Certificate holder" | No change |
| "Collected nursery stock" | No change |
| "Commercially clean" | No change |
| "Common pest" | No change |
| "Director" | No change |
| "General nursery stock inspection certification" | No change |
| "Nursery location" | No change |
| "Quarantine pest" | No change |
| "Single shipment nursery stock inspection certification" | No change |

**B.** No change
1. No change
   a. No change
   b. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
9. No change

**C.** No change
1. No change
2. No change
3. No change

**D.** No change
1. No change
2. No change
3. No change
4. No change

**E.** No change
1. No change

2. No change
3. No change
4. No change
5. No change
6. No change

**F.** No change
1. No change
2. No change
3. No change
4. No change

**G.** ~~Nothwithstanding~~ Notwithstanding subsections (B) through (D), during fiscal year ~~2023~~ 2024, an applicant for nursery stock inspection certification shall pay the following fee:
1. For general certification, $250.
2. For single shipment certification, $50 for the first lot plus $10 for each additional lot per Department site trip.

## NOTICE OF EXEMPT RULEMAKING

### TITLE 3. AGRICULTURE

### CHAPTER 6. DEPARTMENT OF AGRICULTURE
### OFFICE OF COMMODITY DEVELOPMENT AND PROMOTION

[R23-214]

### PREAMBLE

**1. Article, Part, or Section Affected (as applicable)** **Rulemaking Action**
R3-6-102 Amend

**2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**
Authorizing statute: A.R.S. §§ 3-107(A)(1) and (B)(3); Laws 2023, 1st Reg. Sess., Ch. 138, § 9
Implementing statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § 3-109.02(A)
Statute or session law authorizing the exemption: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § 41-1005(A)(5)

**3. The effective date of the rule and the agency's reason it selected the effective date:**
October 30, 2023
The effective date of the rule is based on the effective date of the law authorizing the rulemaking.

**4. A list of all notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:**
None

**5. The agency's contact person who can answer questions about the rulemaking:**

| | |
|---|---|
| Name: | Jack Peterson, Associate Director |
| Address: | Arizona Department of Agriculture<br>1110 W. Washington St., Suite 450<br>Phoenix, AZ 85007 |
| Mailing Address: | Arizona Department of Agriculture<br>1802 W. Jackson St., #78<br>Phoenix, AZ 85007 |
| Telephone: | (602) 542-3575 |
| Fax: | (602) 542-1004 |
| Email: | jpeterson@azda.gov |

**6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**
This rulemaking continues fees from fiscal years 2011 through 2023 in fiscal year 2024 for services provided in fiscal year 2024 for phytosanitary certification in order to make up for decreases in general fund appropriations. See Notice of Exempt Rulemaking: 28 A.A.R. 2022, August 12, 2022; 27 A.A.R. 1269, August 20, 2021; 26 A.A.R. 1475, July 24, 2020; 25 A.A.R. 2088, August 16, 2019; 24 A.A.R. 2226, August 3, 2018; 23 A.A.R. 1943, July 21, 2017; 21 A.A.R. 2412, Oct. 16, 2015; 20 A.A.R. 2449, Sept. 5, 2014; 19 A.A.R. 3146, Oct. 11, 2013; 18 A.A.R. 2066, Aug. 24, 2012; 17 A.A.R. 1765, Sept. 2, 2011; & 16 A.A.R. 1339, July 23, 2010. Continuing these fees is necessary to implement the budget for the plant services division for fiscal year 2024.

**7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
None

**8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable

# 3-607. Annual licenses; inspections; revocation; fees; exceptions

A. A person shall not operate a milk distributing plant or a manufacturing milk processing plant, engage in the business of producer-distributor or producer-manufacturer, or engage in the business of selling at wholesale milk or dairy products, or both, without a license. This section does not require:

1. An Arizona dairy farm producing raw milk for sale to be processed to secure a license to operate.

2. A retailer or wholesaler to secure a license from the division to convert a pasteurized mix into frozen dessert.

3. A food establishment regulated by the department of health services to secure a license from the division to manufacture frozen desserts using pasteurized milk or pasteurized milk-based products if the frozen dessert is manufactured and sold at the same food establishment for consumption on the premises and the food establishment has submitted a plan for approval to the regulatory authority under title 36 demonstrating that the manufacturing process complies with the rules adopted pursuant to section 36-136, subsection I, including pasteurization as defined in rule. The division or the regulatory authority under title 36 may require a food establishment that manufactures frozen desserts using pasteurized milk or pasteurized milk-based products to provide samples of the frozen dessert to verify that the frozen dessert is pasteurized.

B. An application for a license shall be in writing in the form the associate director prescribes and shall be accompanied by the required filing fee. On receipt of an application, the associate director or an authorized representative shall examine the premises in which the applicant proposes to do business, and if it appears that the applicant has complied with all provisions of law, the license shall be issued.

C. After issuance of the first annual license, a license may be issued on inspection of the premises and payment not later than February 1 of each year of the required fee. The inspection shall be made by the associate director or an authorized representative to determine whether the premises are maintained in compliance with law. A written report of the inspection shall be filed in the division office. An annual license is valid for the period beginning January 1 and ending December 31 of each year, and a license that is not renewed on or before February 1 of each year is void.

D. An application for a license to produce grade A milk for human consumption shall be made in the manner prescribed by subsections A and B of this section. The license shall be valid until revoked for failure to comply with the provisions of this article relating to the production of milk. The associate director may suspend a license pending correction of deficiencies that violate this article. If the identified deficiencies are not corrected within a reasonable time after the licensee is notified, the associate director may proceed to revoke the license. Notice of a pending revocation shall be in writing, stating the cause, and setting a time during which the licensee may correct the cause for revocation. If the cause for revocation is not corrected within the time specified, the associate director, after a hearing and three days' notice of intention, may revoke the license. The director shall review the associate director's action on request of any person adversely affected by the action. A person holding a permit issued by a governmental agency operating outside of this state whose requirements are substantially the same as the requirements of this state shall be deemed to have a license meeting the requirements of this article, provided the facilities have first been inspected and approved also by a resident Arizona inspector, if in the opinion of the associate director such an inspection should be made. Any expense incurred for such an inspection shall be at the expense of the licensee.

E. Fees shall be paid as follows:

1. For a license or renewal of a license to operate a milk distributing plant or business, $50.

2. For a license or renewal of a license to operate a manufacturing milk processing plant, $50.

3. For a license or renewal of a license to engage in the business of producer-distributor or producer-manufacturer, $25.

4. For a license or renewal of a license to engage in the business of selling at wholesale milk or dairy products, or both, $25.

F. The associate director or dairy inspectors are authorized to inspect premises affected by this article and located outside of this state, and they shall receive subsistence and travel expenses in the amount provided for state officers, which shall be paid to the inspector by the owner of the premises inspected.

G. This section does not apply to a producer of raw milk.

# 3-619. Qualification of sampler; license; certificate of proficiency; revocation

A. No person shall sample milk or cream for the purpose of determining the amount of milk fat contained therein where the result of the test is used as a basis for payment for the milk or cream, or for official inspection or public record, unless licensed by the division. An applicant for a license shall give proof satisfactory to the associate director of his ability to perform his duties and shall pay a license fee of five dollars. The license shall be valid for the calendar year in which issued and upon payment of a renewal fee of one dollar fifty cents shall be renewed for each year in which the licensee desires to operate. A license not renewed prior to February 1 is void.

B. No person shall test milk or cream for the purpose of determining the butterfat content thereof, when the result of the test is used to determine the purchase sales value or the legal standard of the product, unless the tester has a tester's license. A tester's license may be obtained from the division by presenting a certificate of proficiency, and payment of a license fee of five dollars. The license shall be valid for the calendar year in which issued, and upon payment of a renewal fee of one dollar fifty cents shall be renewed for each year in which the tester desires to operate. A license not renewed prior to February 1 is void.

C. A certificate of proficiency may be obtained only from the department of dairy husbandry of the university of Arizona. The applicant therefor shall appear before the department of dairy husbandry or an official representative thereof and submit to such written examination and conduct such demonstration of laboratory technique as the department of dairy husbandry or its representative may require. Upon successfully completing the examination the department of dairy husbandry shall issue the certificate to an applicant displaying required proficiency. A tester's license issued by a state other than this state shall be accepted from the person named thereon in lieu of the certificate of proficiency, but the tester shall have been actively engaged in testing under the license for a period of not less than ninety days and shall furnish proof thereof. Each license shall be kept at the place in which the licensee is employed and shall be open to inspection.

D. A license may be revoked by the associate director, after a hearing upon due notice to the licensee, for a false statement in the application, dishonesty, incompetency or inaccuracy, or for violating any provision of this article. On request, the director shall review any action taken by the associate director under this subsection.

# 3-1337. Service charge and inspection fee; self-inspection

A. Livestock officers and inspectors shall collect from the person in charge of cattle inspected a service charge of three dollars plus an inspection fee of twenty-five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of cattle.

B. Livestock officers and inspectors shall collect from the person in charge of sheep inspected a service charge of three dollars plus an inspection fee of five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of sheep.

C. Livestock officers and inspectors shall collect from the person in charge of dairy cattle inspected a service charge of three dollars plus an inspection fee of twenty-five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of dairy cattle.

D. The division may approve self-inspection by movers of livestock and feedlots and dairies pursuant to section 3-1203, subsection D. Movement shall be documented on simple and concise self-inspection forms that are provided by the department and that include only the following information:

1. The certificate number.

2. The department contact information.

3. For out-of-state shipments, official identification.

4. For dairy cattle, back tag numbers.

5. The amount collected pursuant to section 3-1236.

6. The number and description of livestock.

7. The livestock owner's or agent's name, signature and address.

8. The transporter's name.

9. The location of the place and date of shipment.

10. The destination or buyer's name and address.

11. For branded animals, the animal's registered brand, including brand number, location and expiration date.

E. Movers of livestock and feedlots and dairies that utilize self-inspection shall purchase the self-inspection book from the department. The director, in consultation with the department of agriculture advisory council established pursuant to section 3-104, may establish a fee for the self-inspection book.

F. Any fees collected by the livestock officers and inspectors and by movers of livestock and feedlots and dairies utilizing self-inspection shall be remitted to the division. Any fees incurred by movers of livestock and feedlots and dairies shall be remitted to the department within ten days after the end of the month in which the livestock were inspected.

# 3-2003. Grant of licenses; fees; expiration date

A. The division may grant a license to slaughter livestock, sheep, goats or swine as set forth in the license issued on payment of the fees.

B. The fees shall be as follows:

1. For not to exceed forty-five head of livestock, and not to exceed fifty-five head of sheep, goats or swine in one calendar year, $5.

2. For more than forty-five and not to exceed one hundred fifty head of livestock and more than forty-five and not to exceed one hundred sixty head of sheep, goats or swine in one calendar year, $15.

3. For more than one hundred fifty head of livestock and more than one hundred sixty head of sheep, goats or swine in any one calendar year, $80.

C. Licenses issued under this section expire on December 31 of the year in which they are issued.

# 3-2081. Licenses for sale or exchange of meat or poultry; fee; records kept by licensee; expiration of license; violation; classification

A. A person, firm or corporation that engages in the business of meat or poultry processing, wholesaling, storing in or for intrastate commerce, transporting in intrastate commerce, distributing, jobbing or brokering other than canned meat or poultry or canned meat or poultry products, except a home consumer, shall, before offering such meat or poultry or meat or poultry food products for sale or exchange, after complying with the minimum requirements of the director, procure a license from the division, for which he shall pay an annual license fee of ten dollars for each place of business, store, stand, market or vehicle in or from which the meat is to be sold or exchanged and shall keep a record of the name and address of each person from whom the licensee obtained such meat or meat food products, the date of purchase, quantity and kind of meat purchased and time and place of purchase. Upon request by an inspector or peace officer, the licensee shall exhibit the record to him. The record shall be retained for one year.

B. All licenses issued under the provisions of this article shall expire on December 31 of the year in which issued.

C. The following persons, firms and corporations shall keep such records as will fully and correctly disclose all transactions involved in their businesses and all persons, firms and corporations subject to such requirements shall at all reasonable times upon notice by a duly authorized representative of the department afford such representative access to their places of business and opportunity to examine the facilities and inventory and to take reasonable samples of their inventory upon payment of the fair market value:

1. Any persons, firms or corporations that engage in the business of slaughtering any cattle, sheep, swine, goats, horses, mules or other equines or preparing, freezing, packaging or labeling any carcasses or parts or products of carcasses of any such animals for use as human food or animal food.

2. Any persons, firms or corporations that engage in the business of buying or selling as meat brokers, wholesalers or otherwise or transporting or storing or importing any carcasses or parts or products of carcasses of any such animals.

3. Any persons, firms or corporations that engage in business as renderers or engage in the business of buying, selling, transporting or importing any dead, dying, disabled or diseased cattle, sheep, swine, goats, horses, mules or other equines or parts of the carcasses of any such animals that died otherwise than by slaughter.

D. Any record required to be maintained by this section shall be maintained for such period of time as the director may by rules prescribe.

E. A person violating any provision of this section is guilty of a class 2 misdemeanor.

# 3-217. Nursery or nursery stock certification; fee; denial, revocation or suspension; hearing

A. The associate director shall:

1. Establish a nursery certification program.

2. By rule, set and collect a variable fee for each nursery or nursery stock certification inspection based on a schedule of costs for services as may be appropriate to recover the actual direct costs incurred by the division, but not more than fifty dollars for each inspection.

B. If the state agricultural laboratory performs tests under a nursery certification program, the laboratory may collect fees prescribed by rule for the tests established as follows:

1. The associate director shall establish by rule the extent and type of testing required for the Arizona certified nursery program including only tests that the department would not otherwise have performed to determine if the nursery or nursery stock is infested or infected with a crop pest or disease.

2. The extent and type of testing required for the export criteria program shall be established according to the requirements of another state, country or commonwealth.

C. The associate director may issue, refuse to issue, revoke or suspend a nursery certificate under the nursery certification program.

D. A person who is aggrieved by any action under the nursery certification program may request a hearing pursuant to title 41, chapter 6, article 10.

## 3-109.02. Office of commodity development and promotion; fees; commodity promotion fund; definition

A. The office of commodity development and promotion shall provide for programs to stimulate, educate, encourage and foster the production and consumption of Arizona agricultural products domestically and abroad.

B. The office may provide authorized or contracted administrative functions for councils and commissions established by law.

C. The director may collect a fee, which the director shall establish by rule, for the issuance of certificates of free sale. The amount of the fee shall not exceed the actual cost of preparing the certificate of free sale. All monies collected from the fees shall be deposited, pursuant to sections 35-146 and 35-147, in the commodity promotion fund.

D. The commodity promotion fund is established. The fund consists of all monies collected pursuant to any promotional service provided to industry under this section and not supported by general fund appropriation, and monies received pursuant to section 3-107, subsection B, paragraph 8. The director shall administer the fund. On notice from the director, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are:

1. Continuously appropriated to the department for the purposes of this section.

2. Exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. For the purposes of this section, "certificate of free sale" means a document that authenticates a commodity that is generally and freely sold in domestic channels of trade.

State of Arizona
Senate
Fifty-sixth Legislature
First Regular Session
2023

# CHAPTER 138

# SENATE BILL 1725

AN ACT

AMENDING TITLE 26, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 26-107; REPEALING SECTION 26-107, ARIZONA REVISED STATUTES; APPROPRIATING MONIES; RELATING TO THE ENVIRONMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 26, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 26-107, to read:

26-107. Hazard mitigation revolving fund

THE HAZARD MITIGATION REVOLVING FUND IS ESTABLISHED CONSISTING OF MONIES APPROPRIATED BY THE LEGISLATURE AND MONIES RECEIVED FROM THE FEDERAL GOVERNMENT. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED. THE DEPARTMENT OF EMERGENCY AND MILITARY AFFAIRS SHALL ADMINISTER THE FUND. MONIES IN THE FUND MAY BE USED IN FISCAL YEARS 2023-2024, 2024-2025, 2025-2026, 2026-2027 AND 2027-2028 IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED PURSUANT TO THE SAFEGUARDING TOMORROW THROUGH ONGOING RISK MITIGATION ACT (P.L. 116-284; 134 STAT. 4869).

Sec. 2. Delayed repeal

Section 26-107, Arizona Revised Statutes, as added by this act, is repealed from and after June 30, 2028.

Sec. 3. Fire incident management fund

A. The fire incident management fund is established for fiscal year 2023-2024 consisting of legislative appropriations. The department of administration shall administer the fund. Not more than $200,000 of monies appropriated to the fund may be used by the department of administration to administer the fund. Monies in the fund are continuously appropriated and shall be used to provide grants to municipal fire departments and fire districts for hardware and software that:

1. Enables the statewide deployment of a secure incident management platform to fire and law enforcement agencies.

2. Provides a standardized incident command and management platform based on federal emergency management agency standards that enable diverse incident management and support entities to work together and ensure the following:

(a) A clearly defined chain of command.

(b) The use of common terminology.

(c) The safety of first responders and others.

(d) The achievement of response objectives.

(e) The efficient use of resources.

3. Provides a collaboration and communications solution that does the following:

(a) Identifies the location, status and assignment of assigned resources.

(b) Allows status updates, tracking and management of an incident.

(c) Allows secure messaging and file sharing to all users involved in an incident.

(d) Allows the sharing of collaborative maps, building floor plans and images between public safety agencies.

(e) Allows collaboration and information sharing between disparate agencies during a mass casualty incident.

(f) Defines a federal emergency management agency or national incident management systems-based organizational structure for the management of incidents.

(g) Provides the ability to print standard integrated computer solutions forms for tracking and cost reimbursement.

(h) Provides enhanced telemetry-based firefighter safety monitoring.

(i) Works in areas without internet access in a disconnected mode.

(j) Provides a seamless and connected platform for notification, response and rostering.

(k) Provides cross-platform functionality.

(l) Provides a smartphone-based application for notification, accountability and situational awareness.

B. Each municipal fire department or fire district in this state may submit a grant request to the department of administration for the costs of the secure incident management system that meets all of the criteria described in subsection A of this section.

C. The department of administration shall award grants on a first-come, first-served basis. Grants that are awarded shall fully fund the costs of the secure incident management system for each municipal fire department or fire district for three years.

Sec. 4. Arizona water protection fund; use of monies

Notwithstanding section 45-2114, Arizona Revised Statutes, in fiscal year 2023-2024, the Arizona water protection fund commission may grant to the department of water resources up to $336,000 of the unobligated balance in the Arizona water protection fund established by section 45-2111, Arizona Revised Statutes, to pay for administrative costs of the department in fiscal year 2023-2024.

Sec. 5. Underground storage tank revolving fund; use of monies

Notwithstanding any other law, in fiscal year 2023-2024, the department of environmental quality may use up to $6,531,000 from the underground storage tank revolving fund established by section 49-1015, Arizona Revised Statutes, in fiscal year 2023-2024 for:

1. Administrative costs of the department.

2. Remediating sewage discharge issues in Naco, Arizona and other border areas of this state.

Sec. 6. Arizona water banking fund; use of monies

In addition to the purposes provided in section 45-2425, Arizona Revised Statutes, monies appropriated to the Arizona navigable stream adjudication commission from the Arizona water banking fund established by section 45-2425, Arizona Revised Statutes, may be used in fiscal year 2023-2024 to pay legal fees.

Sec. 7. Appropriation limit; water quality assurance revolving fund

Notwithstanding section 49-282, Arizona Revised Statutes, the appropriation from the state general fund to the water quality assurance revolving fund established by section 49-282, Arizona Revised Statutes, for fiscal year 2023-2024 may not exceed $15,000,000.

Sec. 8. Department of environmental quality; vehicle emissions testing fees; exemption from rulemaking

A. Notwithstanding any other law, the director of environmental quality shall charge fees in fiscal year 2023-2024 that are not more than the fees that were charged in fiscal year 2022-2023 for tests conducted in Area A, as defined in section 49-541, Arizona Revised Statutes.

B. The department of environmental quality is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2024 for the purpose of establishing fees pursuant to this section.

Sec. 9. Agricultural fees; continuation; intent; exemption from rulemaking

A. Notwithstanding any other law, the director of the Arizona department of agriculture, with the assistance of the department of agriculture advisory council, may continue to increase or lower existing fees from fiscal years 2021-2022 and 2022-2023 in fiscal year 2023-2024 for services provided in fiscal year 2023-2024.

B. The legislature intends that the additional revenue generated by the fees prescribed in subsection A of this section not exceed $218,000 to the state general fund, $113,000 to the pesticide trust fund established by section 3-350, Arizona Revised Statutes, and $26,000 to the dangerous plants, pests and diseases trust fund established by section 3-214.01, Arizona Revised Statutes, in fiscal year 2023-2024.

C. The Arizona department of agriculture is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2024 for the purpose of establishing fees pursuant to this section.

APPROVED BY THE GOVERNOR MAY 11, 2023.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 12, 2023.

State of Arizona
House of Representatives
Fifty-sixth Legislature
Second Regular Session
2024

# CHAPTER 214

# HOUSE BILL 2902

AN ACT

AMENDING SECTIONS 3-109.03, 26-305, 41-511.24 AND 49-1333, ARIZONA REVISED STATUTES; AMENDING LAWS 2023, CHAPTER 138, SECTION 3; APPROPRIATING MONIES; RELATING TO THE ENVIRONMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 3-109.03, Arizona Revised Statutes, is amended to read:

3-109.03. Livestock operator fire and flood assistance grant program; requirements; fund; exemption; definition

A. The livestock operator fire and flood assistance grant program is established under the department to provide grant monies to landowners and lessees of a livestock operation of more than forty animals under normal operating conditions for infrastructure projects that are required as a result of a wildfire ~~and~~ OR associated flooding and that are either:

1. Not eligible for funding from another federal or state program.

2. Partially funded by another federal or state program.

B. The department shall:

1. Develop guidelines and criteria to implement the program, including an application process that includes a description of the intended use for the grant monies.

2. Award all grants pursuant to title 41, chapter 24.

3. Not grant more than fifty percent of the monies in the livestock operator fire and flood assistance fund for infrastructure projects on land in one county in any fiscal year.

4. Ensure that grants from the livestock operator fire and flood assistance GRANT program do not exceed more than:

(a) Fifty percent of the total costs of any infrastructure project.

(b) An aggregate of $250,000 per livestock operation for infrastructure projects that are required as a result of a single wildfire and that wildfire's associated flooding.

5. Require each grantee to submit to the department, within twelve months after receiving the grant, a written report detailing how the grant monies were used to achieve the infrastructure project described in the application. If the infrastructure project takes longer than one year to complete, the grantee shall submit a written report to the department annually until the infrastructure project is complete.

6. On or before December 31 of each year, submit a report of the disposition of monies appropriated to the livestock operator fire and flood assistance fund each fiscal year to the governor, the president of the senate and the speaker of the house of representatives and shall provide a copy of this report to the secretary of state and to any person who requests a copy.

C. The department is exempt from title 41, chapter 6 with respect to adopting rules for the purposes of this section, except that the department shall provide for public notice and sixty days for public comment on the annual grant guidelines and criteria, including public hearings.

D. The livestock operator fire and flood assistance fund is established consisting of federal monies, legislative appropriations from the state general fund, public and private grants and private donations received for the purpose of providing grant monies to landowners and lessees of a livestock operation OF MORE THAN FORTY ANIMALS UNDER NORMAL OPERATING CONDITIONS for infrastructure projects pursuant to this section. The department shall administer the fund. Monies in the fund are continuously appropriated. On notice from the department, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. The department may use up to five percent of the monies appropriated to the livestock operator fire and flood assistance fund in any fiscal year for the purposes of administering the program.

F. For the purposes of this section, "infrastructure" includes wells, buildings, fences, pipelines, spring and water developments, corrals and other essential components to a livestock operation.

Sec. 2. Section 26-305, Arizona Revised Statutes, is amended to read:

26-305. Division of emergency management; duties; director; term; qualifications; compensation; emergency management training revolving fund

A. There is established in the department of emergency and military affairs the division of emergency management, which is administered by the department under the authority of the adjutant general, subject to powers vested in the governor as provided by law.

B. The division shall prepare for and coordinate those emergency management activities that may be required to reduce the impact of disaster on persons or property.

C. Through the powers vested in the governor, the division shall coordinate the cooperative effort of all governmental agencies including the federal government, this state and its political subdivisions to alleviate suffering and loss resulting from disaster.

D. The adjutant general shall appoint the director who serves at the pleasure of the adjutant general. The adjutant general shall select the director on the basis of demonstrated ability in governmental functions or business administration and general knowledge of contingency planning and disaster preparedness.

E. The director is eligible to receive compensation pursuant to section 38-611.

F. The emergency management training REVOLVING fund is established consisting of ~~monies received from~~ LEGISLATIVE APPROPRIATIONS, REIMBURSEMENTS RECEIVED AND fees collected by the division for coordinating ~~symposiums, training~~ conferences ~~and seminars~~, TRAININGS AND

EXERCISES relating to ~~its~~ THE DIVISION'S powers and duties. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS. The director of the division shall deposit all fees collected for these activities in the fund, which shall be used only for expenses of the activities. ~~All monies collected from each event that are in excess of the expenses of the event shall revert to the state general fund by the end of the fiscal year.~~

Sec. 3. Section 41-511.24, Arizona Revised Statutes, is amended to read:

41-511.24. Arizona state parks store fund

A. The Arizona state parks store fund is established consisting of monies deposited pursuant to a fee schedule for goods and services determined by the Arizona state parks board. The board shall administer the fund. Monies in the fund are subject to legislative appropriation and shall be used by the board to operate and maintain gift shops.

B. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations. All monies in the fund exceeding ~~$1,250,000~~ $1,750,000 at the end of a fiscal year are transferred to the state parks revenue fund established by section 41-511.21.

Sec. 4. Section 49-1333, Arizona Revised Statutes, is amended to read:

49-1333. Water conservation grant fund; procedures

A. In compliance with any applicable requirements, an eligible entity as defined in section 49-1301 may apply to the authority for and accept grants from the water conservation grant fund for a water conservation program or project that complies with the requirements of sections 49-1332 and 49-1334. A nongovernment organization that focuses on water conservation or environmental protection may apply to the authority for and accept grants from the water conservation grant fund for a water conservation program or project if it partners with an eligible entity as defined in section 49-1301. AN ELIGIBLE ENTITY MAY APPLY TO THE AUTHORITY FOR AND ACCEPT GRANTS FROM THE WATER CONSERVATION GRANT FUND TO DISTRIBUTE REBATES FOR THE INSTALLATION OF GRAY WATER SYSTEMS.

B. The authority shall:

1. Prescribe a simplified form and procedure to apply for and approve assistance.

2. Establish by rule criteria that are consistent with this article by which assistance will be awarded.

3. Determine the order and priority of water conservation programs or projects assisted under this section based on the merits of the application with respect to the requirements of sections 49-1332 and 49-1334.

4. Provide that a single water conservation program grant may not exceed $3,000,000, a single water conservation project grant may not

exceed $250,000 and at least a twenty-five percent match is required for each water conservation program or project. Monies from any other source may satisfy the match requirement.

Sec. 5. Laws 2023, chapter 138, section 3 is amended to read:

Sec. 3. Fire incident management fund; exemption; delayed repeal; transfer of monies

A. The fire incident management fund is established ~~for fiscal year 2023-2024~~ consisting of legislative appropriations. The department of administration shall administer the fund. Not more than $200,000 of monies appropriated to the fund may be used by the department of administration to administer the fund. Monies in the fund are continuously appropriated and ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190, ARIZONA REVISED STATUTES, RELATING TO LAPSING OF APPROPRIATIONS. THE DEPARTMENT OF ADMINISTRATION shall ~~be used~~ DISTRIBUTE MONIES FROM THE FUND to provide grants to municipal fire departments and fire districts for hardware and software that:

1. Enables the statewide deployment of a secure incident management platform to fire and law enforcement agencies.

2. Provides a standardized incident command and management platform based on federal emergency management agency standards that enable diverse incident management and support entities to work together and ensure the following:

(a) A clearly defined chain of command.

(b) The use of common terminology.

(c) The safety of first responders and others.

(d) The achievement of response objectives.

(e) The efficient use of resources.

3. Provides a collaboration and communications solution that does the following:

(a) Identifies the location, status and assignment of assigned resources.

(b) Allows status updates, tracking and management of an incident.

(c) Allows secure messaging and file sharing to all users involved in an incident.

(d) Allows the sharing of collaborative maps, building floor plans and images between public safety agencies.

(e) Allows collaboration and information sharing between disparate agencies during a mass casualty incident.

(f) Defines a federal emergency management agency or national incident management systems-based organizational structure for the management of incidents.

(g) Provides the ability to print standard integrated computer solutions forms for tracking and cost reimbursement.

(h) Provides enhanced telemetry-based firefighter safety monitoring.

(i) Works in areas without internet access in a disconnected mode.

(j) Provides a seamless and connected platform for notification, response and rostering.

(k) Provides cross-platform functionality.

(l) Provides a smartphone-based application for notification, accountability and situational awareness.

B. Each municipal fire department or fire district in this state may submit a grant request to the department of administration for the costs of the secure incident management system that meets all of the criteria described in subsection A of this section.

C. The department of administration shall award grants on a first-come, first-served basis. Grants that are awarded shall fully fund the costs of the secure incident management system for each municipal fire department or fire district for three years.

D. FROM AND AFTER JUNE 30, 2025, THIS SECTION IS REPEALED AND ALL UNEXPENDED AND UNENCUMBERED MONIES IN THE FIRE INCIDENT MANAGEMENT FUND ESTABLISHED BY THIS SECTION REVERT TO THE STATE GENERAL FUND.

Sec. 6. Arizona water protection fund; use of monies

Notwithstanding section 45-2114, Arizona Revised Statutes, in fiscal year 2024-2025, the Arizona water protection fund commission may grant to the department of water resources up to $336,000 of the unobligated balance in the Arizona water protection fund established by section 45-2111, Arizona Revised Statutes, to pay for administrative costs of the department in fiscal year 2024-2025.

Sec. 7. Underground storage tank revolving fund; use of monies

Notwithstanding any other law, in fiscal year 2024-2025, the department of environmental quality may use up to $6,531,000 from the underground storage tank revolving fund established by section 49-1015, Arizona Revised Statutes, in fiscal year 2024-2025 for:

1. Administrative costs of the department.

2. Remediating sewage discharge issues in Naco, Arizona and other border areas of this state.

Sec. 8. Arizona water banking fund; use of monies

In addition to the purposes provided in section 45-2425, Arizona Revised Statutes, monies appropriated to the Arizona navigable stream adjudication commission from the Arizona water banking fund established by section 45-2425, Arizona Revised Statutes, may be used in fiscal year 2024-2025 to pay legal fees.

Sec. 9. Appropriation limit; water quality assurance revolving fund

Notwithstanding section 49-282, Arizona Revised Statutes, the appropriation from the state general fund to the water quality assurance revolving fund established by section 49-282, Arizona Revised Statutes, for fiscal year 2024-2025 may not exceed $15,000,000.

Sec. 10. Department of environmental quality; vehicle emissions testing fees; exemption from rulemaking

A. Notwithstanding any other law, in fiscal year 2024-2025, the director of the department of environmental quality shall reduce fees for tests conducted in area A so that vehicle emissions testing fee revenues collected from area A are reduced by five percent of fiscal year 2023-2024 area A collections. For the purposes of this subsection, "area A" has the same meaning prescribed in section 49-541, Arizona Revised Statutes.

B. The department of environmental quality is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2025 for the purpose of establishing fees pursuant to this section.

Sec. 11. Agricultural fees; emergency rulemaking

A. For fiscal year 2024-2025, notwithstanding any other law, the director of the Arizona department of agriculture, subject to the review of the department of agriculture advisory council, may lower existing fees for any funds held in trust by the department.

B. The Arizona department of agriculture shall adopt emergency rules pursuant to title 41, chapter 6, Arizona Revised Statutes, through July 1, 2025, in conjunction with the industry, to modify fees deposited in the dangerous plants, pests and diseases trust fund established by section 3-214.01, Arizona Revised Statutes. These rules must be reviewed by the department of agriculture advisory council.

Sec. 12. Authorization for liabilities and expenses; fiscal year 2024-2025

Notwithstanding section 35-192, Arizona Revised Statutes, in fiscal year 2024-2025, the governor may allocate $500,000 to the emergency management assistance compact and Arizona mutual aid compact revolving fund established by section 26-403, Arizona Revised Statutes, and $300,000 to the emergency management training revolving fund established by section 26-305, Arizona Revised Statutes, as amended by this act. Each allocation the governor makes pursuant to this section counts toward the $4,000,000 aggregate amount allowed in fiscal year 2024-2025 as prescribed by section 35-192, subsection F, Arizona Revised Statutes.

APPROVED BY THE GOVERNOR JUNE 18, 2024.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 18, 2024.

**E-3.**

**DEPARTMENT OF AGRICULTURE**
Title 3, Chapter 6, Article 1

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **DEPARTMENT OF AGRICULTURE**
Title 3, Chapter 6, Article 1

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**Summary**

This One-Year Review Report (1YRR) from the Department of Agriculture (Department) relates to one (1) rule in Title 3, Chapter 6, Article 1 regarding Marketing. Specifically, rule R3-6-102 sets out temporary fee increases as authorized by 2023 session law for fees that must be paid to obtain certification documents from the Department stating that regulated plant product commodities meet the phytosanitary entry requirements for domestic shipments.

The Department issues certificates, pursuant to A.R.S. § 3-109.02(A), as a service to shippers of plants and plant products, not covered under A.R.S. § 3-217 and R3-4-301, to meet the phytosanitary entry requirements for domestic shipments of regulated plant product commodities that are found free of regulated plant pests and diseases. Beginning in fiscal year (FY) 2011, the Department changed fees for state phytosanitary certification from $50 per Department site trip to $50 for the first lot plus $10 for each additional lot per site trip. The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations.

Each year since that time, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. The fee increase were to end at the end of the FY 2023. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorized these fees to continue in FY

2024-2025. The Department filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2024-2025, which became effective October 30, 2023. The exempt rulemaking was superseded by an emergency rulemaking filed with the Arizona Attorney General's Office to continue the fee increase through FY 2024-2025 for services provided in FY 2024-2025 as authorized under Laws 2024, 2nd Reg. Sess., Ch 214 § 11(B)

**Proposed Action**

The Department proposes to maintain the rule as is. The Department intends to submit a request to the Governor's Office in July 2025 to request approval to conduct rulemaking for rule R3-6-102 pursuant to A.R.S. § 41-1039(A) and/or laws established during Legislative Session 2025, 1st Reg. Sess. Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office, the Department will file a rulemaking to continue phytosanitary certification fees from FY 2024 in FY 2025, or amend the rule to remove the fee increase related to FY 2024-2025.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific authorizing statutes for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Department, because this rule was adopted by exempt rulemaking, a formal economic, small business, and consumer impact comparison was not prepared.

The Department issues certificates, pursuant to A.R.S. § 3-109.02(A), as a service to shippers of plants and plant products, not covered under A.R.S. § 3-217 and R3-4-301, to meet the phytosanitary entry requirements for domestic shipments of regulated plant product commodities that are found free of regulated plant pests and diseases. Fees generated by the rule pay the administrative costs to produce the certificates. Without the income generated, the Department would not be able to provide these services and the regulated community would not be able to export regulated plant products out of the state, decreasing the overall impact to the State's economy. The rule does not directly affect employment, consumers or state revenues.

Beginning in fiscal year (FY) 2011, the Department changed fees for state phytosanitary certification from $50 per Department site trip to $50 for the first lot plus $10 for each additional lot per site trip. The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations.

Each year, since that time, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. The fee increase ended at the end of the fiscal year 2023. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorized these fees to continue in FY 2024-2025. The Department filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2024-2025. The exempt rulemaking was superseded by an Emergency

Rulemaking filed with the Arizona Attorney General's Office to continue the fee increase through FY 2024-2025 for services provided in FY 2024-2025 as authorized under Laws 2024, 2nd Reg. Sess., Ch 214 § 11(B).

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department has determined that the benefits of the rule R3-6-102 outweighs the costs imposed by the regulatory community, and are the least burdensome and cost effective.

**4. Has the agency received any written criticisms of the rules since the rule was adopted?**

The Department has not received any written criticisms regarding these rules.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates there is no corresponding federal law.

**10. Has the agency completed any additional process required by law?**

The Department was not required to complete any additional processes.

**11. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates rule R3-6-102 does not require the issuance of a permit, license, or agency authorization.

## 12. Conclusion

This 1YRR from the Department relates to one (1) rule in Title 3, Chapter 6, Article 1 regarding Marketing. Specifically, rule R3-6-102 sets out temporary fee increases as authorized by 2023 session law for fees that must be paid to obtain certification documents from the Department stating that regulated plant product commodities meet the phytosanitary entry requirements for domestic shipments. The Department proposes to maintain the rule as is. The Department intends to submit a request to the Governor's Office in July 2025 to request approval to conduct rulemaking for rule R3-6-102 pursuant to A.R.S. § 41-1039(A) and/or laws established during Legislative Session 2025, 1st Reg. Sess. Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office, the Department will file a rulemaking to continue phytosanitary certification fees from FY 2024 in FY 2025, or amend the rule to remove the fee increase related to FY 2024-2025.

Council staff recommends approval of this report.

KATIE HOBBS
Governor

PAUL E. BRIERLEY
Director

# Arizona Department of Agriculture

Physical Address: 1110 W. Washington Street, Suite 450 Phoenix, AZ 85007
Mailing Address: 1802 W. Jackson Street, #78 Phoenix, AZ 85007

February 27, 2025

grrc@azdoa.gov
Jessica Klein, Chair
Governor's Regulatory Review Council
100 N. 15th Avenue, Suite 302
Phoenix, Arizona 85007

**RE: One-Year Review Report for A.A.C. Title 3, Chapter 6, R3-6-102**

Dear Ms. Klein:

Enclosed please find the Arizona Department of Agriculture's (Department) one-year review report for A.A.C. Title 3, Chapter 6, R3-6-102 which is due on February 27, 2025. This rule has been reviewed, and there is no intention for this rule to expire under § 41-1056(J). However, Laws 2023, 1st Reg. Sess., Ch. 138, § 9 set fees for fiscal year 2024, and were filed under an exempt rulemaking on October 12, 2023. The Department filed an emergency rulemaking in accordance with Laws 2024, 2nd Reg. Sess., Ch. 214, Section 11 to modify fees deposited in the dangerous plants, pests, and disease trust fund in order to continue these fees in fiscal year 2025. Also enclosed are copies of the 2024 session law, rule and the authorizing statutes.

The Department certifies, in accordance with A.R.S. § 41-1056(A), that it is in compliance with A.R.S. § 41-1091.

Please contact Brian McGrew at (602) 542-3228 or bmcgrew@azda.gov with any questions about this report.

Sincerely,

Paul E Brierley

Paul E. Brierley
Director

Enclosures:
One-Year Review Report
2023 Session Law
2024 Session Law
Current Rule
Authorizing Statutes

**ARIZONA DEPARTMENT OF AGRICULTURE**

**1 YEAR REVIEW REPORT**

**Title 3, Chapter 6**

**February 27, 2025**

**1. Authorization of the rule by existing statutes**

Authorizing Statute: A.R.S. §§ 3-107(A)(1) and (B)(3); Laws 2023, 1st Reg. Sess., Ch. 138, § 9.

Implementing Statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § 3-109.02(A).

Statute or session law authorizing the exemption: Laws 2023, 1st Reg. Sess., Ch. 138, § 9.

**2. The objective of each rule:**

| Rule | Objective |
|---|---|
| R3-6-102 | Sets out temporary fee increases as authorized by 2023 session law for fees that must be paid to obtain certification documents from the Department stating that regulated plant product commodities meet the phytosanitary entry requirements for domestic shipments. |

**3. Are the rules effective in achieving their objectives?** **Yes x** **No ___**

R3-6-102 is effective in achieving its objective.

**4. Are the rules consistent with other rules and statutes?** **Yes x** **No ___**

R3-6-102 is consistent with other rules and statutes.

**5. Are the rules enforced as written?** **Yes x** **No ___**

R3-6-102 is enforced as written.

**6. Are the rules clear, concise, and understandable?** **Yes x** **No ___**

R3-6-102 is clear, concise and understandable.

**7. Has the agency received written criticisms of the rules within the last five years?** **Yes ___** **No x**

The Department has not received written criticisms of the rules within the last five years.

**8. Economic, small business, and consumer impact comparison:**

Because this rule was adopted by exempt rulemaking, a formal economic, small business, and consumer impact comparison was not prepared.

The Department issues certificates, pursuant to A.R.S. § 3-109.02(A), as a service to shippers of plants and plant products, not covered under A.R.S. § 3-217 and R3-4-301, to meet the phytosanitary entry requirements for

domestic shipments of regulated plant product commodities that are found free of regulated plant pests and diseases. Fees generated by the rule pay the administrative costs to produce the certificates. Without the income generated, the Department would not be able to provide these services and the regulated community would not be able to export regulated plant products out of the state, decreasing the overall impact to the State's economy. The rule does not directly affect employment, consumers or state revenues.

Beginning in fiscal year (FY) 2011, the Department changed fees for state phytosanitary certification from $50 per Department site trip to $50 for the first lot plus $10 for each additional lot per site trip. The fee increases were implemented through legislation that allowed for a one year increase in fees in order to make up for decreases in general fund appropriations.

Each year, since that time, similar legislation has passed allowing the Department to keep up these fee increases for one more year at a time. The fee increase will ended at the end of the fiscal year 2023. Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorized these fees to continue in FY 2024-2025. The Department filed an exempt rulemaking with the Secretary of State's Office to continue these fees in FY 2024-2025. The exempt rulemaking was superseded by an Emergency Rulemaking filed with the Arizona Attorney General's Office to continue the fee increase through FY 2024-2025 for services provided in FY 2024-2025 as authorized under Laws 2024, 2nd Reg. Sess., Ch 214 § 11(B)

**9. Has the agency received any business competitiveness analyses of the rules? Yes____No x___**

No business competitive analysis has been received.

**10. Has the agency completed the course of action indicated in the agency's previous one-year-review report?**

The Department completed the course of action in the previous one-year-review report by filing a notice of exempt rulemaking on October 12, 2024.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department has determined that the benefits of the rule R3-6-102 outweighs the costs imposed by the regulatory community, and are the least burdensome and cost effective.

**12. Are the rules more stringent than corresponding federal laws? Yes____ No x___**

R3-6-102 has no corresponding federal law and is therefore not more stringent than a corresponding Federal law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

R3-6-102 does not require a permit.

**14. Proposed course of action**

The Department proposes to maintain the rule as is. The Department intends to submit a request to the Governor's Office Policy Advisor in July, 2025 to request approval to conduct rulemaking for rule R3-6-102 pursuant to A.R.S. § 41-1039(A) and/or laws established during Legislative Session 2025, 1st Reg. Sess. Within 30-days of receiving approval to proceed with rulemaking from the Governor's Office Policy Advisor, the Department will file a rulemaking to continue phytosanitary certification fees from fiscal year 2024 in fiscal year 2025, or amend the rule

to remove the fee increase related to FY 2024-2025.

2. No change
3. No change
4. No change
5. No change
6. No change

**F.** No change
1. No change
2. No change
3. No change
4. No change

**G.** ~~Nothwithstanding~~ Notwithstanding subsections (B) through (D), during fiscal year ~~2023~~ 2024, an applicant for nursery stock inspection certification shall pay the following fee:
1. For general certification, $250.
2. For single shipment certification, $50 for the first lot plus $10 for each additional lot per Department site trip.

## NOTICE OF EXEMPT RULEMAKING

### TITLE 3. AGRICULTURE

### CHAPTER 6. DEPARTMENT OF AGRICULTURE
### OFFICE OF COMMODITY DEVELOPMENT AND PROMOTION

[R23-214]

### PREAMBLE

**1. Article, Part, or Section Affected (as applicable)** **Rulemaking Action**
R3-6-102 Amend

**2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific), and the statute or session law authorizing the exemption:**
Authorizing statute: A.R.S. §§ 3-107(A)(1) and (B)(3); Laws 2023, 1st Reg. Sess., Ch. 138, § 9
Implementing statute: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § 3-109.02(A)
Statute or session law authorizing the exemption: Laws 2023, 1st Reg. Sess., Ch. 138, § 9; A.R.S. § 41-1005(A)(5)

**3. The effective date of the rule and the agency's reason it selected the effective date:**
October 30, 2023
The effective date of the rule is based on the effective date of the law authorizing the rulemaking.

**4. A list of all notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the exempt rulemaking:**
None

**5. The agency's contact person who can answer questions about the rulemaking:**

| | |
|---|---|
| Name: | Jack Peterson, Associate Director |
| Address: | Arizona Department of Agriculture<br>1110 W. Washington St., Suite 450<br>Phoenix, AZ 85007 |
| Mailing Address: | Arizona Department of Agriculture<br>1802 W. Jackson St., #78<br>Phoenix, AZ 85007 |
| Telephone: | (602) 542-3575 |
| Fax: | (602) 542-1004 |
| Email: | jpeterson@azda.gov |

**6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**
This rulemaking continues fees from fiscal years 2011 through 2023 in fiscal year 2024 for services provided in fiscal year 2024 for phytosanitary certification in order to make up for decreases in general fund appropriations. See Notice of Exempt Rulemaking: 28 A.A.R. 2022, August 12, 2022; 27 A.A.R. 1269, August 20, 2021; 26 A.A.R. 1475, July 24, 2020; 25 A.A.R. 2088, August 16, 2019; 24 A.A.R. 2226, August 3, 2018; 23 A.A.R. 1943, July 21, 2017; 21 A.A.R. 2412, Oct. 16, 2015; 20 A.A.R. 2449, Sept. 5, 2014; 19 A.A.R. 3146, Oct. 11, 2013; 18 A.A.R. 2066, Aug. 24, 2012; 17 A.A.R. 1765, Sept. 2, 2011; & 16 A.A.R. 1339, July 23, 2010. Continuing these fees is necessary to implement the budget for the plant services division for fiscal year 2024.

**7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
None

**8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable

**9. The summary of the economic, small business, and consumer impact, if applicable:**

Laws 2023, 1st Reg. Sess., Ch. 138, § 9 authorizes an exemption from the rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purpose of establishing fees pursuant to those sections until July 1, 2024. As a result, this rulemaking is exempt from the requirements of the Administrative Procedures Act and no economic, small business, and consumer impact statement is required.

**10. A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):**

Not applicable

**11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:**

None received

**12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**

The Department of Agriculture Advisory Council voted on June 29, 2023 in favor of continuing the fees set out in this rulemaking through fiscal year 2024.

**a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**

The rule does not require a permit.

**b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**

The federal administrative user fee is set out in 7 CFR 354.3(g)(3)(i). This rule is not more stringent than federal law.

**c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**

Not applicable

**13. A list of any incorporated by reference material and its location in the rule:**

7 CFR 354.3(g)(3)(i), revised January 1, 2016, is incorporated by reference in R3-6-102(A)(2).

**14. Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:**

Not applicable

**15. The full text of the rules follows:**

## TITLE 3. AGRICULTURE

## CHAPTER 6. DEPARTMENT OF AGRICULTURE
## OFFICE OF COMMODITY DEVELOPMENT AND PROMOTION

### ARTICLE 1. MARKETING

Section
R3-6-102. Phytosanitary Certification

### ARTICLE 1. MARKETING

**R3-6-102. Phytosanitary Certification**

**A.** During fiscal year ~~2023~~ 2024, a person who applies to the Department for phytosanitary certification shall pay the following fee:

1. For state certification, $50 for the first lot plus $10 for each additional lot per Department site trip.
2. For federal certification, $50 plus the federal administrative user fee set out in 7 CFR 354.3(g)(3)(i), revised January 1, 2016, which is incorporated by reference and does not include any later amendments or editions. A copy of the incorporated material is available for inspection at the Department, 1110 W. Washington St., Suite 450, Phoenix, Arizona 85007 or may also be viewed at http://www.gpo.gov/fdsys/.

**B.** This Section does not apply to phytosanitary certification under A.A.C. R3-4-301.

# 3-607. Annual licenses; inspections; revocation; fees; exceptions

A. A person shall not operate a milk distributing plant or a manufacturing milk processing plant, engage in the business of producer-distributor or producer-manufacturer, or engage in the business of selling at wholesale milk or dairy products, or both, without a license. This section does not require:

1. An Arizona dairy farm producing raw milk for sale to be processed to secure a license to operate.

2. A retailer or wholesaler to secure a license from the division to convert a pasteurized mix into frozen dessert.

3. A food establishment regulated by the department of health services to secure a license from the division to manufacture frozen desserts using pasteurized milk or pasteurized milk-based products if the frozen dessert is manufactured and sold at the same food establishment for consumption on the premises and the food establishment has submitted a plan for approval to the regulatory authority under title 36 demonstrating that the manufacturing process complies with the rules adopted pursuant to section 36-136, subsection I, including pasteurization as defined in rule. The division or the regulatory authority under title 36 may require a food establishment that manufactures frozen desserts using pasteurized milk or pasteurized milk-based products to provide samples of the frozen dessert to verify that the frozen dessert is pasteurized.

B. An application for a license shall be in writing in the form the associate director prescribes and shall be accompanied by the required filing fee. On receipt of an application, the associate director or an authorized representative shall examine the premises in which the applicant proposes to do business, and if it appears that the applicant has complied with all provisions of law, the license shall be issued.

C. After issuance of the first annual license, a license may be issued on inspection of the premises and payment not later than February 1 of each year of the required fee. The inspection shall be made by the associate director or an authorized representative to determine whether the premises are maintained in compliance with law. A written report of the inspection shall be filed in the division office. An annual license is valid for the period beginning January 1 and ending December 31 of each year, and a license that is not renewed on or before February 1 of each year is void.

D. An application for a license to produce grade A milk for human consumption shall be made in the manner prescribed by subsections A and B of this section. The license shall be valid until revoked for failure to comply with the provisions of this article relating to the production of milk. The associate director may suspend a license pending correction of deficiencies that violate this article. If the identified deficiencies are not corrected within a reasonable time after the licensee is notified, the associate director may proceed to revoke the license. Notice of a pending revocation shall be in writing, stating the cause, and setting a time during which the licensee may correct the cause for revocation. If the cause for revocation is not corrected within the time specified, the associate director, after a hearing and three days' notice of intention, may revoke the license. The director shall review the associate director's action on request of any person adversely affected by the action. A person holding a permit issued by a governmental agency operating outside of this state whose requirements are substantially the same as the requirements of this state shall be deemed to have a license meeting the requirements of this article, provided the facilities have first been inspected and approved also by a resident Arizona inspector, if in the opinion of the associate director such an inspection should be made. Any expense incurred for such an inspection shall be at the expense of the licensee.

E. Fees shall be paid as follows:

1. For a license or renewal of a license to operate a milk distributing plant or business, $50.

2. For a license or renewal of a license to operate a manufacturing milk processing plant, $50.

3. For a license or renewal of a license to engage in the business of producer-distributor or producer-manufacturer, $25.

4. For a license or renewal of a license to engage in the business of selling at wholesale milk or dairy products, or both, $25.

F. The associate director or dairy inspectors are authorized to inspect premises affected by this article and located outside of this state, and they shall receive subsistence and travel expenses in the amount provided for state officers, which shall be paid to the inspector by the owner of the premises inspected.

G. This section does not apply to a producer of raw milk.

# 3-619. Qualification of sampler; license; certificate of proficiency; revocation

A. No person shall sample milk or cream for the purpose of determining the amount of milk fat contained therein where the result of the test is used as a basis for payment for the milk or cream, or for official inspection or public record, unless licensed by the division. An applicant for a license shall give proof satisfactory to the associate director of his ability to perform his duties and shall pay a license fee of five dollars. The license shall be valid for the calendar year in which issued and upon payment of a renewal fee of one dollar fifty cents shall be renewed for each year in which the licensee desires to operate. A license not renewed prior to February 1 is void.

B. No person shall test milk or cream for the purpose of determining the butterfat content thereof, when the result of the test is used to determine the purchase sales value or the legal standard of the product, unless the tester has a tester's license. A tester's license may be obtained from the division by presenting a certificate of proficiency, and payment of a license fee of five dollars. The license shall be valid for the calendar year in which issued, and upon payment of a renewal fee of one dollar fifty cents shall be renewed for each year in which the tester desires to operate. A license not renewed prior to February 1 is void.

C. A certificate of proficiency may be obtained only from the department of dairy husbandry of the university of Arizona. The applicant therefor shall appear before the department of dairy husbandry or an official representative thereof and submit to such written examination and conduct such demonstration of laboratory technique as the department of dairy husbandry or its representative may require. Upon successfully completing the examination the department of dairy husbandry shall issue the certificate to an applicant displaying required proficiency. A tester's license issued by a state other than this state shall be accepted from the person named thereon in lieu of the certificate of proficiency, but the tester shall have been actively engaged in testing under the license for a period of not less than ninety days and shall furnish proof thereof. Each license shall be kept at the place in which the licensee is employed and shall be open to inspection.

D. A license may be revoked by the associate director, after a hearing upon due notice to the licensee, for a false statement in the application, dishonesty, incompetency or inaccuracy, or for violating any provision of this article. On request, the director shall review any action taken by the associate director under this subsection.

# 3-1337. Service charge and inspection fee; self-inspection

A. Livestock officers and inspectors shall collect from the person in charge of cattle inspected a service charge of three dollars plus an inspection fee of twenty-five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of cattle.

B. Livestock officers and inspectors shall collect from the person in charge of sheep inspected a service charge of three dollars plus an inspection fee of five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of sheep.

C. Livestock officers and inspectors shall collect from the person in charge of dairy cattle inspected a service charge of three dollars plus an inspection fee of twenty-five cents per head for making inspections for the transfer of ownership, sale, slaughter or transportation of dairy cattle.

D. The division may approve self-inspection by movers of livestock and feedlots and dairies pursuant to section 3-1203, subsection D. Movement shall be documented on simple and concise self-inspection forms that are provided by the department and that include only the following information:

1. The certificate number.

2. The department contact information.

3. For out-of-state shipments, official identification.

4. For dairy cattle, back tag numbers.

5. The amount collected pursuant to section 3-1236.

6. The number and description of livestock.

7. The livestock owner's or agent's name, signature and address.

8. The transporter's name.

9. The location of the place and date of shipment.

10. The destination or buyer's name and address.

11. For branded animals, the animal's registered brand, including brand number, location and expiration date.

E. Movers of livestock and feedlots and dairies that utilize self-inspection shall purchase the self-inspection book from the department. The director, in consultation with the department of agriculture advisory council established pursuant to section 3-104, may establish a fee for the self-inspection book.

F. Any fees collected by the livestock officers and inspectors and by movers of livestock and feedlots and dairies utilizing self-inspection shall be remitted to the division. Any fees incurred by movers of livestock and feedlots and dairies shall be remitted to the department within ten days after the end of the month in which the livestock were inspected.

# 3-2003. Grant of licenses; fees; expiration date

A. The division may grant a license to slaughter livestock, sheep, goats or swine as set forth in the license issued on payment of the fees.

B. The fees shall be as follows:

1. For not to exceed forty-five head of livestock, and not to exceed fifty-five head of sheep, goats or swine in one calendar year, $5.

2. For more than forty-five and not to exceed one hundred fifty head of livestock and more than forty-five and not to exceed one hundred sixty head of sheep, goats or swine in one calendar year, $15.

3. For more than one hundred fifty head of livestock and more than one hundred sixty head of sheep, goats or swine in any one calendar year, $80.

C. Licenses issued under this section expire on December 31 of the year in which they are issued.

# 3-2081. Licenses for sale or exchange of meat or poultry; fee; records kept by licensee; expiration of license; violation; classification

A. A person, firm or corporation that engages in the business of meat or poultry processing, wholesaling, storing in or for intrastate commerce, transporting in intrastate commerce, distributing, jobbing or brokering other than canned meat or poultry or canned meat or poultry products, except a home consumer, shall, before offering such meat or poultry or meat or poultry food products for sale or exchange, after complying with the minimum requirements of the director, procure a license from the division, for which he shall pay an annual license fee of ten dollars for each place of business, store, stand, market or vehicle in or from which the meat is to be sold or exchanged and shall keep a record of the name and address of each person from whom the licensee obtained such meat or meat food products, the date of purchase, quantity and kind of meat purchased and time and place of purchase. Upon request by an inspector or peace officer, the licensee shall exhibit the record to him. The record shall be retained for one year.

B. All licenses issued under the provisions of this article shall expire on December 31 of the year in which issued.

C. The following persons, firms and corporations shall keep such records as will fully and correctly disclose all transactions involved in their businesses and all persons, firms and corporations subject to such requirements shall at all reasonable times upon notice by a duly authorized representative of the department afford such representative access to their places of business and opportunity to examine the facilities and inventory and to take reasonable samples of their inventory upon payment of the fair market value:

1. Any persons, firms or corporations that engage in the business of slaughtering any cattle, sheep, swine, goats, horses, mules or other equines or preparing, freezing, packaging or labeling any carcasses or parts or products of carcasses of any such animals for use as human food or animal food.

2. Any persons, firms or corporations that engage in the business of buying or selling as meat brokers, wholesalers or otherwise or transporting or storing or importing any carcasses or parts or products of carcasses of any such animals.

3. Any persons, firms or corporations that engage in business as renderers or engage in the business of buying, selling, transporting or importing any dead, dying, disabled or diseased cattle, sheep, swine, goats, horses, mules or other equines or parts of the carcasses of any such animals that died otherwise than by slaughter.

D. Any record required to be maintained by this section shall be maintained for such period of time as the director may by rules prescribe.

E. A person violating any provision of this section is guilty of a class 2 misdemeanor.

# 3-217. Nursery or nursery stock certification; fee; denial, revocation or suspension; hearing

A. The associate director shall:

1. Establish a nursery certification program.

2. By rule, set and collect a variable fee for each nursery or nursery stock certification inspection based on a schedule of costs for services as may be appropriate to recover the actual direct costs incurred by the division, but not more than fifty dollars for each inspection.

B. If the state agricultural laboratory performs tests under a nursery certification program, the laboratory may collect fees prescribed by rule for the tests established as follows:

1. The associate director shall establish by rule the extent and type of testing required for the Arizona certified nursery program including only tests that the department would not otherwise have performed to determine if the nursery or nursery stock is infested or infected with a crop pest or disease.

2. The extent and type of testing required for the export criteria program shall be established according to the requirements of another state, country or commonwealth.

C. The associate director may issue, refuse to issue, revoke or suspend a nursery certificate under the nursery certification program.

D. A person who is aggrieved by any action under the nursery certification program may request a hearing pursuant to title 41, chapter 6, article 10.

## 3-109.02. Office of commodity development and promotion; fees; commodity promotion fund; definition

A. The office of commodity development and promotion shall provide for programs to stimulate, educate, encourage and foster the production and consumption of Arizona agricultural products domestically and abroad.

B. The office may provide authorized or contracted administrative functions for councils and commissions established by law.

C. The director may collect a fee, which the director shall establish by rule, for the issuance of certificates of free sale. The amount of the fee shall not exceed the actual cost of preparing the certificate of free sale. All monies collected from the fees shall be deposited, pursuant to sections 35-146 and 35-147, in the commodity promotion fund.

D. The commodity promotion fund is established. The fund consists of all monies collected pursuant to any promotional service provided to industry under this section and not supported by general fund appropriation, and monies received pursuant to section 3-107, subsection B, paragraph 8. The director shall administer the fund. On notice from the director, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are:

1. Continuously appropriated to the department for the purposes of this section.

2. Exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. For the purposes of this section, "certificate of free sale" means a document that authenticates a commodity that is generally and freely sold in domestic channels of trade.

State of Arizona
Senate
Fifty-sixth Legislature
First Regular Session
2023

# CHAPTER 138

# SENATE BILL 1725

AN ACT

AMENDING TITLE 26, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 26-107; REPEALING SECTION 26-107, ARIZONA REVISED STATUTES; APPROPRIATING MONIES; RELATING TO THE ENVIRONMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 26, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 26-107, to read:

26-107. Hazard mitigation revolving fund

THE HAZARD MITIGATION REVOLVING FUND IS ESTABLISHED CONSISTING OF MONIES APPROPRIATED BY THE LEGISLATURE AND MONIES RECEIVED FROM THE FEDERAL GOVERNMENT. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED. THE DEPARTMENT OF EMERGENCY AND MILITARY AFFAIRS SHALL ADMINISTER THE FUND. MONIES IN THE FUND MAY BE USED IN FISCAL YEARS 2023-2024, 2024-2025, 2025-2026, 2026-2027 AND 2027-2028 IN ACCORDANCE WITH THE GUIDELINES ESTABLISHED PURSUANT TO THE SAFEGUARDING TOMORROW THROUGH ONGOING RISK MITIGATION ACT (P.L. 116-284; 134 STAT. 4869).

Sec. 2. Delayed repeal

Section 26-107, Arizona Revised Statutes, as added by this act, is repealed from and after June 30, 2028.

Sec. 3. Fire incident management fund

A. The fire incident management fund is established for fiscal year 2023-2024 consisting of legislative appropriations. The department of administration shall administer the fund. Not more than $200,000 of monies appropriated to the fund may be used by the department of administration to administer the fund. Monies in the fund are continuously appropriated and shall be used to provide grants to municipal fire departments and fire districts for hardware and software that:

1. Enables the statewide deployment of a secure incident management platform to fire and law enforcement agencies.

2. Provides a standardized incident command and management platform based on federal emergency management agency standards that enable diverse incident management and support entities to work together and ensure the following:

(a) A clearly defined chain of command.

(b) The use of common terminology.

(c) The safety of first responders and others.

(d) The achievement of response objectives.

(e) The efficient use of resources.

3. Provides a collaboration and communications solution that does the following:

(a) Identifies the location, status and assignment of assigned resources.

(b) Allows status updates, tracking and management of an incident.

(c) Allows secure messaging and file sharing to all users involved in an incident.

(d) Allows the sharing of collaborative maps, building floor plans and images between public safety agencies.

(e) Allows collaboration and information sharing between disparate agencies during a mass casualty incident.

(f) Defines a federal emergency management agency or national incident management systems-based organizational structure for the management of incidents.

(g) Provides the ability to print standard integrated computer solutions forms for tracking and cost reimbursement.

(h) Provides enhanced telemetry-based firefighter safety monitoring.

(i) Works in areas without internet access in a disconnected mode.

(j) Provides a seamless and connected platform for notification, response and rostering.

(k) Provides cross-platform functionality.

(l) Provides a smartphone-based application for notification, accountability and situational awareness.

B. Each municipal fire department or fire district in this state may submit a grant request to the department of administration for the costs of the secure incident management system that meets all of the criteria described in subsection A of this section.

C. The department of administration shall award grants on a first-come, first-served basis. Grants that are awarded shall fully fund the costs of the secure incident management system for each municipal fire department or fire district for three years.

Sec. 4. Arizona water protection fund; use of monies

Notwithstanding section 45-2114, Arizona Revised Statutes, in fiscal year 2023-2024, the Arizona water protection fund commission may grant to the department of water resources up to $336,000 of the unobligated balance in the Arizona water protection fund established by section 45-2111, Arizona Revised Statutes, to pay for administrative costs of the department in fiscal year 2023-2024.

Sec. 5. Underground storage tank revolving fund; use of monies

Notwithstanding any other law, in fiscal year 2023-2024, the department of environmental quality may use up to $6,531,000 from the underground storage tank revolving fund established by section 49-1015, Arizona Revised Statutes, in fiscal year 2023-2024 for:

1. Administrative costs of the department.

2. Remediating sewage discharge issues in Naco, Arizona and other border areas of this state.

Sec. 6. Arizona water banking fund; use of monies

In addition to the purposes provided in section 45-2425, Arizona Revised Statutes, monies appropriated to the Arizona navigable stream adjudication commission from the Arizona water banking fund established by section 45-2425, Arizona Revised Statutes, may be used in fiscal year 2023-2024 to pay legal fees.

Sec. 7. Appropriation limit; water quality assurance revolving fund

Notwithstanding section 49-282, Arizona Revised Statutes, the appropriation from the state general fund to the water quality assurance revolving fund established by section 49-282, Arizona Revised Statutes, for fiscal year 2023-2024 may not exceed $15,000,000.

Sec. 8. Department of environmental quality; vehicle emissions testing fees; exemption from rulemaking

A. Notwithstanding any other law, the director of environmental quality shall charge fees in fiscal year 2023-2024 that are not more than the fees that were charged in fiscal year 2022-2023 for tests conducted in Area A, as defined in section 49-541, Arizona Revised Statutes.

B. The department of environmental quality is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2024 for the purpose of establishing fees pursuant to this section.

Sec. 9. Agricultural fees; continuation; intent; exemption from rulemaking

A. Notwithstanding any other law, the director of the Arizona department of agriculture, with the assistance of the department of agriculture advisory council, may continue to increase or lower existing fees from fiscal years 2021-2022 and 2022-2023 in fiscal year 2023-2024 for services provided in fiscal year 2023-2024.

B. The legislature intends that the additional revenue generated by the fees prescribed in subsection A of this section not exceed $218,000 to the state general fund, $113,000 to the pesticide trust fund established by section 3-350, Arizona Revised Statutes, and $26,000 to the dangerous plants, pests and diseases trust fund established by section 3-214.01, Arizona Revised Statutes, in fiscal year 2023-2024.

C. The Arizona department of agriculture is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2024 for the purpose of establishing fees pursuant to this section.

APPROVED BY THE GOVERNOR MAY 11, 2023.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 12, 2023.

State of Arizona
House of Representatives
Fifty-sixth Legislature
Second Regular Session
2024

# CHAPTER 214

# HOUSE BILL 2902

AN ACT

AMENDING SECTIONS 3-109.03, 26-305, 41-511.24 AND 49-1333, ARIZONA REVISED STATUTES; AMENDING LAWS 2023, CHAPTER 138, SECTION 3; APPROPRIATING MONIES; RELATING TO THE ENVIRONMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 3-109.03, Arizona Revised Statutes, is amended to read:

3-109.03. Livestock operator fire and flood assistance grant program; requirements; fund; exemption; definition

A. The livestock operator fire and flood assistance grant program is established under the department to provide grant monies to landowners and lessees of a livestock operation of more than forty animals under normal operating conditions for infrastructure projects that are required as a result of a wildfire ~~and~~ OR associated flooding and that are either:

1. Not eligible for funding from another federal or state program.

2. Partially funded by another federal or state program.

B. The department shall:

1. Develop guidelines and criteria to implement the program, including an application process that includes a description of the intended use for the grant monies.

2. Award all grants pursuant to title 41, chapter 24.

3. Not grant more than fifty percent of the monies in the livestock operator fire and flood assistance fund for infrastructure projects on land in one county in any fiscal year.

4. Ensure that grants from the livestock operator fire and flood assistance GRANT program do not exceed more than:

(a) Fifty percent of the total costs of any infrastructure project.

(b) An aggregate of $250,000 per livestock operation for infrastructure projects that are required as a result of a single wildfire and that wildfire's associated flooding.

5. Require each grantee to submit to the department, within twelve months after receiving the grant, a written report detailing how the grant monies were used to achieve the infrastructure project described in the application. If the infrastructure project takes longer than one year to complete, the grantee shall submit a written report to the department annually until the infrastructure project is complete.

6. On or before December 31 of each year, submit a report of the disposition of monies appropriated to the livestock operator fire and flood assistance fund each fiscal year to the governor, the president of the senate and the speaker of the house of representatives and shall provide a copy of this report to the secretary of state and to any person who requests a copy.

C. The department is exempt from title 41, chapter 6 with respect to adopting rules for the purposes of this section, except that the department shall provide for public notice and sixty days for public comment on the annual grant guidelines and criteria, including public hearings.

D. The livestock operator fire and flood assistance fund is established consisting of federal monies, legislative appropriations from the state general fund, public and private grants and private donations received for the purpose of providing grant monies to landowners and lessees of a livestock operation OF MORE THAN FORTY ANIMALS UNDER NORMAL OPERATING CONDITIONS for infrastructure projects pursuant to this section. The department shall administer the fund. Monies in the fund are continuously appropriated. On notice from the department, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

E. The department may use up to five percent of the monies appropriated to the livestock operator fire and flood assistance fund in any fiscal year for the purposes of administering the program.

F. For the purposes of this section, "infrastructure" includes wells, buildings, fences, pipelines, spring and water developments, corrals and other essential components to a livestock operation.

Sec. 2. Section 26-305, Arizona Revised Statutes, is amended to read:

26-305. Division of emergency management; duties; director; term; qualifications; compensation; emergency management training revolving fund

A. There is established in the department of emergency and military affairs the division of emergency management, which is administered by the department under the authority of the adjutant general, subject to powers vested in the governor as provided by law.

B. The division shall prepare for and coordinate those emergency management activities that may be required to reduce the impact of disaster on persons or property.

C. Through the powers vested in the governor, the division shall coordinate the cooperative effort of all governmental agencies including the federal government, this state and its political subdivisions to alleviate suffering and loss resulting from disaster.

D. The adjutant general shall appoint the director who serves at the pleasure of the adjutant general. The adjutant general shall select the director on the basis of demonstrated ability in governmental functions or business administration and general knowledge of contingency planning and disaster preparedness.

E. The director is eligible to receive compensation pursuant to section 38-611.

F. The emergency management training REVOLVING fund is established consisting of ~~monies received from~~ LEGISLATIVE APPROPRIATIONS, REIMBURSEMENTS RECEIVED AND fees collected by the division for coordinating ~~symposiums, training~~ conferences ~~and seminars~~, TRAININGS AND

EXERCISES relating to ~~its~~ THE DIVISION'S powers and duties. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS. The director of the division shall deposit all fees collected for these activities in the fund, which shall be used only for expenses of the activities. ~~All monies collected from each event that are in excess of the expenses of the event shall revert to the state general fund by the end of the fiscal year.~~

Sec. 3. Section 41-511.24, Arizona Revised Statutes, is amended to read:

41-511.24. Arizona state parks store fund

A. The Arizona state parks store fund is established consisting of monies deposited pursuant to a fee schedule for goods and services determined by the Arizona state parks board. The board shall administer the fund. Monies in the fund are subject to legislative appropriation and shall be used by the board to operate and maintain gift shops.

B. Monies in the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations. All monies in the fund exceeding ~~$1,250,000~~ $1,750,000 at the end of a fiscal year are transferred to the state parks revenue fund established by section 41-511.21.

Sec. 4. Section 49-1333, Arizona Revised Statutes, is amended to read:

49-1333. Water conservation grant fund; procedures

A. In compliance with any applicable requirements, an eligible entity as defined in section 49-1301 may apply to the authority for and accept grants from the water conservation grant fund for a water conservation program or project that complies with the requirements of sections 49-1332 and 49-1334. A nongovernment organization that focuses on water conservation or environmental protection may apply to the authority for and accept grants from the water conservation grant fund for a water conservation program or project if it partners with an eligible entity as defined in section 49-1301. AN ELIGIBLE ENTITY MAY APPLY TO THE AUTHORITY FOR AND ACCEPT GRANTS FROM THE WATER CONSERVATION GRANT FUND TO DISTRIBUTE REBATES FOR THE INSTALLATION OF GRAY WATER SYSTEMS.

B. The authority shall:

1. Prescribe a simplified form and procedure to apply for and approve assistance.

2. Establish by rule criteria that are consistent with this article by which assistance will be awarded.

3. Determine the order and priority of water conservation programs or projects assisted under this section based on the merits of the application with respect to the requirements of sections 49-1332 and 49-1334.

4. Provide that a single water conservation program grant may not exceed $3,000,000, a single water conservation project grant may not

exceed $250,000 and at least a twenty-five percent match is required for each water conservation program or project. Monies from any other source may satisfy the match requirement.

Sec. 5. Laws 2023, chapter 138, section 3 is amended to read:

Sec. 3. Fire incident management fund; exemption; delayed repeal; transfer of monies

A. The fire incident management fund is established ~~for fiscal year 2023-2024~~ consisting of legislative appropriations. The department of administration shall administer the fund. Not more than $200,000 of monies appropriated to the fund may be used by the department of administration to administer the fund. Monies in the fund are continuously appropriated and ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190, ARIZONA REVISED STATUTES, RELATING TO LAPSING OF APPROPRIATIONS. THE DEPARTMENT OF ADMINISTRATION shall ~~be used~~ DISTRIBUTE MONIES FROM THE FUND to provide grants to municipal fire departments and fire districts for hardware and software that:

1. Enables the statewide deployment of a secure incident management platform to fire and law enforcement agencies.

2. Provides a standardized incident command and management platform based on federal emergency management agency standards that enable diverse incident management and support entities to work together and ensure the following:

(a) A clearly defined chain of command.

(b) The use of common terminology.

(c) The safety of first responders and others.

(d) The achievement of response objectives.

(e) The efficient use of resources.

3. Provides a collaboration and communications solution that does the following:

(a) Identifies the location, status and assignment of assigned resources.

(b) Allows status updates, tracking and management of an incident.

(c) Allows secure messaging and file sharing to all users involved in an incident.

(d) Allows the sharing of collaborative maps, building floor plans and images between public safety agencies.

(e) Allows collaboration and information sharing between disparate agencies during a mass casualty incident.

(f) Defines a federal emergency management agency or national incident management systems-based organizational structure for the management of incidents.

(g) Provides the ability to print standard integrated computer solutions forms for tracking and cost reimbursement.

(h) Provides enhanced telemetry-based firefighter safety monitoring.

(i) Works in areas without internet access in a disconnected mode.

(j) Provides a seamless and connected platform for notification, response and rostering.

(k) Provides cross-platform functionality.

(l) Provides a smartphone-based application for notification, accountability and situational awareness.

B. Each municipal fire department or fire district in this state may submit a grant request to the department of administration for the costs of the secure incident management system that meets all of the criteria described in subsection A of this section.

C. The department of administration shall award grants on a first-come, first-served basis. Grants that are awarded shall fully fund the costs of the secure incident management system for each municipal fire department or fire district for three years.

D. FROM AND AFTER JUNE 30, 2025, THIS SECTION IS REPEALED AND ALL UNEXPENDED AND UNENCUMBERED MONIES IN THE FIRE INCIDENT MANAGEMENT FUND ESTABLISHED BY THIS SECTION REVERT TO THE STATE GENERAL FUND.

Sec. 6. Arizona water protection fund; use of monies

Notwithstanding section 45-2114, Arizona Revised Statutes, in fiscal year 2024-2025, the Arizona water protection fund commission may grant to the department of water resources up to $336,000 of the unobligated balance in the Arizona water protection fund established by section 45-2111, Arizona Revised Statutes, to pay for administrative costs of the department in fiscal year 2024-2025.

Sec. 7. Underground storage tank revolving fund; use of monies

Notwithstanding any other law, in fiscal year 2024-2025, the department of environmental quality may use up to $6,531,000 from the underground storage tank revolving fund established by section 49-1015, Arizona Revised Statutes, in fiscal year 2024-2025 for:

1. Administrative costs of the department.

2. Remediating sewage discharge issues in Naco, Arizona and other border areas of this state.

Sec. 8. Arizona water banking fund; use of monies

In addition to the purposes provided in section 45-2425, Arizona Revised Statutes, monies appropriated to the Arizona navigable stream adjudication commission from the Arizona water banking fund established by section 45-2425, Arizona Revised Statutes, may be used in fiscal year 2024-2025 to pay legal fees.

Sec. 9. Appropriation limit; water quality assurance revolving fund

Notwithstanding section 49-282, Arizona Revised Statutes, the appropriation from the state general fund to the water quality assurance revolving fund established by section 49-282, Arizona Revised Statutes, for fiscal year 2024-2025 may not exceed $15,000,000.

Sec. 10. Department of environmental quality; vehicle emissions testing fees; exemption from rulemaking

A. Notwithstanding any other law, in fiscal year 2024-2025, the director of the department of environmental quality shall reduce fees for tests conducted in area A so that vehicle emissions testing fee revenues collected from area A are reduced by five percent of fiscal year 2023-2024 area A collections. For the purposes of this subsection, "area A" has the same meaning prescribed in section 49-541, Arizona Revised Statutes.

B. The department of environmental quality is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, until July 1, 2025 for the purpose of establishing fees pursuant to this section.

Sec. 11. Agricultural fees; emergency rulemaking

A. For fiscal year 2024-2025, notwithstanding any other law, the director of the Arizona department of agriculture, subject to the review of the department of agriculture advisory council, may lower existing fees for any funds held in trust by the department.

B. The Arizona department of agriculture shall adopt emergency rules pursuant to title 41, chapter 6, Arizona Revised Statutes, through July 1, 2025, in conjunction with the industry, to modify fees deposited in the dangerous plants, pests and diseases trust fund established by section 3-214.01, Arizona Revised Statutes. These rules must be reviewed by the department of agriculture advisory council.

Sec. 12. Authorization for liabilities and expenses; fiscal year 2024-2025

Notwithstanding section 35-192, Arizona Revised Statutes, in fiscal year 2024-2025, the governor may allocate $500,000 to the emergency management assistance compact and Arizona mutual aid compact revolving fund established by section 26-403, Arizona Revised Statutes, and $300,000 to the emergency management training revolving fund established by section 26-305, Arizona Revised Statutes, as amended by this act. Each allocation the governor makes pursuant to this section counts toward the $4,000,000 aggregate amount allowed in fiscal year 2024-2025 as prescribed by section 35-192, subsection F, Arizona Revised Statutes.

APPROVED BY THE GOVERNOR JUNE 18, 2024.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 18, 2024.

**E-4.**

**ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**
Title 4, Chapter 17, Rule R4-17-401

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - ONE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** **June 17, 2025**

**SUBJECT:** **ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**
Title 4, Chapter 17, Article 4

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**Summary**

This One-Year Review Report (1YRR) from the Arizona Regulatory Board of Physician Assistants ("Board") relates to R4-17-401. Under Laws 2023, Chapter 54 (HB 2043), the Board completed an exempt rulemaking that made rules R4-17-401 and R4-17-402, with the exempt rulemaking date of December 31, 2023, *see Arizona Administrative Register (A.A.R) Volume 30, Issue 2, January 12, 2024, pg. 63*. HB 2043 provides the Department an exemption from rulemaking one year after the effective date of the Bill. The Bill had an effective date of December 31, 2023. On July 30, 2024, the Council determined that R4-17-402(B)-(G) exceeded statutory authority and was thus void. In response, the Department completed an exempt rulemaking for the entirety of R4-17-402, with an effective date of December 17, 2024. *See A.A.R. Volume 31, Issue 2, January 10, 2025, pg. 129.* Due to the Council holding R4-17-402(B)-(G) void and the Department completing a new exempt rulemaking, the only rule before the Council as part of this 1YRR is R4-17-401.

Pursuant to HB 2043, the Board was required to adopt rules establishing additional certification standards or requirements for PAs who previously completed 8,000 hours of AZPA-certified clinical practice and who are seeking employment with a collaborating physician or entity for a position that is not substantially similar to the practice setting or specialty in which

the PA was previously certified. R4-17-401 specifically deals with the necessary steps and the necessary documentation a physician assistant must provide the Board to receive certification.

Pursuant to A.R.S. § 41-1095, "for an agency that the legislature has granted a one-time rulemaking exemption, within one year after a rule has been adopted the agency shall review the rule adopted under the rulemaking exemption to determine whether any rule adopted under the rulemaking exemption should be amended or repealed." Furthermore,"the agency shall prepare and obtain council approval of a written report summarizing its findings, its supporting reasons and any proposed course of action." Id. The Board submits this 1YRR for the Council's consideration in compliance with A.R.S. § 41-1095.

**Proposed Action**

The Board does not propose any course of action at this time.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Board cites both general and specific statutory authority. The Board indicates that the Board has general rulemaking authority under A.R.S § 32-2504(C) and specific subject matter authority to conduct rulemaking under A.R.S. § 32-2536.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Board, because the rule was made under an exemption, no economic impact statement was prepared. There are currently 5,170 licensed physician assistants in Arizona. Since the rule went into effect in December 2023, the Board has received 379 applications for certification of clinical practice hours. The Board's website currently lists 274 physician assistants as eligible to practice in collaboration with a physician, physician group practice,or health care institution. The Board does not maintain records of how physician assistants actually practice collaboratively.

Stakeholders include the Board, physician assistants, and the general public.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

According to the Board, statute requires a physician assistant to have 8,000 hours of clinical practice to qualify to practice collaboratively. Statute also requires the Board to make rules establishing certification standards regarding the 8,000 hours of clinical practice. R4-17-401 fulfills this statutory responsibility. The Board determined the benefits of the rule, certifying whether a physician assistant has 8,000 hours of clinical practice and fulfilling the Board's statutory responsibility, outweigh the costs of providing evidence of the clinical practice hours and completing the rulemaking. The

Board reduced potential regulatory burdens by providing procedures for obtaining a waiver of documentation requirements.

**4. Has the agency received any written criticisms of the rules since the rule was adopted?**

The Board indicates that they have not received any written criticisms of the rule.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Board indicates the rule is clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Board states the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Board states the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Board states the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board indicates that there is no corresponding federal law.

**10. Has the agency completed any additional process required by law?**

The Board was not required to complete any additional processes.

**11. Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Board indicates that the rule being reviewed does not require a permit or a license. The Board does indicate that physician assistants are required to be licensed under A.R.S. § 32-2521 and lay out specific requirements that do not allow for the issuance of a general permit.

**12. Conclusion**

This One-Year Review Report (1YRR) from the Arizona Regulatory Board of Physician Assistants ("Board") relates to R4-17-401. As indicated above, the Department received an exemption from the rulemaking requirements to adopt rules necessary to carry out Laws 2023, Chapter 54 (HB 2043). The rule deals with the necessary steps and necessary documentation that

a physician assistant must provide to receive certification. The Department is not proposing any amendments to the rule.

Council staff believes that the Department has satisfied the requirements of A.R.S. § 41-1095 and Council staff recommends approval of this report.

Katie Hobbs
Governor

Susan Reina, PA-C
Chair

**Arizona Regulatory Board of Physician Assistants**
1740 W. Adams, Suite 4000 · Phoenix, Arizona 85007
Telephone: 480-551-2700 · Toll Free: 877-255-2212 · Fax: 480-551-2704
Website: www.azpa.gov

March 18, 2025

**VIA EMAIL: grrc@azdoa.gov**
Jessica Klein, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

**RE: Arizona Regulatory Board of Physician Assistants**
**One-year-review Report of R4-17-401**

Dear Ms Klein:

The Board submits the enclosed one-year-review report, required under A.R.S. § 41-1095, of R4-17-401. The report is due under an extension on April 30, 2025.

The Board complies with A.R.S. § 41-1091.

For questions about this report, please contact the Board's executive director, Patricia McSorley, at 480-551-2700 or patricia.mcsorley@azmd.gov.

Sincerely,

Patricia C. McSorley
Executive Director

**One-year-review Report of**

**Title 4. Professions and Occupations**

**Chapter 17. Arizona Regulatory Board of Physician Assistants**

INTRODUCTION

Under Laws 2023, Chapter 54, the legislature amended the statutes applicable to physician assistants to address the scope of practice for physician assistants and authorize certain physician assistants to practice in collaboration with a physician, physician group practice, or healthcare institution rather than under the supervision of a physician. The Board made exempt rules (R4-17-401 and R4-17-402) to implement statute in December 2023. However, in response to a petition filed under A.R.S. § 41-1033(F) and (G) by the Arizona State Association of Physician Assistants, the Council voided the provisions of R4-17-402(B)-(G) after finding the subsections exceeded the Board's statutory authority and were not specifically authorized by statute. In an exempt rulemaking that went into effect on December 17, 2024, the Board amended R4-17-402. As a result, this one-year-review report addresses only the remaining rule made in December 2023, R4-17-401.

Statute that generally authorizes the agency to make rules: A.R.S. § 32-2504(C)

1. Specific statute authorizing the rules:
   R4-17-401: A.R.S. § 32-2536
2. Objective of the rules:
   R4-17-401: The objective of the rule is to inform physician assistants of the requirements for obtaining certification of the clinical practice hours needed to qualify to practice collaboratively with a physician or entity.
3. Are the rules effective in achieving their objectives?
   Yes
4. Were there written criticisms of the rules, including written analyses questioning whether the rules are based on valid scientific or reliable principles or methods?
   No
5. Are the rules consistent with other rules and statutes?
   Yes. The rule is consistent with A.R.S. § 32-2536.
6. Are the rules enforced as written?
   Yes

7. Are the rules clear, concise, and understandable?

   Yes

8. Estimated economic, small business, and consumer impact of the rule:

   Because the rule was made under an exemption (See Laws 2023, Chapter 54, Section 11), no economic impact statement was prepared. There are currently 5170 licensed physician assistants in Arizona. Since the rule went into effect in December 2023, the Board has received 379 applications for certification of clinical practice hours. The Board's website currently lists 274 physician assistants as eligible to practice in collaboration with a physician, physician group practice, or health care institution. The Board does not maintain records of how many physician assistants actually practice collaboratively.

9. Has the agency received any business competitiveness analyses of the rule?

   No

10. If applicable, whether the agency completed additional processes required by law:

    Not applicable

11. A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

    Statute requires a physician assistant to have 8000 hours of clinical practice to qualify to practice collaboratively. Statute also requires the Board to make rules establishing certification standards regarding the 8000 hours of clinical practice. R4-17-401 fulfills this statutory responsibility. The Board determined the benefits of the rule, certifying whether a physician assistant has 8000 hours of clinical practice and fulfilling the Board's statutory responsibility, outweigh the costs of providing evidence of the clinical practice hours and completing the rulemaking. The Board reduced potential regulatory burdens by providing procedures for obtaining a waiver of documentation requirements.

12. Is the rule more stringent than corresponding federal laws?

    No. There is no corresponding federal law.

13. For a rule that requires issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:

    Physician assistants are required to be licensed (See A.R.S. § 32-2521). However, R4-17-401, which simply establishes the procedure for obtaining certification that a physician assistant has 8000 hours of clinical practice, does not require issuance of a regulatory permit, license, or agency authorization.

14. Proposed course of action:

    None

## ARTICLE 4. COLLABORATIVE PRACTICE; REGULATION

**R4-17-401. Application for Certification of Clinical Practice Hours; Waiver of Documentation**

**A.** As required under A.R.S. § 32-2536(A), a physician assistant who is licensed by the Board and in good standing may apply to the Board for certification of the clinical practice hours required to practice collaboratively with a physician or entity. A physician assistant is in good standing if the physician assistant is not:
1. Under investigation by a regulatory authority, or
2. Subject to a public or confidential probation order.

**B.** To be eligible to practice collaboratively with a physician or entity, a physician assistant shall have at least 8,000 hours of clinical practice, as described in subsection (E), obtained:
1. In the five years before the date of the application submitted under subsection (C), or
2. In the 10 years before the date of the application submitted under subsection (C) if:
   a. At least 2,000 hours of clinical practice were obtained in the three years before the date of application submitted under subsection (C); and
   b. The physician assistant is currently certified by the National Commission on Certification of Physician Assistants.

**C.** To apply for certification of clinical practice hours, a physician assistant shall submit to the Board an application form, which is available on the Board's website.

**D.** In addition to complying with subsection (C), a physician assistant applying for certification of clinical practice hours shall have submitted directly to the Board by the document custodian or an individual with direct knowledge, documentation of hours of clinical practice performed by the physician assistant. Documentation may be submitted by multiple persons.

**E.** Clinical practice includes:
1. Performing medical services related directly to patient care;
2. Providing instruction to physician assistants at an institution accredited by the Accreditation Review Commission on Education for the Physician Assistant. Time spent preparing to provide instruction or preforming administrative tasks related to providing instruction is not clinical practice.

**F.** The Board may waive the documentation requirement specified under subsection (D). To obtain a waiver of the documentation requirement, the physician assistant shall submit to the Board a written request that includes the following information:
1. The physician assistant's name and license number;
2. Date on the request for waiver;
3. Identification and an estimate of the number of clinical hours for which documentation has not been submitted under subsection (D);
4. Description of the physician assistant's efforts to have the documentation submitted as required under subsection (D);
5. Explanation of why the documentation cannot be submitted;
6. If applicable, evidence that supports the request for waiver; and
7. The physician assistant's affirmation that the physician assistant has performed the required hours of clinical practice even though documentation has not been submitted.

**G.** The Board shall waive the documentation requirement if the Board determines the documentation is unavailable for a reason beyond the control of the physician assistant requesting the waiver. In making this determination, the Board shall consider:
1. The sufficiency of the physician assistant's effort to have the documentation submitted;
2. Evidence it is not possible to have the documentation submitted because:
   a. The required document does not exist;
   b. The individual or entity responsible for maintaining and submitting the documentation is unable to do so; or
   c. Another reason beyond the control of the physician assistant; and
3. Whether the Board is able to obtain the required documentation from another source.

**H.** The Board shall document the Board's decision regarding a request for waiver submitted under subsection (F) in the official record regarding the application submitted under subsection (C). The Board's decision regarding a request for waiver is not subject to review or appeal.

**I.** The Board shall maintain on the Board's website a list of physician assistants who have at least 8,000 hours of clinical practice certified by the Board and are eligible to practice in collaboration with a physician, physician group practice, or health care institution.

## 32-2504. Powers and duties; delegation of authority; rules; subcommittees; immunity

A. The board shall:

1. As its primary duty, protect the public from unlawful, incompetent, unqualified, impaired or unprofessional physician assistants.

2. License and regulate physician assistants pursuant to this chapter.

3. Order and evaluate physical, psychological, psychiatric and competency testing of licensees and applicants the board determines is necessary to enforce this chapter.

4. Review the credentials and the abilities of applicants for licensure whose professional records or physical or mental capabilities may not meet the requirements of this chapter.

5. Initiate investigations and determine on its own motion whether a licensee has engaged in unprofessional conduct or is or may be incompetent or mentally or physically unable to safely perform health care tasks.

6. Establish fees and penalties pursuant to section 32-2526.

7. Develop and recommend standards governing the profession.

8. Engage in the full exchange of information with the licensing and disciplinary boards and professional associations of other states and jurisdictions of the United States and foreign countries and a statewide association for physician assistants.

9. Direct the preparation and circulation of educational material the board determines is helpful and proper for its licensees.

10. Discipline and rehabilitate physician assistants pursuant to this chapter.

11. Certify physician assistants for thirty-day prescription privileges for schedule II, schedule III, schedule IV and schedule V controlled substances that are opioids or benzodiazepine and ninety-day prescription privileges for schedule II, schedule III, schedule IV and schedule V controlled substances that are not opioids or benzodiazepine if the physician assistant either:

(a) Within the preceding three years of application, completed forty-five hours in pharmacology or clinical management of drug therapy or at the time of application is certified by a national commission on the certification of physician assistants or its successor.

(b) Met any other requirement established by board rule.

B. The board may delegate to the executive director the board's authority pursuant to this section or section 32-2551. The board shall adopt a substantive policy statement pursuant to section 41-1091 for each specific licensing and regulatory authority the board delegates to the executive director.

C. The board may make and adopt rules necessary or proper for the administration of this chapter.

D. The chairperson may establish subcommittees consisting of board members and define their duties as the chairperson deems necessary to carry out the functions of the board.

E. Board employees, including the executive director, temporary personnel and professional medical investigators, are immune from civil liability for good faith actions they take to enforce this chapter.

F. In performing its duties pursuant to subsection A of this section, the board may receive and review staff reports on complaints, malpractice cases and all investigations.

G. The chairperson and vice chairperson of the Arizona regulatory board of physician assistants are members of the committee on executive director selection and retention established by section 32-1403, subsection G, which is responsible for the appointment of the executive director pursuant to section 32-1405.

## 32-2536. Physician assistants; documentation; certification; rules

A. A physician assistant who is licensed pursuant to this chapter, who is in good standing, who has graduated from an accredited physician assistant program in the United States and who has at least eight thousand clinical practice hours within the previous five years in this state or another jurisdiction shall provide the board with documentation of having completed at least eight thousand hours of clinical practice in order to meet the requirements of section 32-2531, subsection B. The board shall develop:

1. A policy that sets forth the process of attestation or documentation required as proof of completion of at least eight thousand clinical practice hours and issuance of certification of completion of the eight thousand clinical practice hours.

2. An alternative comparable standard for certification of eight thousand hours of clinical practice for physician assistants who have been actively practicing for more than five years.

B. The board shall adopt rules establishing additional certification standards or requirements for physician assistants who previously completed eight thousand clinical practice hours certified by the board and who are seeking employment with a collaborating physician or entity for a position that is not substantially similar to the practice setting or specialty in which the physician assistant was previously certified. The certification standards or requirements shall ensure appropriate training and oversight, including a supervision agreement if warranted, for the physician assistant's new practice setting or specialty.

State of Arizona
House of Representatives
Fifty-sixth Legislature
First Regular Session
2023

## CHAPTER 54

# HOUSE BILL 2043

AN ACT

AMENDING SECTIONS 32-2501, 32-2502, 32-2531, 32-2532 AND 32-2533, ARIZONA REVISED STATUTES; REPEALING SECTION 32-2534, ARIZONA REVISED STATUTES; AMENDING TITLE 32, CHAPTER 25, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING A NEW SECTION 32-2534; AMENDING SECTION 32-2535, ARIZONA REVISED STATUTES; AMENDING TITLE 32, CHAPTER 25, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 32-2536; AMENDING SECTION 32-2551, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 32-2501, Arizona Revised Statutes, is amended to read:

32-2501. Definitions

In this chapter, unless the context otherwise requires:

1. "Active license" means a regular license issued pursuant to this chapter.

2. "Adequate records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

3. "Advisory letter" means a nondisciplinary letter to notify a physician assistant that either:

(a) While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.

(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

(c) While the licensee has demonstrated substantial compliance through rehabilitation or remediation that has mitigated the need for disciplinary action, the board believes that repetition of the activities that led to the investigation may result in further board action against the licensee.

4. "Approved program" means a physician assistant educational program accredited by the accreditation review commission on education for physician assistants, or one of its predecessor agencies, the committee on allied health education and accreditation or the commission on the accreditation of allied health educational programs.

5. "Board" means the Arizona regulatory board of physician assistants.

6. "COLLABORATING PHYSICIAN OR ENTITY" MEANS A PHYSICIAN, PHYSICIAN GROUP PRACTICE, PHYSICIAN PRIVATE PRACTICE OR LICENSED HEALTH CARE INSTITUTION THAT EMPLOYS OR COLLABORATES WITH A PHYSICIAN ASSISTANT WHO HAS AT LEAST EIGHT THOUSAND HOURS OF CLINICAL PRACTICE AS CERTIFIED BY THE BOARD PURSUANT TO SECTION 32-2536 AND DOES NOT REQUIRE A SUPERVISION AGREEMENT AND THAT DESIGNATES ONE OR MORE PHYSICIANS BY NAME OR POSITION WHO IS RESPONSIBLE FOR THE OVERSIGHT OF THE PHYSICIAN ASSISTANT.

~~6.~~ 7. "Completed application" means an application for which the applicant has supplied all required fees, information and correspondence requested by the board on forms and in a manner acceptable to the board.

~~7.~~ 8. "Immediate family" means the spouse, natural or adopted children, father, mother, brothers and sisters of the physician assistant and the natural or adopted children, father, mother, brothers and sisters of the physician assistant's spouse.

~~8.~~ 9. "Letter of reprimand" means a disciplinary letter that is issued by the board and that informs the physician assistant that the physician assistant's conduct violates state or federal law and may require the board to monitor the physician assistant.

~~9.~~ 10. "Limit" means a nondisciplinary action that is taken by the board and that alters a physician assistant's practice or medical activities if there is evidence that the physician assistant is or may be mentally or physically unable to safely engage in health care tasks.

~~10.~~ 11. "Medically incompetent" means that a physician assistant lacks sufficient medical knowledge or skills, or both, in performing delegated health care tasks to a degree likely to endanger the health or safety of patients.

~~11.~~ 12. "Minor surgery":

(a) Means those invasive procedures that may be ~~delegated to~~ PERFORMED BY a physician assistant ~~by a supervising physician~~, that are consistent with the training and experience of the physician assistant, that are normally taught in courses of training approved by the board, ~~and~~ that have been approved by the board as falling within ~~a~~ THE scope of practice of a physician assistant AND THAT ARE CONSISTENT WITH THE PRACTICE SETTING REQUIREMENTS OF THE PHYSICIAN ASSISTANT. ~~Minor surgery~~

(b) Does not include a surgical abortion.

~~12.~~ 13. "Physician" means a physician who is licensed pursuant to chapter 13 or 17 of this title.

~~13.~~ 14. "Physician assistant" means a person who is licensed pursuant to this chapter ~~and who practices medicine with physician supervision~~.

~~14.~~ 15. "Regular license" means a valid and existing license that is issued pursuant to section 32-2521 to perform health care tasks.

~~15.~~ 16. "Restrict" means a disciplinary action that is taken by the board and that alters a physician assistant's practice or medical activities if there is evidence that the physician assistant is or may be medically incompetent or guilty of unprofessional conduct.

~~16.~~ 17. "Supervising physician" means a physician who holds a current unrestricted license, who supervises a physician assistant WHO HAS LESS THAN EIGHT THOUSAND HOURS OF CLINICAL PRACTICE and who assumes legal responsibility for health care tasks performed by the physician assistant.

~~17.~~ 18. "Supervision" means a physician's opportunity or ability to provide or exercise direction and control over the services of a physician assistant. Supervision does not require a physician's constant physical presence if the supervising physician is or can be easily in contact with the physician assistant by telecommunication.

19. "SUPERVISION AGREEMENT" MEANS A WRITTEN OR ELECTRONIC SIGNED AGREEMENT THAT BOTH:

(a) DESCRIBES THE SCOPE OF PRACTICE FOR A PHYSICIAN ASSISTANT WHO HAS LESS THAN EIGHT THOUSAND HOURS OF CLINICAL PRACTICE.

(b) IS BETWEEN THE PHYSICIAN ASSISTANT AND A PHYSICIAN OR THE PHYSICIAN ASSISTANT'S EMPLOYER THAT EMPLOYS OR HAS ON MEDICAL STAFF AT LEAST ONE PHYSICIAN WHO MAY PROVIDE OVERSIGHT, AS APPLICABLE, AND WHO HOLDS A CURRENT UNRESTRICTED LICENSE. FOR THE PURPOSES OF THIS SUBDIVISION, "EMPLOYER" MEANS A PHYSICIAN, PHYSICIAN GROUP PRACTICE, PHYSICIAN PRIVATE PRACTICE OR LICENSED HEALTH CARE INSTITUTION.

~~18.~~ 20. "Unprofessional conduct" includes the following acts by a physician assistant that occur in this state or elsewhere:

(a) Violating any federal or state law or rule that applies to the performance of health care tasks as a physician assistant. Conviction in any court of competent jurisdiction is conclusive evidence of a violation.

(b) Claiming to be a physician or knowingly ~~permitting~~ ALLOWING another person to represent that person as a physician.

(c) Performing health care tasks that ~~have not been delegated by the supervising physician~~ DO NOT MEET THE SUPERVISION OR COLLABORATION REQUIREMENTS, AS APPLICABLE, PURSUANT TO SECTION 32-2531.

(d) Exhibiting a pattern of using or being under the influence of alcohol or drugs or a similar substance while performing health care tasks or to the extent that judgment may be impaired and the ability to perform health care tasks detrimentally affected.

(e) Signing a blank, undated or predated prescription form.

(f) Committing gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient.

(g) Representing that a manifestly incurable disease or infirmity can be permanently cured or that a disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if this is not true.

(h) Refusing to divulge to the board on demand the means, method, procedure, modality of treatment or medicine used in ~~the treatment of~~ TREATING a disease, injury, ailment or infirmity.

(i) Prescribing or dispensing controlled substances or prescription-only drugs for which the physician assistant is not approved or in excess of the amount authorized pursuant to this chapter.

(j) Committing any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.

(k) Violating a formal order, probation or stipulation issued by the board.

(l) Failing to clearly disclose the person's identity as a physician assistant in the course of the physician assistant's employment.

(m) Failing to use and affix the initials "P.A." or "P.A.-C." after the physician assistant's name or signature on charts, prescriptions or professional correspondence.

(n) Procuring or attempting to procure a physician assistant license by fraud, misrepresentation or knowingly taking advantage of the mistake of another.

(o) Having professional connection with or lending the physician assistant's name to an illegal practitioner of any of the healing arts.

(p) Failing or refusing to maintain adequate records ~~on~~ FOR a patient.

(q) Using controlled substances that have not been prescribed by a physician, physician assistant, dentist or nurse practitioner for use during a prescribed course of treatment.

(r) Prescribing or dispensing controlled substances to members of the physician assistant's immediate family.

(s) Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes.

(t) Dispensing a schedule II controlled substance that is an opioid, except as provided in section 32-2532.

(u) Knowingly making any written or oral false or fraudulent statement in connection with the performance of health care tasks or when applying for privileges or renewing an application for privileges at a health care institution.

(v) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

(w) Having a certification or license refused, revoked, suspended, limited or restricted by any other licensing jurisdiction for the inability to safely and skillfully perform health care tasks or for unprofessional conduct as defined by that jurisdiction that directly or indirectly corresponds to any act of unprofessional conduct as prescribed by this paragraph.

(x) Having sanctions including restriction, suspension or removal from practice imposed by an agency of the federal government.

(y) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate a provision of this chapter.

(z) Using the term "doctor" or the abbreviation "Dr." on a name tag or in a way that leads the public to believe that the physician assistant is licensed to practice as an allopathic or ~~an~~ osteopathic physician in this state.

(aa) Failing to furnish legally requested information to the board or its investigator in a timely manner.

(bb) Failing to allow properly authorized board personnel to examine on demand documents, reports and records of any kind relating to the physician assistant's performance of health care tasks.

(cc) Knowingly making a false or misleading statement on a form required by the board or in written correspondence or attachments furnished to the board.

(dd) Failing to submit to a body fluid examination and other examinations known to detect the presence of alcohol or other drugs pursuant to an agreement with the board or an order of the board.

(ee) Violating a formal order, probation agreement or stipulation issued or entered into by the board or its executive director.

(ff) Except as otherwise required by law, intentionally betraying a professional secret or intentionally violating a privileged communication.

(gg) Allowing the use of the licensee's name in any way to enhance or ~~permit~~ ALLOW the continuance of the activities of, or maintaining a professional connection with, an illegal practitioner of medicine or the performance of health care tasks by a person who is not licensed pursuant to this chapter.

(hh) Committing false, fraudulent, deceptive or misleading advertising by a physician assistant or the physician assistant's staff or representative.

(ii) Knowingly failing to disclose to a patient on a form that is prescribed by the board and that is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the licensee has a direct financial interest in a separate diagnostic or treatment agency or in nonroutine goods or services that the patient is being prescribed and ~~if~~ WHETHER the prescribed treatment, goods or services are available on a competitive basis. This subdivision does not apply to a referral by one physician assistant to another physician assistant or to a doctor of medicine or a doctor of osteopathic medicine within a group working together.

(jj) With the exception of heavy metal poisoning, using chelation therapy in the treatment of arteriosclerosis or as any other form of therapy without adequate informed patient consent or without conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a medical peer review committee, or without approval by the United States food and drug administration or its successor agency.

(kk) Prescribing, dispensing or administering anabolic or androgenic steroids for other than therapeutic purposes.

(ll) Prescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a professional relationship with the person. This subdivision does not apply to:

(i) A physician assistant who provides temporary patient care on behalf of the patient's regular treating licensed health care professional.

(ii) Emergency medical situations as defined in section 41-1831.

(iii) Prescriptions written to prepare a patient for a medical examination.

(iv) Prescriptions written or antimicrobials dispensed to a contact as defined in section 36-661 who is believed to have had significant exposure risk as defined in section 36-661 with another person who has been diagnosed with a communicable disease as defined in section 36-661 by the prescribing or dispensing physician assistant.

(mm) Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the professional relationship, was in a dating or engagement relationship with the licensee. For the purposes of this subdivision, "sexual conduct" includes:

(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual.

(ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature with a patient.

(iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

(nn) Performing health care tasks under a false or assumed name in this state.

Sec. 2. Section 32-2502, Arizona Revised Statutes, is amended to read:

32-2502. Arizona regulatory board of physician assistants; membership; appointment; terms; immunity

A. The Arizona regulatory board of physician assistants is established consisting of the following members:

1. Five physician assistants who hold a current regular license pursuant to this chapter. The governor may appoint these members from a list of qualified candidates submitted by the Arizona state association of physician assistants. The governor may seek additional input and nominations before the governor makes the physician assistant appointments.

2. Two public members who are appointed by the governor.

3. Two physicians who are actively engaged in the practice of medicine and who are licensed pursuant to chapter 17 of this title, one of whom supervises OR COLLABORATES WITH a physician assistant at the time of appointment, and who are appointed by the governor.

4. Two physicians who are actively engaged in the practice of medicine and who are licensed pursuant to chapter 13 of this title, one of whom supervises OR COLLABORATES WITH a physician assistant at the time of appointment, and who are appointed by the governor.

B. Before appointment by the governor, a prospective member of the board shall submit a full set of fingerprints to the governor for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

C. The term of office of members of the board is four years to begin and end on July 1.

D. Each board member is eligible for appointment to not more than two full terms, except that the term of office for a member appointed to fill a vacancy that is not caused by the expiration of a full term is for the unexpired portion of that term and the governor may reappoint that member to not more than two additional full terms. Each board member may continue to hold office until the appointment and qualification of that member's successor. ~~However,~~ The governor may remove a member after notice and a hearing~~,~~ on a finding of continued neglect of duty, incompetence or unprofessional or dishonorable conduct. That member's term ends when the finding is made.

E. A board member's term automatically ends:

1. On written resignation submitted to the board chairperson or to the governor.

2. If the member is absent from this state for more than six months during a one-year period.

3. If the member fails to attend three consecutive regular board meetings.

4. Five years after retirement from active practice.

F. Board members are immune from civil liability for all good faith actions they take pursuant to this chapter.

Sec. 3. Section 32-2531, Arizona Revised Statutes, is amended to read:

32-2531. Physician assistant scope of practice; health care tasks; supervision agreements; supervising physician duties; civil penalty

~~A. A supervising physician may delegate health care tasks to a physician assistant.~~

A. EXCEPT AS PROHIBITED IN SUBSECTION E OF THIS SECTION, A PHYSICIAN ASSISTANT MAY PROVIDE ANY LEGAL MEDICAL SERVICE FOR WHICH THE PHYSICIAN ASSISTANT HAS BEEN PREPARED BY EDUCATION, TRAINING AND EXPERIENCE AND THAT THE PHYSICIAN ASSISTANT IS COMPETENT TO PERFORM, INCLUDING:

1. OBTAINING COMPREHENSIVE HEALTH HISTORIES AND PERFORMING PHYSICAL EXAMINATIONS.

2. EVALUATING AND DIAGNOSING PATIENTS AND MANAGING AND PROVIDING MEDICAL TREATMENT AND THERAPEUTIC INTERVENTIONS.

3. ORDERING, PERFORMING AND INTERPRETING DIAGNOSTIC STUDIES AND THERAPEUTIC PROCEDURES.

4. EDUCATING PATIENTS ON HEALTH PROMOTION AND DISEASE PREVENTION AND PROVIDING COUNSELING AND EDUCATION TO MEET PATIENT NEEDS.

5. PROVIDING CONSULTATION ON REQUEST.

6. WRITING MEDICAL ORDERS.

7. OBTAINING INFORMED CONSENT.

8. ASSISTING IN SURGERY.

9. DELEGATING AND ASSIGNING THERAPEUTIC AND DIAGNOSTIC MEASURES TO AND SUPERVISING LICENSED OR UNLICENSED PERSONNEL.

10. MAKING APPROPRIATE REFERRALS.

11. ORDERING, PRESCRIBING, DISPENSING AND ADMINISTERING DRUGS AND MEDICAL DEVICES.

12. PRESCRIBING PRESCRIPTION-ONLY MEDICATIONS.

13. PRESCRIBING SCHEDULE IV OR SCHEDULE V CONTROLLED SUBSTANCES AS DEFINED IN THE CONTROLLED SUBSTANCES ACT (P.L. 91-513; 84 STAT. 1242; 21 UNITED STATES CODE SECTION 802).

14. PRESCRIBING SCHEDULE II AND SCHEDULE III CONTROLLED SUBSTANCES AS DEFINED IN THE CONTROLLED SUBSTANCES ACT.

15. PERFORMING MINOR SURGERY.

16. PERFORMING NONSURGICAL HEALTH CARE TASKS THAT ARE NORMALLY TAUGHT IN COURSES OF TRAINING APPROVED BY THE BOARD AND THAT ARE CONSISTENT WITH THE PHYSICIAN ASSISTANT'S EDUCATION, TRAINING AND EXPERIENCE.

17. CERTIFYING THE HEALTH OR DISABILITY OF A PATIENT AS REQUIRED BY ANY LOCAL, STATE OR FEDERAL PROGRAM.

18. ORDERING HOME HEALTH SERVICES.

B. PURSUANT TO THE REQUIREMENTS OF THIS CHAPTER AND THE STANDARD OF CARE, A PHYSICIAN ASSISTANT WHO HAS AT LEAST EIGHT THOUSAND HOURS OF CLINICAL PRACTICE CERTIFIED BY THE BOARD PURSUANT TO SECTION 32-2536 IS NOT REQUIRED TO PRACTICE PURSUANT TO A SUPERVISION AGREEMENT BUT SHALL CONTINUE TO COLLABORATE WITH, CONSULT WITH OR REFER TO THE APPROPRIATE HEALTH CARE PROFESSIONAL AS INDICATED BY THE PATIENT'S CONDITION AND BY THE PHYSICIAN ASSISTANT'S EDUCATION, EXPERIENCE AND COMPETENCIES. THE LEVEL OF COLLABORATION REQUIRED BY THIS SUBSECTION IS DETERMINED BY THE POLICIES OF THE PRACTICE SETTING AT WHICH THE PHYSICIAN ASSISTANT IS EMPLOYED, INCLUDING A PHYSICIAN EMPLOYER, PHYSICIAN GROUP PRACTICE OR HEALTH CARE INSTITUTION. COLLABORATION, CONSULTATION OR A REFERRAL PURSUANT TO THIS SUBSECTION MAY OCCUR THROUGH ELECTRONIC MEANS AND DOES NOT REQUIRE THE PHYSICAL PRESENCE OF THE APPROPRIATE HEALTH CARE PROFESSIONAL AT THE TIME OR PLACE THE PHYSICIAN ASSISTANT PROVIDES MEDICAL

SERVICES. THIS SUBSECTION DOES NOT PROHIBIT A PHYSICIAN ASSISTANT WHO HAS AT LEAST EIGHT THOUSAND HOURS OF CLINICAL PRACTICE CERTIFIED BY THE BOARD PURSUANT TO SECTION 32-2536 FROM PRACTICING PURSUANT TO A SUPERVISION AGREEMENT.

C. A PHYSICIAN ASSISTANT WHO HAS LESS THAN EIGHT THOUSAND HOURS OF CLINICAL PRACTICE CERTIFIED BY THE BOARD SHALL WORK IN ACCORDANCE WITH A SUPERVISION AGREEMENT THAT DESCRIBES THE PHYSICIAN ASSISTANT'S SCOPE OF PRACTICE. A PHYSICIAN ASSISTANT MAY NOT PERFORM HEALTH CARE TASKS UNTIL THE PHYSICIAN ASSISTANT HAS COMPLETED AND SIGNED A SUPERVISION AGREEMENT. UNDER A SUPERVISION AGREEMENT, SUPERVISION MAY OCCUR THROUGH ELECTRONIC MEANS AND DOES NOT REQUIRE THE PHYSICAL PRESENCE OF THE SUPERVISING PHYSICIAN AT THE TIME OR PLACE THE PHYSICIAN ASSISTANT PROVIDES MEDICAL SERVICES. THE SUPERVISION AGREEMENT MUST BE KEPT ON FILE AT THE MAIN LOCATION OF THE PHYSICIAN ASSISTANT'S PRACTICE AND, ON REQUEST, BE MADE AVAILABLE TO THE BOARD OR THE BOARD'S REPRESENTATIVE. ON RECEIPT OF BOARD CERTIFICATION OF THE PHYSICIAN ASSISTANT'S COMPLETION OF AT LEAST EIGHT THOUSAND HOURS OF CLINICAL PRACTICE, A PHYSICIAN ASSISTANT IS NO LONGER SUBJECT TO THE REQUIREMENTS OF THIS SUBSECTION. THE BOARD MAY COUNT PRACTICE HOURS EARNED IN ANOTHER JURISDICTION TOWARD THE HOURS OF CLINICAL PRACTICE REQUIRED BY THIS SUBSECTION.

D. A PHYSICIAN ASSISTANT WHO DOES NOT PRACTICE PURSUANT TO A SUPERVISION AGREEMENT IS LEGALLY RESPONSIBLE FOR THE HEALTH CARE SERVICES PERFORMED BY THE PHYSICIAN ASSISTANT.

~~B.~~ E. A physician assistant shall not perform surgical abortions as defined in section 36-2151.

~~C. The physician assistant may perform those duties and responsibilities, including the ordering, prescribing, dispensing and administration of drugs and medical devices, that are delegated by the supervising physician.~~

~~D. The physician assistant may provide any medical service that is delegated by the supervising physician if the service is within the physician assistant's skills, is within the physician's scope of practice and is supervised by the physician.~~

~~E.~~ F. ~~The~~ A physician assistant may pronounce death and~~, if delegated,~~ may authenticate, by the physician assistant's signature, CERTIFICATION, STAMP, VERIFICATION, AFFIDAVIT OR ENDORSEMENT, any form that may be authenticated by a physician's signature, CERTIFICATION, STAMP, VERIFICATION, AFFIDAVIT OR ENDORSEMENT.

~~F. The physician assistant is the agent of the physician assistant's supervising physician in the performance of all practice related activities, including the ordering of diagnostic, therapeutic and other medical services.~~

~~G. The physician assistant may perform health care tasks in any setting authorized by the supervising physician, including physician offices, clinics, hospitals, ambulatory surgical centers, patient homes,~~

~~nursing homes and other health care institutions. These tasks may include:~~

~~1. Obtaining patient histories.~~

~~2. Performing physical examinations.~~

~~3. Ordering and performing diagnostic and therapeutic procedures.~~

~~4. Formulating a diagnostic impression.~~

~~5. Developing and implementing a treatment plan.~~

~~6. Monitoring the effectiveness of therapeutic interventions.~~

~~7. Assisting in surgery.~~

~~8. Offering counseling and education to meet patient needs.~~

~~9. Making appropriate referrals.~~

~~10. Prescribing schedule IV or V controlled substances as defined in the federal controlled substances act of 1970 (P.L. 91-513; 84 Stat. 1242; 21 United States Code section 802) and prescription-only medications.~~

~~11. Prescribing schedule II and III controlled substances as defined in the federal controlled substances act of 1970.~~

~~12. Performing minor surgery as defined in section 32-2501.~~

~~13. Performing other nonsurgical health care tasks that are normally taught in courses of training approved by the board, that are consistent with the training and experience of the physician assistant and that have been properly delegated by the supervising physician.~~

~~H. The supervising physician shall:~~

~~1. Meet the requirements established by the board for supervising a physician assistant.~~

~~2. Accept responsibility for all tasks and duties the physician delegates to a physician assistant.~~

~~3. Notify the board and the physician assistant in writing if the physician assistant exceeds the scope of the delegated health care tasks.~~

~~4. Maintain a written agreement with the physician assistant. The agreement must state that the physician will exercise supervision over the physician assistant and retains professional and legal responsibility for the care rendered by the physician assistant. The agreement must be signed by the supervising physician and the physician assistant and updated annually. The agreement must be kept on file at the practice site and made available to the board on request. Each year the board shall randomly audit at least five per cent of these agreements for compliance.~~

~~I. A physician's ability to supervise a physician assistant is not affected by restrictions imposed by the board on a physician assistant pursuant to disciplinary action taken by the board.~~

~~J. Supervision must be continuous but does not require the personal presence of the physician at the place where health care tasks are performed if the physician assistant is in contact with the supervising physician by telecommunication. If the physician assistant practices in a location where a supervising physician is not routinely present, the physician assistant must meet in person or by telecommunication with a~~

~~supervising physician at least once each week to ensure ongoing direction and oversight of the physician assistant's work. The board by order may require the personal presence of a supervising physician when designated health care tasks are performed.~~

~~K. At all times while a physician assistant is on duty, the physician assistant shall wear a name tag with the designation "physician assistant" on it.~~

~~L.~~ G. The board by rule may prescribe a civil penalty for a violation of this article. The penalty shall not exceed ~~fifty dollars~~ $50 for each violation. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it receives from this penalty in the state general fund. A physician assistant and the supervising PHYSICIAN OR COLLABORATING physician OR ENTITY may contest the imposition of this penalty pursuant to board rule. The imposition of a civil penalty is public information, and the board may use this information in any future disciplinary actions.

Sec. 4. Section 32-2532, Arizona Revised Statutes, is amended to read:

32-2532. Prescribing, administering and dispensing drugs; limits and requirements; notice

A. Except as provided in subsection ~~F~~ G of this section, a physician assistant shall not prescribe, dispense or administer:

1. A schedule II or schedule III controlled substance as defined in the ~~federal~~ controlled substances act ~~of 1970~~ (P.L. 91-513; 84 Stat. 1242; 21 United States Code section 802) without ~~delegation by the supervising physician,~~ board approval and United States drug enforcement administration registration. IF THE PHYSICIAN ASSISTANT HAS LESS THAN EIGHT THOUSAND CLINICAL PRACTICE HOURS, THE SUPERVISION AGREEMENT SHALL SPECIFY THE PHYSICIAN ASSISTANT'S ABILITY TO PRESCRIBE, DISPENSE OR ADMINISTER A SCHEDULE II OR SCHEDULE III CONTROLLED SUBSTANCE.

2. A schedule IV or schedule V controlled substance as defined in the ~~federal~~ controlled substances act ~~of 1970~~ without United States drug enforcement administration registration ~~and delegation by the supervising physician~~. IF THE PHYSICIAN ASSISTANT HAS LESS THAN EIGHT THOUSAND CLINICAL PRACTICE HOURS, THE SUPERVISION AGREEMENT SHALL SPECIFY THE PHYSICIAN ASSISTANT'S ABILITY TO PRESCRIBE, DISPENSE OR ADMINISTER A SCHEDULE IV OR SCHEDULE V CONTROLLED SUBSTANCE.

~~3. Prescription-only medication without delegation by the supervising physician.~~

~~4.~~ 3. Prescription medication intended to perform or induce an abortion.

B. IF THE PHYSICIAN ASSISTANT HAS LESS THAN EIGHT THOUSAND CLINICAL PRACTICE HOURS, THE SUPERVISION AGREEMENT SHALL SPECIFY THE PHYSICIAN ASSISTANT'S ABILITY TO PRESCRIBE, DISPENSE OR ADMINISTER PRESCRIPTION-ONLY MEDICATION.

~~B.~~ C. All prescription orders issued by a physician assistant shall contain the name, address and telephone number of the physician assistant. A physician assistant shall issue prescription orders for controlled substances under the physician assistant's own United States drug enforcement administration registration number.

~~C.~~ D. If THE PHYSICIAN ASSISTANT IS certified for prescription privileges pursuant to section 32-2504, subsection A, initial prescriptions BY THE PHYSICIAN ASSISTANT for schedule II controlled substances that are opioids are subject to the limits prescribed in sections 32-3248 and 32-3248.01 ~~if the physician assistant has been delegated to prescribe schedule II controlled substances by the supervising physician pursuant to this section~~. For each schedule IV or schedule V controlled substance, the physician assistant may not prescribe the controlled substance more than five times in a six-month period for each patient.

~~D.~~ E. A prescription BY A PHYSICIAN ASSISTANT for a schedule III controlled substance that is an opioid or benzodiazepine is not refillable without the written consent of ~~the supervising~~ A physician.

~~E.~~ F. A PHYSICIAN ASSISTANT MAY NOT DISPENSE, PRESCRIBE OR REFILL prescription-only drugs ~~shall not be dispensed, prescribed or refillable~~ for a period exceeding one year FOR EACH PATIENT.

~~F.~~ G. Except in an emergency, a physician assistant may dispense schedule II or schedule III controlled substances for a period of use of not to exceed seventy-two hours with board approval or any other controlled substance for a period of use of not to exceed ninety days and may administer controlled substances without board approval if it is medically indicated in an emergency dealing with potential loss of life or limb or major acute traumatic pain. Notwithstanding the authority granted in this subsection, a physician assistant may not dispense a schedule II controlled substance that is an opioid, except for an implantable device or an opioid that is for medication-assisted treatment for substance use disorders.

~~G.~~ H. Except for samples provided by manufacturers, all drugs dispensed by a physician assistant shall be labeled to show the name of the physician assistant.

~~H.~~ I. A physician assistant shall not obtain a drug from any source other than ~~the supervising~~ A physician or a pharmacist. A physician assistant may receive manufacturers' samples ~~if delegated to do so by the supervising physician~~.

~~I.~~ J. If a physician assistant is approved by the board to prescribe, administer or dispense schedule II and schedule III controlled substances, the physician assistant shall maintain an up-to-date and complete log of all schedule II and schedule III controlled substances the physician assistant administers or dispenses. The board may not grant a physician assistant the authority to dispense schedule II controlled

substances that are opioids, except for implantable devices or opioids that are for medication-assisted treatment for substance use disorders.

~~J.~~ K. The ARIZONA REGULATORY board OF PHYSICIAN ASSISTANTS shall advise the Arizona state board of pharmacy and the United States drug enforcement administration of all physician assistants who are authorized to prescribe or dispense drugs and any modification of their authority.

~~K.~~ L. The Arizona state board of pharmacy shall notify all pharmacies at least quarterly of physician assistants who are authorized to prescribe or dispense drugs.

Sec. 5. Section 32-2533, Arizona Revised Statutes, is amended to read:

32-2533. Supervising physicians; responsibilities

A. A supervising physician is responsible for all aspects of the performance of a physician assistant WHO HAS LESS THAN EIGHT THOUSAND HOURS OF CLINICAL PRACTICE, whether or not the supervising physician actually pays the physician assistant a salary. The supervising physician is responsible for supervising the physician assistant and ensuring that the health care tasks performed by a physician assistant are within the physician assistant's scope of training and experience and have been properly delegated by the supervising physician.

B. Each physician-physician assistant team must ensure that:

1. The physician assistant's scope of practice is identified.

2. The delegation of medical tasks is appropriate to the physician assistant's level of competence.

3. The relationship of, and access to, the supervising physician is defined.

4. A process for evaluating the physician assistant's performance is established.

C. A supervising physician shall not supervise more than six physician assistants who work at the same time.

D. A supervising physician shall develop a system for recording and reviewing all instances in which the physician assistant prescribes schedule II or schedule III controlled substances.

Sec. 6. Repeal

Section 32-2534, Arizona Revised Statutes, is repealed.

Sec. 7. Title 32, chapter 25, article 3, Arizona Revised Statutes, is amended by adding a new section 32-2534, to read:

32-2534. Billing; direct payment

A PHYSICIAN ASSISTANT MAY BILL AND RECEIVE DIRECT PAYMENT FOR THE PROFESSIONAL SERVICES PROVIDED BY THE PHYSICIAN ASSISTANT.

Sec. 8. Section 32-2535, Arizona Revised Statutes, is amended to read:

32-2535. Emergency medical care

A. Notwithstanding the requirements of this article, in response to a natural disaster, accident or other emergency, a physician assistant who

is licensed pursuant to this chapter, licensed or certified by another regulatory jurisdiction in the United States or credentialed as a physician assistant by a federal employer may provide medical care at any location, and ~~with or without supervision.~~ THE PHYSICIAN ASSISTANT IS NOT REQUIRED TO HAVE COMPLETED EIGHT THOUSAND CLINICAL PRACTICE HOURS PURSUANT TO SECTION 32-2531.

B. A physician who supervises a physician assistant who is providing medical care pursuant to this section is not required to comply with the requirements of this article relating to supervising physicians.

Sec. 9. Title 32, chapter 25, article 3, Arizona Revised Statutes, is amended by adding section 32-2536, to read:

32-2536. Physician assistants; documentation; certification; rules

A. A PHYSICIAN ASSISTANT WHO IS LICENSED PURSUANT TO THIS CHAPTER, WHO IS IN GOOD STANDING, WHO HAS GRADUATED FROM AN ACCREDITED PHYSICIAN ASSISTANT PROGRAM IN THE UNITED STATES AND WHO HAS AT LEAST EIGHT THOUSAND CLINICAL PRACTICE HOURS WITHIN THE PREVIOUS FIVE YEARS IN THIS STATE OR ANOTHER JURISDICTION SHALL PROVIDE THE BOARD WITH DOCUMENTATION OF HAVING COMPLETED AT LEAST EIGHT THOUSAND HOURS OF CLINICAL PRACTICE IN ORDER TO MEET THE REQUIREMENTS OF SECTION 32-2531, SUBSECTION B. THE BOARD SHALL DEVELOP:

1. A POLICY THAT SETS FORTH THE PROCESS OF ATTESTATION OR DOCUMENTATION REQUIRED AS PROOF OF COMPLETION OF AT LEAST EIGHT THOUSAND CLINICAL PRACTICE HOURS AND ISSUANCE OF CERTIFICATION OF COMPLETION OF THE EIGHT THOUSAND CLINICAL PRACTICE HOURS.

2. AN ALTERNATIVE COMPARABLE STANDARD FOR CERTIFICATION OF EIGHT THOUSAND HOURS OF CLINICAL PRACTICE FOR PHYSICIAN ASSISTANTS WHO HAVE BEEN ACTIVELY PRACTICING FOR MORE THAN FIVE YEARS.

B. THE BOARD SHALL ADOPT RULES ESTABLISHING ADDITIONAL CERTIFICATION STANDARDS OR REQUIREMENTS FOR PHYSICIAN ASSISTANTS WHO PREVIOUSLY COMPLETED EIGHT THOUSAND CLINICAL PRACTICE HOURS CERTIFIED BY THE BOARD AND WHO ARE SEEKING EMPLOYMENT WITH A COLLABORATING PHYSICIAN OR ENTITY FOR A POSITION THAT IS NOT SUBSTANTIALLY SIMILAR TO THE PRACTICE SETTING OR SPECIALTY IN WHICH THE PHYSICIAN ASSISTANT WAS PREVIOUSLY CERTIFIED. THE CERTIFICATION STANDARDS OR REQUIREMENTS SHALL ENSURE APPROPRIATE TRAINING AND OVERSIGHT, INCLUDING A SUPERVISION AGREEMENT IF WARRANTED, FOR THE PHYSICIAN ASSISTANT'S NEW PRACTICE SETTING OR SPECIALTY.

Sec. 10. Section 32-2551, Arizona Revised Statutes, is amended to read:

32-2551. Grounds for disciplinary action; duty to report; immunity; proceedings; board action; notice; civil penalty

A. The board on its own motion may investigate any evidence that appears to show that a physician assistant is or may be medically

incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable to carry out approved health care tasks. Any physician, physician assistant or health care institution as defined in section 36-401 shall, and any other person may, report to the board any information the physician, physician assistant, health care institution or other person has that appears to show that a physician assistant is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable to carry out approved health care tasks. If the board begins an investigation pursuant to this section, it may require the physician assistant to promptly provide the name and address of the ~~physician assistant's~~ supervising physician or ~~physicians~~ COLLABORATING PHYSICIAN OR ENTITY, AS APPLICABLE. The board or the executive director shall notify the physician assistant ~~and the supervising physician~~ of the content of the reported information in writing within one hundred twenty days ~~of its~~ AFTER THE BOARD'S receipt of the information. Any physician, physician assistant, health care institution or other person that reports or provides information to the board in good faith is not subject to an action for civil damages as a result of reporting or providing information, and, if requested, the name of the reporter shall not be disclosed unless the information is essential to proceedings conducted pursuant to this section.

B. The board or, if delegated by the board, the executive director may require a mental, physical or medical competency examination or any combination of those examinations or may make investigations, including investigational interviews, between representatives of the board and the physician assistant and the supervising physician, THE COLLABORATING PHYSICIAN OR A PHYSICIAN REPRESENTATIVE OF THE COLLABORATING ENTITY, AS APPLICABLE, as ~~it~~ THE BOARD deems necessary to fully inform itself with respect to any information reported pursuant to subsection A of this section. These examinations may include biological fluid testing and other examinations known to detect the presence of alcohol or other drugs. The board or, if delegated by the board, the executive director may require the physician assistant, at the physician assistant's expense, to undergo assessment by a ~~board approved~~ BOARD-APPROVED rehabilitative, retraining or assessment program.

C. If the board finds, based on the information it receives under subsections A and B of this section, that the public safety imperatively requires emergency action~~,~~ and incorporates a finding to that effect in its order, the board may restrict a license or order a summary suspension of a license pending proceedings for revocation or other action. If the board acts pursuant to this subsection, the physician assistant shall also be served with a written notice of complaint and formal hearing, setting forth the charges, and is entitled to a formal hearing before the board or an administrative law judge on the charges within sixty days pursuant to title 41, chapter 6, article 10.

D. If, after completing its investigation, the board finds that the information provided pursuant to subsection A of this section is not of sufficient seriousness to merit disciplinary action against the physician assistant's license, ~~it~~ THE BOARD may take the following actions:

1. Dismiss if, in the opinion of the board, the complaint is without merit.

2. File an advisory letter. The licensee may file a written response with the board within thirty days after receiving the advisory letter.

3. Require the licensee to complete designated continuing medical education courses.

E. If the board finds that it can take rehabilitative or disciplinary action without the presence of the physician assistant at a formal interview it may enter into a consent agreement with the physician assistant to limit or restrict the physician assistant's practice or to rehabilitate the physician assistant, protect the public and ensure the physician assistant's ability to safely practice. The board may also require the physician assistant to successfully complete a ~~board approved~~ BOARD-APPROVED rehabilitative, retraining or assessment program at the physician assistant's own expense.

F. The board shall not disclose the name of the person who provided the information regarding a licensee's drug or alcohol impairment or the name of the person who files a complaint if that person requests anonymity.

G. If, after completing its investigation, the board believes that the information is or may be true and that the information may be of sufficient seriousness to merit direct action against the physician assistant's license, it may request a formal interview with the physician assistant and the supervising physician, THE COLLABORATING PHYSICIAN OR A PHYSICIAN REPRESENTATIVE OF THE COLLABORATING ENTITY, AS APPLICABLE. If the physician assistant refuses the invitation for a formal interview, the board may issue a formal complaint and order that a hearing be held pursuant to title 41, chapter 6, article 10. The board shall notify the physician assistant in writing of the time, date and place of the formal interview at least twenty days before the interview. The notice shall include the right to be represented by counsel and shall fully set forth the conduct or matters to be discussed.

H. After the formal interview, the board may take the following actions:

1. Dismiss if, in the opinion of the board, the information is without merit.

2. File an advisory letter. The licensee may file a written response with the board within thirty days after receiving the advisory letter.

3. Enter into a stipulation with the physician assistant to restrict or limit the physician assistant's practice or medical activities or to rehabilitate, retrain or assess the physician assistant, in order to protect the public and ensure the physician assistant's ability to safely perform health care tasks. The board may also require the physician assistant to successfully complete a ~~board approved~~ BOARD-APPROVED rehabilitative, retraining or assessment program at the physician assistant's own expense as prescribed in subsection E of this section.

4. File a letter of reprimand.

5. Issue a decree of censure. A decree of censure is a disciplinary action against the physician assistant's license and may include a requirement for restitution of fees to a patient resulting from violations of this chapter or rules adopted under this chapter.

6. Fix a period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the physician assistant. Failure to comply with any terms of probation is cause for initiating formal proceedings pursuant to title 41, chapter 6, article 10. Probation may include:

(a) Restrictions on the health care tasks the physician assistant may perform.

(b) Temporary suspension for not ~~to exceed~~ MORE THAN twelve months.

(c) Restitution of patient fees.

(d) Education or rehabilitation at the licensee's own expense.

7. Require the licensee to complete designated continuing medical education courses.

I. If the board finds that the information provided pursuant to subsection A of this section warrants suspension or revocation of a physician assistant's license, ~~it~~ THE BOARD shall immediately initiate formal proceedings ~~for the suspension~~ TO SUSPEND or ~~revocation of~~ REVOKE the license as provided in title 41, chapter 6, article 10. The notice of complaint and hearing is fully effective by mailing a true copy of the notice of complaint and hearing by certified mail addressed to the physician assistant's last known address of record in the board's files. The notice of complaint and hearing is complete at the time of its deposit in the mail.

J. A physician assistant who after a formal hearing pursuant to title 41, chapter 6, article 10 is found to be medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely carry out the physician assistant's approved health care tasks, or any combination of these, is subject to censure, probation, suspension or revocation, or any combination of these, for a period of time or permanently and under conditions the board deems appropriate ~~for the protection of~~ TO PROTECT the public health and safety.

K. In a formal interview pursuant to subsection G of this section or in a hearing pursuant to subsection I of this section, the board in

addition to any other action may impose a civil penalty in the amount of ~~not less than three hundred dollars nor~~ AT LEAST $300 BUT NOT more than ~~ten thousand dollars~~ $10,000 for each violation of this chapter or a rule adopted under this chapter.

L. An advisory letter is a public document and may be used in future disciplinary actions against a physician assistant.

M. The board may charge the costs of a formal hearing to the licensee if it finds the licensee in violation of this chapter.

N. If the board acts to modify a physician assistant's prescription writing privileges, the Arizona regulatory board of physician assistants shall immediately notify the Arizona state board of pharmacy and the United States drug enforcement administration of this modification.

O. If during the course of an investigation the ~~Arizona regulatory~~ board ~~of physician assistants~~ determines that a criminal violation may have occurred involving the PHYSICIAN ASSISTANT'S performance of health care tasks, ~~it~~ THE BOARD shall provide evidence of the violation to the appropriate criminal justice agency.

P. The board may accept the surrender of an active license from a person who admits in writing to any of the following:

1. Being unable to safely engage in the practice of medicine.

2. Having committed an act of unprofessional conduct.

3. Having violated this chapter or a board rule.

Q. In determining the appropriate disciplinary action under this section, the board shall consider all previous nondisciplinary and disciplinary actions against a licensee.

Sec. 11. Rulemaking; exemption

Notwithstanding any other law, for the purposes of this act, the Arizona regulatory board of physician assistants is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, for one year after the effective date of this act.

Sec. 12. Effective date

This act is effective from and after December 31, 2023.

APPROVED BY THE GOVERNOR APRIL 17, 2023.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 17, 2023.

**ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**
Title 4, Chapter 17

# GOVERNOR'S REGULATORY REVIEW COUNCIL

**ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT**

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**MEETING DATE:** July 1, 2025

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 17, 2025

**SUBJECT:** **ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**
Title 4 Chapter 17

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**Summary**

This Five-Year Review Report (5YRR) from the Arizona Regulatory Board of Physician Assistants ("Board") covers eighteen (18) rules in Title 4, Chapter 17, Articles 1-4. The Articles cover the following:

- Article 1 - General Provisions
- Article 2 - Physician Assistant Licensure
- Article 3 - Duties of the Executive Director
- Article 4 - Regulation

In the previous report approved by the Council, the Board proposed to amend R4-17-203 and to add a new rule that allows the Board to hear requests for review of a delegated action made by the Executive Director. The Board completed this proposed course of action through a rulemaking approved by the Council on July 6, 2022.

**Proposed Action**

In this report, the Board indicates that R4-17-205 and R4-17-308 will need to be amended to be more consistent with statute, specifically clarifying continued education

requirements and the types of consent agreements that the Director may enter into. The Board has indicated that the rulemaking will be completed by December 31, 2025.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Board cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Board, it has received no information since May 5, 2020, when the Council approved the Board's last 5YRR, that causes the Board to believe its previous assessment of the economic, small business, and consumer impact of the rules is incorrect. The Board has completed four rulemakings since the Board's last 5YRR was completed. Below is a summary of the Board's economic impact comparison for each of these rules:

September 2021 rulemaking (27 A.A.R. 1647) – In this exempt rulemaking, the Board amended R4-17-204 to establish the fee for an out-of-state health care provider of telehealth services to register to provide telehealth services in Arizona. Because the rulemaking was exempt from the requirements at A.R.S. Title 41, Chapter 6, no economic impact statement was prepared. However, the Board estimated the minimal, one-time, fee to register with the Board would be offset by the benefits from the opportunity to provide telehealth services in Arizona

September 2022 rulemaking (28 A.A.R. 1757) - In this rulemaking, the Board completed the rulemaking plan of work identified in the 5YRR approved by the Council on May 5, 2020. Additionally, the Board amended relevant application questions at R4-17-203 and R4-17-206 to comply with the Americans with Disabilities Act. The Board does not comment directly on the economic impact of these amendments but references the economic impact statement (EIS) prepared with the rulemaking. In a summary of that EIS, the Board believed that these amendments would benefit physician assistants who might be reluctant to obtain needed help for medical conditions that potentially impair practice. As the Board indicated previously, no information appears to have altered this belief.
The Board also added R4-17-307, the procedure for appealing an action delegated by the Board to the executive director. While again the Board does not comment on the economic impact, in the summary of the EIS for this rule, the Board believed that the addition of R4-17-307 will benefit individuals aggrieved by a decision made by the executive director.

December 2023 (30 A.A.R. 63) and December 2024 (31 A.A.R. 129) rulemakings - The 2023 rulemaking concerned rules the Board made in December 2023 to implement statute amendments under Laws 2023, Chapter 54. In response to a petition filed under A.R.S. § 41-1033(F) and (G) by the Arizona State Association of Physician Assistants, the Council voided the provisions of R4-17-402(B)-(G) after finding the subsections exceeded the Board's statutory authority and were not specifically authorized

by statute. Therefore, the Board amended the voided provisions in 2024. Because both rulemakings were made under an exemption (See Laws 2024, Chapter 54, Section 11), no economic impact statement was prepared.

Described in the prior EIS, and indicated in the 5YYR, the Board identified applicants, licensees, and the Board as those that are directly affected by, bear the costs, and directly benefit from the rulemaking.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

Yes, according to the Board, most of the costs associated with being a physician assistant in Arizona, including paperwork and other compliance costs result from statute rather than rule. It believes the minimal costs and burdens are considerably outweighed by the opportunity to be employed as a physician assistant as evidenced by the increasing number of individuals who seek licensure from the Board.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Board indicates it received no written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Board indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Board indicates the rules are generally consistent with other rules and statutes with the exception of R4-17-205 and R4-17-308.

For R4-17-205, the Board has indicated that the rule could be improved to align with language found in A.R.S. § 32-2523(F) which allows for a physician holding a certificate of good standing to be exempt from certain continuing education requirements for license renewal. Additionally, the Board indicates that the rules can be more consistent with A.R.S. § 32-3248.02 by adding the requirement that individuals who hold a DEA certificate must complete at least three hours of opioid-related, substance-use disorder-related, or addiction related coursework during a license renewal cycle.

For R4-17-308, the Board indicates that the rule could be improved by adding a new section that allows the executive director to enter into an interim consent agreement with a physician assistant when there is evidence a restriction is needed to mitigate imminent danger to public health and safety and the investigative staff, supervising medical consultant, and lead Board member concur. Consent agreements are permitted by A.R.S. § 32-2505(C)(18)(23)(26) and would bring the Board of Physician Assistants in alignment with the Medical Board rules.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Board indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Board indicates the rules are enforced as written

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board states that there is no corresponding federal law for the rules.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Board has indicated that the rules do require a license be issued. The Board states that a general permit is not appropriate because A.R.S. §§ 32-2521 and 32-2523 specifically authorize the Board to issue individualized licenses. Council staff believes this is a valid reason under A.R.S. § 41-1037(A).

**11. Conclusion**

This Five-Year Review Report (5YRR) from the Arizona Regulatory Board of Physician Assistants ("Board") covers eighteen (18) rules in Title 4, Chapter 17, Articles 1-4. The Board completed their proposed course of action from their previous report. In this report, the Board is proposing to amend two rules with an expected completion date prior to December 31, 2025. The rules are being amended to better align with statute and the Medical Board rules.

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends approval of this report.

March 24, 2025

VIA EMAIL: grrc@azdoa.gov

Jessica Klein, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Arizona Regulatory Board of Physician Assistants
Five-year-review Report
4 A.A.C. 17

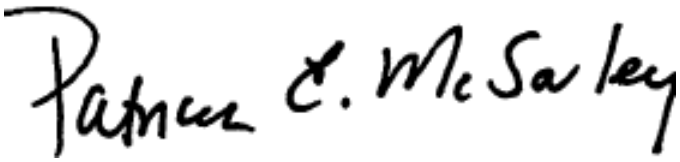
Dear Ms. Klein:

The Board submits the referenced 5YRR for the Council's review and approval. The 5YRR is due under
an extension on March 31, 2025.

The Board certifies that it complies with A.R.S. § 41-1091.

For questions about this report, please contact me at patricia.mcsorley@azmd.gov.

Sincerely,



Patricia McSorley
Executive Director

# Five-year-review Report
# A.A.C. Title 4. Professions and Occupations
# Chapter 17. Arizona Regulatory Board of Physician Assistants
# Submitted for June 3, 2025

INTRODUCTION

The Arizona legislature recognized Physician Assistants in law in the early 1970s. Physician Assistants were believed to be a way to address health care in rural and underserved areas. In 1984, the legislature established the Joint Board on the Regulation of Physicians Assistants to define the physician assistant regulatory program. In 2002, the legislature changed the Board's name to the Arizona Regulatory Board of Physician Assistants. Under A.R.S. § 32-2504(A)(1), the Board's primary duty is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional physician assistants.

The executive director employed by the Arizona Medical Board and all of its staff carry out the administrative responsibilities of the Regulatory Board of Physician Assistants.

Statute that generally authorizes the agency to make rules: A.R.S. § 32-2504(C)

1. Specific statute authorizing the rule:
   R4-17-101. Definitions: A.R.S. Title 32, Chapter 25
   R4-17-102. Time-frames for Licenses and Approvals: A.R.S. §§ 41-1072 through 41-1079
   Table 1. Time Frames (in days): A.R.S. §§ 41-1072 through 41-1079
   R4-17-202. Examination: A.R.S. § 32-2521(A)(2)
   R4-17-203. Regular License Application: A.R.S. §§ 32-2521 and 32-2522
   R4-17-204. Fees and Charges: A.R.S. § 32-2526
   R4-17-205. Continuing Medical Education; Request for Extension of Time: A.R.S. § 32-2523(A)
   R4-17-206. License Renewal: A.R.S. § 32-2523

R4-17-207. Denial of License or Extension to Complete Continuing Education: A.R.S. §§ 32-2522(I), 32-2523(E), and 41-1092.03
R4-17-301. Dismissal of Complaint: A.R.S. §§ 32-2504(B) and 32-2505(C)(19)
R4-17-302. Referral to Formal Hearing: A.R.S. §§ 32-2504(B) and 32-2505(C)(20)
R4-17-303. Non-disciplinary Consent Agreement: A.R.S. § 32-2504(B)
R4-17-304. Request for Inactive Status and License Cancellation: A.R.S. § 32-2504(B)
R4-17-305. Referral to Formal Interview: A.R.S. §§ 32-2504(B) and 32-2505(C)(25)
R4-17-306. Denial of License: A.R.S. § 32-2504(B)
R4-17-307. Appealing Executive Director Actions: A.R.S. § 32-2505(C)
R4-17-401. Application for Certification of Clinical Practice Hours; Waiver of Documentation: A.R.S. §32-2536
R4-17-402. Practicing Collaboratively with a Physician Assistant: A.R.S. §32-2536
R4-17-403. Rehearing or Review: A.R.S. § 41-1092.09

2. Objective of the rules:

R4-17-101. Definitions: The objective of the rule is to define terms used in the rules that are not explained adequately by a dictionary definition.

R4-17-102. Time-frames for Licenses and Approvals: The objective of this rule is to specify the time frames within which the Board will act on a license or renewal application.

Table 1. Time Frames (in days): The objective of this rule is to specify in table form the time frames within which the Board will act on a license or renewal application.

R4-17-202. Examination: The objective of this rule is to provide information to applicants regarding the examination that must be passed to obtain licensure and the requirement to be certified by the NCCPA at the time of application.

R4-17-203. Regular License Application: The objective of this rule is to specify the content of an application for a license including information required to be submitted directly to the Board by third parties.

R4-17-204. Fees and Charges: The objective of the rule is to specify the fees the Board charges for its licensing activities and the other charges made for specified Board services.

R4-17-205. Continuing Medical Education; Request for Extension of Time: The objective of this rule is to reiterate the statutory requirement that a licensee complete 40 hours of category I continuing medical education during each biennial period and specify the manner in which a licensee may request an extension of time to complete the required continuing medical education.

R4-17-206. License Renewal: The objective of this rule is to specify the requirements for license renewal and the manner in which renewal application is made.

R4-17-207.Denial of License or Extension to Complete Continuing Education: The objective of this rule is to provide notice of the right to appeal certain Board actions, the time within which an appeal must be made, and the procedure the Board will use to conduct an appeal hearing.

R4-17-301. Dismissal of Complaint: The objective of the rule is to specify the circumstances under which the executive director may dismiss a complaint.

R4-17-302. Referral to Formal Hearing: The objective of the rule is to specify the circumstances under which the executive director may directly refer a case for formal hearing.

R4-17-303. Non-disciplinary Consent Agreement: The objective of the rule is to specify the circumstances under which the executive director may enter into a non-disciplinary consent agreement with a physician assistant.

R4-17-304. Request for Inactive Status and License Cancellation: The objective of the rule is to specify the conditions under which the executive director shall grant a request for inactive status of license cancellation.

R4-17-305. Referral to Formal Interview: The objective of the rule is to specify requirements for referral of a case to a formal interview.

R4-17-306. Denial of License: The objective of the rule is to specify the standards for the executive director to deny a license to an applicant.

R4-17-307. Appealing Executive Director Actions: The objective of the rule is to inform a person aggrieved by a delegated action of the executive director of the procedure for appealing the action to the Board.

R4-17-401. Application for Certification of Clinical Practice Hours; Waiver of Documentation: The objective of the rule is to inform a licensee of the procedure for obtaining certification of clinical practice hours required to practice collaboratively with a physician or entity.

R4-17-402. Practicing Collaboratively with a Physician Assistant: The objective of the rule is to specify the manner in which a collaborating physician or entity is to work with a qualified physician assistant.

R4-17-403. Rehearing or Review: The objective of the rule is to specify the procedures and standards for requesting a rehearing or review of a Board decision.

3. Are the rules effective in achieving their objectives? Yes

The Board determined the rules are effective because the Board is able to license and regulate physician assistants and fulfill its statutory responsibility to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional physician assistants.

4. Are the rules consistent with other rules and statutes? Yes

However, the Board has determined the following changes will clarify the relationship between statute and rules:

R4-17-205(A): Adding a provision consistent with A.R.S. § 32-2523(F), which provides that a physician assistant who holds a certification in good standing from a certifying body

approved by the Board is exempt from the continuing education requirement for biennial renewal.

R4-17-205: Adding a provision consistent with A.R.S. § 32-3248.02, which requires all healthcare professionals who hold a DEA certificate to complete at least three hours of continuing education in an opioid-related, substance-use disorder-related, or addiction related course during each renewal cycle.

R4-17-308: Adding a new Section allowing the executive director to enter into an interim consent agreement with a physician assistant when there is evidence a restriction is needed to mitigate imminent danger to public health and safety and the investigative staff, supervising medical consultant, and lead Board member concur.

5. Are the rules enforced as written? Yes

6. Are the rules clear, concise, and understandable? Yes

7. Has the agency received written criticisms of the rules within the last five years? No

Comments received regarding each rulemaking were addressed during the rulemaking process. No additional comments were received.

8. Economic, small business, and consumer impact comparison:

The Board has received no information since May 5, 2020, when the Council approved the Board's last 5YRR, that causes the Board to believe its previous assessment of the economic, small business, and consumer impact of the rules is incorrect. The Board has completed four rulemakings since the Board's last 5YRR was completed.

September 2021 rulemaking (27 A.A.R. 1647)

Under Laws 2021, Chapter 320, the legislature added an emergency measure to expand use of telehealth in meeting the health-care needs of Arizonans. The statute allowed an out-of-state health care provider to provide telehealth services to individuals in Arizona if the out-of-state health care provider registered with the applicable Arizona regulatory board and paid a registration fee. In this exempt rulemaking, the Board amended R4-17-204 to establish

the fee for an out-of-state health care provider of telehealth services to register to provide telehealth services in Arizona. Because the rulemaking was exempt from the requirements at A.R.S. Title 41, Chapter 6, no economic impact statement was prepared. However, the Board estimated the minimal, one-time, fee to register with the Board would be offset by the benefits from the opportunity to provide telehealth services in Arizona. There are currently 41 out-of-state health care providers registered to provide telehealth services in Arizona.

September 2022 rulemaking (28 A.A.R. 1757)

In this rulemaking, the Board completed the rulemaking plan of work identified in the 5YRR approved by the Council on May 5, 2020. Additionally, in response to a U.S. Department of Justice report concluding that questions similar to those asked by the Board single out applicants based on their status of having a mental health disability rather than their conduct and violate the Americans with Disabilities Act, the Board amended relevant application questions at R4-17-203 and R4-17-206. The economic impact statement prepared with the rulemaking was available for review.

The initial and renewal applications were amended to ask whether the physician assistant has a medical condition that impairs judgment or ability to practice medicine in a competent, ethical, and professional manner. There are currently 5185 licensed physician assistants in Arizona. In FY 24, there were 645 applications for initial licensure and 2,181 for renewal licensure.

In this rulemaking, the Board also added R4-17-307, which established the procedure for appealing an action delegated by the Board to the executive director. During the last year, 2024, one licensee appealed an action taken by the executive director. The Board upheld the executive director's action in this case.

December 2023 (30 A.A.R. 63) and December 2024 (31 A.A.R. 129) rulemakings

Under Laws 2023, Chapter 54, the legislature amended the statutes applicable to physician assistants to address the scope of practice for physician assistants and authorize certain physician assistants to practice in collaboration with a physician, physician group practice, or healthcare institution rather than under the supervision of a physician. The Board made rules to implement statute in December 2023. However, in response to a petition filed under A.R.S. § 41-1033(F) and (G) by the Arizona State Association of Physician Assistants, the Council voided the provisions of R4-17-402(B)-(G) after finding the subsections exceeded the Board's statutory authority and were not specifically

authorized by statute. In the 2024 rulemaking, the Board amended the voided provisions. Because both rulemakings were made under an exemption (See Laws 2023, Chapter 54, Section 11), no economic impact statement was prepared.

Since R4-17-401 went into effect in December 2023, the Board has received 379 applications for certification of clinical practice hours. The Board's website currently lists 280 physician assistants as eligible to practice in collaboration with a physician, physician group practice, or health care institution. The Board does not maintain records of how many physician assistants actually practice collaboratively.

9. Has the agency received any business competitiveness analyses of the rules? No

10. Has the agency completed the course of action indicated in the agency's previous 5YRR: Yes
    The Board completed all the actions identified as needed in the 5YRR approved by Council on May 5, 2020, in a rulemaking that went into effect on September 4, 2022 (See 28 A.A.R.1757, July 22, 2022).

11. A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:
    Most of the costs associated with being a physician assistant in Arizona, including paperwork and other compliance costs result from statute rather than rule. For example:
    A.R.S. § 32-2501 defines 41 actions as unprofessional conduct and A.R.S. § 32-2551 lists multiple disciplinary and non-disciplinary actions the Board is authorized to take against the license of a physician assistant. During FY24, 129 complaints were opened against physician assistants alleging issues with quality of care, malpractice settlements, and unprofessional conduct. In FY24, 1 case was referred to formal hearing but settled prior to the hearing when the physician assistant entered in to a consent agreement for non- disciplinary continuing medical education. In FY 24, 11 cases resulted in disciplinary action.

A.R.S. § 32-2521 prescribes the qualifications an individual must possess to be licensed and requires that an examination approved by the Board be passed.
A.R.S. § 32-2522(A) requires an applicant to submit an application and pay an application fee.
A.R.S. § 32-2523 requires a license be renewed biennially and the licensee complete 40 hours of continuing medical education provided by entities specified in statute. As allowed under statute (A.R.S. § 32-2523(F)), Arizona allows a physician assistant certified by NCCPA (approximately 90 percent of licensees) to meet the continuing education requirement by affirming ongoing certification.
A.R.S. § 32-2527 requires a licensee to report to the Board a change in contact information.
A.R.S. § 32-2528 requires a licensee to obtain Board approval before placing the license on inactive status. During the last year, 14 licensees requested license inactivation or cancellation.
A.R.S. § 32-2531 prescribes a licensee's scope of practice. A physician assistant may work under the supervision of a physician or, if qualified, may work in collaboration with a physician or health care entity.
A.R.S. § 32-2532 specifies the information a licensee must include on a prescription order, requires Board approval to prescribe controlled substances, and requires a licensee to maintain a log of all controlled substances prescribed or dispensed.

The rules:
Specify the examination approved by the Board (R4-17-202). The Board has approved two examinations used nationally.
Outline the information included in the required application for licensure (R4-17-203) or application for renewal (R4-17-206).
Inform a licensee how to obtain an extension of time to complete continuing medical education (R4-17-205).
Establish fees consistent with the statutory maximums (R4-17-204).
Establish requirements for certification of clinical practice hours needed for a physician assistant to work collaboratively with a physician or health car entity (R4-17-401).

Establish requirements for the physician or health care entity working collaboratively with a physician assistant (R4-17-402).

The rules impose minimal costs and burdens on applicants and licensees and are necessary to enable the Board to protect the public by licensing and regulating physician assistants. The minimal costs and burdens are considerably outweighed by the opportunity to be employed as a physician assistant as evidenced by the increasing number of individuals who seek licensure from the Board.

12. Are the rules more stringent than corresponding federal laws? No

There are no federal laws specifically applicable to licensure and regulation of physician assistants. There are numerous federal laws relating to the provision of health care, but the laws are not applicable to the Board's rules.

13. For a rule made after July 29, 2010, that requires issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:

All of the Board's rules were made after July 29, 2010. However, the Board's statutes (See A.R.S. §§ 32-2521 and 32-2523) require individualized licenses be issued so a general permit is not applicable.

14. Proposed course of action:

The Board will complete a rulemaking addressing the changes identified in item 4 before the end of 2025.

**ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT**[1]

**TITLE 4. PROFESSIONS AND OCCUPATIONS**

**CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS**

1. Identification of the rulemaking:

The Board is completing the rulemaking plan of work identified in a 5YRR approved by the Council on May 5, 2020. Specifically, the Board is adding a Section prescribing procedures to appeal for Board review of an action by the executive director. An exemption from Executive Order 2021-02 was provided for this rulemaking by Trista Guzman Glover of the Governor's Office in an e-mail dated November 29, 2021.

In response to a U.S. Department of Justice report concluding that questions similar to those asked by the Board single out applicants based on their status of having a mental health disability rather than their conduct and violate the Americans with Disabilities Act, the Board is amending relevant application questions at R4-17-203 and R4-17-206. An exemption from Executive Order 2021-02 for this provision was provided by Ms Guzman in an email dated December 9, 2021.

a. The conduct and its frequency of occurrence that the rule is designed to change:
   Until the rulemaking is completed, the rules will continue to lack prescribed procedures for appealing for Board review of an action by the executive director and will continue to violate the Americans with Disabilities Act.

b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:
   Until the rulemaking is completed, the lack of a prescribed procedure for appealing for Board review of an action by the executive director may cause some applicants and licensees to be unaware of the right to appeal. Others may call the Board office for information, consuming staff time and other resources.

   Because of application questions regarding a health disability, some applicants may be reluctant to apply for licensure and others may not answer accurately.

c. The estimated change in frequency of the targeted conduct expected from the rule change:

[1] If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms. (A.R.S. § 41-1055(C)).

When the rulemaking is completed, the identified issues will no longer exist.

2. A brief summary of the information included in the economic, small business, and consumer impact statement:

   The addition of R4-17-307 will benefit individuals aggrieved by a decision made by the executive director. The amendments to R4-17-203 and R4-17-206 will benefit physician assistants who might be reluctant to obtain needed help for medical conditions that potentially impair practice.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

   Name: Patricia McSorley, Executive Director
   Address: Arizona Medical Board
   1740 W Adams Street, Suite 4000
   Phoenix, AZ 85007
   Telephone: (480) 551-2700
   Fax: (480) 551-2704
   E-mail: patricia.mcsorley@azmd.gov
   Web site: www.azmd.gov

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

   Applicants, licensees, and the Board will be directly affected by, bear the costs of, and directly benefit from this rulemaking.

   There are currently 4,211 licensed physician assistants in Arizona. During the last year, there were 512 applications for initial licensure and 714 for renewal licensure. Twenty-three of the renewal applicants (3.2 percent) indicated they have a mental health disability. None of the applicants for initial licensure indicated they have a mental health disability. This may indicate that those with a disability choose not to apply for licensure because of the application question.

   During the last year, two licensees appealed an action by the executive director to the Board. In both cases, the Board upheld the executive director's action. The rule change will provide information needed by licensees who wish to appeal an action by the executive director.

The Board incurred the cost of completing this rulemaking and will incur the cost of implementing it. The Board determined these costs are outweighed by the benefits, which are described above.

5. Cost-benefit analysis:
    a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:
    The Board is the only state agency directly affected by the rulemaking. The Board will not need a new full-time employee to implement or enforce the rulemaking.
    b. Costs and benefits to political subdivisions directly affected by the rulemaking:
    No political subdivision is directly affected by the rulemaking.
    c. Costs and benefits to businesses directly affected by the rulemaking:
    Physician assistants are the only businesses directly affected by the rulemaking. Their costs and benefits are described in item 4.
6. Impact on private and public employment:
    The rulemaking will have no impact on private or public employment.
7. Impact on small businesses[2]:
    a. Identification of the small business subject to the rulemaking:
    Physician assistants are small businesses subject to this rulemaking.
    b. Administrative and other costs required for compliance with the rulemaking:
    A licensee who wishes to appeal an action by the executive director is required to submit a written request and to provide evidence of how the executive director erred. Applicants for initial or renewal licensure are required to complete and submit an application form that includes questions regarding the applicant's current medical condition.
    c. Description of methods that may be used to reduce the impact on small businesses:
    The Board determined there are no methods that will reduce the impact of the rulemaking on small businesses because all licensees are small businesses.
8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:
    The rulemaking will not directly affect private persons or consumers.
9. Probable effects on state revenues:
    There will be no effect on state revenues.

[2] Small business has the meaning specified in A.R.S. § 41-1001(21).

10. Less intrusive or less costly alternative methods considered:

The costs of the rulemaking are minimal and considerably outweighed by the benefits. No less intrusive or less costly alternative method was considered.

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# TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of

October 1, 2024 through December 31, 2024



**Questions about these rules? Contact:**

Board: Arizona Medical Board
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Phoenix, AZ 85007
Website: www.azmd.gov
Name: Patricia McSorley, Executive Director
Telephone: (480) 551-2700
Fax: (480) 551-2704
Email: patricia.mcsorley@azmd.gov

### PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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**RULES**
The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

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The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

**RULE HISTORY**
Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

**AUTHENTICATION OF PDF CODE CHAPTERS**
The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

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**HOW TO USE THE CODE**
Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

**ARIZONA REVISED STATUTE REFERENCES**
The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

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An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

Authority: A.R.S. § 32-2504

**Supp. 24-4**

## CHAPTER TABLE OF CONTENTS

***Editor's Note: The name of the Joint Board on the Regulation of Physician's [sic] Assistants was changed to the Arizona Regulatory Board of Physician Assistants by Laws 2002, Ch. 277, § 7, effective August 22, 2002 (Supp. 03-2).***

*Laws 1984, Ch. 102, changed the name of the Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery to Joint Board on the Regulation of Physician's Assistants.*

*Chapter 17 consisting of Article 1, Section R4-17-101; Article 2, Sections R4-17-201 through R4-17-204; Article 3, Sections R4-17-301 through R4-17-304; Article 4, Sections R4-17-401 and R4-17-402 adopted effective July 8, 1986.*

*Former Chapter 17 consisting of Article 1, Section R4-17-01; Article 2, Sections R4-17-02 through R4-17-06; Article 3, Sections R4-17-07 through R4-17-12; Article 4, Sections R4-17-13 through R4-17-17; Article 5, Sections R4-17-18 through R4-17-22; and Article 6, Section R4-17-23 repealed effective July 8, 1985.*

### ARTICLE 1. GENERAL PROVISIONS



### ARTICLE 2. PHYSICIAN ASSISTANT LICENSURE



### ARTICLE 3. DUTIES OF THE EXECUTIVE DIRECTOR

*New Article 3, consisting of Sections R4-17-301 through R4-17-306, made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).*

## ARTICLE 4. COLLABORATIVE PRACTICE; REGULATION



## ARTICLE 1. GENERAL PROVISIONS

**R4-17-101. Definitions**

For the purposes of A.R.S. Title 32, Chapter 25 and this Chapter:

1. "Ability to perform health care tasks authorized by A.R.S. § 32-2531" means:
   a. The cognitive capacity to make clinical diagnoses and exercise medical judgments and to learn and keep abreast of medical developments through the completion of continuing medical education,
   b. The ability to communicate medical judgments and medical information to patients and other professionals, and
   c. The physical capability to perform the health care tasks authorized by A.R.S. § 32-2531.
2. "Applicant" means an individual seeking a regular license or renewal license.
3. "Category I" means a designation given to a continuing medical education activity provided by an institution or organization that has been accredited for continuing medical education by the:
   a. Accreditation Council for Continuing Medical Education,
   b. American Medical Association,
   c. American Academy of Physician Assistants,
   d. American Osteopathic Association,
   e. Accreditation Council for Continuing Medical Education,
   f. Accreditation Review Commission on Education for Physician Assistants, or
   g. Commission on the Accreditation of Allied Health Education Programs.
4. "Controlled Substance" means the same as in A.R.S. § 32-1901.
5. "Dispense" means the same as in A.R.S. § 32-1901.
6. "Drug" means the same as in A.R.S. § 32-1901.
7. "Health care institution" means the same as in A.R.S. § 36-401.
8. "Health professional" means the same as in A.R.S. § 32-3201 or its equivalent in another state.
9. "Health profession regulatory authority" means a state or federal entity that issues and regulates health professional licenses.
10. "NCCPA" means the National Commission on the Certification of Physician Assistants.
11. "PANCE" means the Physician Assistant National Certifying Examination.
12. "PANRE" means the Physicians Assistants National Recertification Examination.
13. "Prescribe" means to issue:
    a. A signed, written order to a pharmacist for drugs or medical devices; or
    b. An order transmitted to a pharmacist by word of mouth, telephone, or other means of communication.
14. "Privileges" means the authority granted by a health care institution to a physician or physician assistant to practice medicine at the health care institution.

15. "Service" means personal delivery or mailing by certified mail to a physician assistant, supervising physician, or applicant affected by a decision of the Board at the physician assistant's, supervising physician's, or applicant's last known residence or place of business.
16. "State fiscal year" means from July 1 of one calendar year to June 30 of the next calendar year.
17. "Substance use disorder" means the maladaptive pattern of the use of a drug, alcohol, or chemical leading to effects that are detrimental to an individual's physical or mental health.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Amended effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**R4-17-102. Time-frames for Licenses and Approvals**

**A.** The overall time-frame described in A.R.S. § 41-1072(2) for a regular license or renewal license is set forth in Table 1.

**B.** The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for a regular license or renewal license is set forth in Table 1 and begins on the date the Board receives an application.
1. If the application is not administratively complete, the Board shall send a deficiency notice to the applicant.
   a. The deficiency notice shall state each deficiency and the information needed to complete the application.
   b. Within the time provided in Table 1 for response to the deficiency notice, the applicant shall submit to the Board the missing information specified in the deficiency notice. The time-frame for the Board to finish the administrative completeness review is suspended from the date the Board mails the deficiency notice to the applicant until the date the Board receives the missing information.
   c. If the applicant does not submit the missing information within the time to respond to the deficiency notice set forth in Table 1, the Board shall send a written notice to the applicant informing the applicant that the application is deemed withdrawn.
2. If the application is administratively complete, the Board shall send a written notice of administrative completeness to the applicant.

**C.** The substantive review time-frame described in A.R.S. § 41-1072(3) for a regular license or renewal license is set forth in Table 1 and begins on the date the Board sends written notice of administrative completeness to the applicant.
1. During the substantive review time-frame, the Board may make one comprehensive written request for additional information. The applicant shall submit the additional information within the time provided in Table 1 for response to a comprehensive written request for additional information. The time-frame for the Board to finish the substantive review is suspended from the date the Board mails the request until the Board receives the information.
2. The Board shall issue a written notice informing the applicant that the application is deemed withdrawn if the applicant does not submit the requested additional information within the time-frame in Table 1.
3. The Board shall issue a written notice of denial of a license or license renewal if the Board determines that the applicant does not meet all of the substantive criteria required by statute or this Chapter for licensure or license renewal.
4. If the applicant meets all of the substantive criteria required by statute and this Chapter for a license or license renewal, the Board shall issue the license or license renewal to the applicant.

**D.** In computing any period of time prescribed in this Section, the day of the act, event, or default shall not be included. The last day of the period shall be included unless it is Saturday, Sunday, or a state holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or state holiday. The computation shall include intermediate Saturdays, Sundays, and holidays. The time period for an applicant to respond to a deficiency notice or request for additional information shall commence on the date of personal service or the date of mailing.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**Table 1. Time Frames (in days)**

| Type of License | Overall Time Frame | Administrative Review Time Frame | Time to Respond to Deficiency Notice | Substantive Review Time Frame | Time to Respond to Request for Additional Information |
|---|---|---|---|---|---|
| Regular License including schedule II or schedule III controlled substances approval R4-17-203 | 120 | 30 | 365 | 90 | 90 |
| License Renewal R4-17-206 | 75 | 30 | 60 | 45 | 60 |
| Registration as an Out-of-state Health Care Provider of Telehealth Services A.R.S. § 36-3606(A)(3) | 40 | 20 | 30 | 20 | 30 |

**Historical Note**

Adopted effective April 22, 1998Amended by final exempt rulemaking at 27 A.A.R 1647, with an immediate effective date of September 22, 2021 (Supp. 21-3). (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final exempt rulemaking at 27 A.A.R 1647, with an immediate effective date of September 22, 2021 (Supp. 21-3).

## ARTICLE 2. PHYSICIAN ASSISTANT LICENSURE

**R4-17-201. Repealed**

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-201 renumbered to R4-17-202; new Section adopted effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**R4-17-202. Examination**

An applicant for a regular license as a physician assistant shall pass the PANCE or PANRE and be certified by the NCCPA at the time of application for licensure.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section R4-17-202 renumbered from R4-17-201 and amended effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-203. Regular License Application**

**A.** An applicant for a regular license shall submit a completed application to the Board that includes:

1. The applicant's:
   a. First, last, and middle name;
   b. Every other name used by the applicant;
   c. Social Security number;
   d. Office, mailing, e-mail, and home addresses;
   e. Office, mobile, and home telephone numbers; and
   f. Birth date and state or country of birth;
2. The name and address of the approved physician assistant program completed by the applicant and the date of completion;
3. The name of each state or province in which the applicant has ever been certified, registered, or licensed as a physician assistant, including the certificate, registration, or license number, and current status;
4. Whether the applicant has practiced as a physician assistant for 10 continuous years before the date the application was submitted to the Board or since graduation from a physician assistant program and if not, an explanation;
5. A questionnaire that includes answers to the following:
   a. Whether the applicant has had an application for a certificate, registration, or license refused or denied by any licensing authority, and if so, an explanation;

b. Whether the applicant has had the privilege of taking an examination for a professional license refused or denied by any entity, and if so, an explanation;
c. Whether the applicant has ever resigned or been requested to resign, been suspended or expelled from, been placed on probation, or been fined while enrolled in an approved physician assistant program or a postsecondary educational program, and if so, an explanation;
d. Whether, while attending an approved physician assistant program, the applicant has ever had any action taken against the applicant by the approved program, resigned, or been asked to leave the approved program for any amount of time, and if so, an explanation;
e. Whether the applicant has ever surrendered a health professional license, and if so, an explanation;
f. Whether the applicant has ever had a health professional license suspended or revoked, or whether any other disciplinary action has ever been taken against a health professional license held by the licensee, and if so, an explanation;
g. Whether the applicant is currently under investigation by any health profession regulatory authority, health care association, licensed health care institution, or there are any pending complaints or disciplinary actions against the applicant, and if so, an explanation;
h. Whether the applicant has ever had any action taken against the applicant's privileges, including termination, resignation, or withdrawal by a health care institution or health profession regulatory authority, and if so, an explanation;
i. Whether the applicant has ever had a federal or state regulatory authority take any action against the applicant's authority to prescribe, dispense, or administer controlled substances including revocation, suspension, or denial, or whether the applicant ever surrendered the authority in lieu of any of these actions, and if so, an explanation;
j. Whether the applicant has ever been charged with, convicted of, pleaded guilty to, or entered into a plea of no contest to a felony or misdemeanor involving moral turpitude or has been pardoned or had a record expunged or vacated, and if so, an explanation;
k. Whether the applicant has ever been charged with or convicted of a violation of any federal or state drug statute, rule, or regulation, regardless of whether a sentence was or was not imposed, and if so, an explanation;
l. Whether the applicant has been named as a defendant in a malpractice matter currently pending or that resulted in a judgment or settlement entered against the applicant, and if so, an explanation;
m. Whether the applicant has ever been court-martialed or discharged other than honorably from any component of the uniformed services of the United States, and if so, an explanation;
n. Whether the applicant has ever been involuntarily terminated from a health professional position, resigned, or been asked to leave the health care position, and if so, an explanation;
o. Whether the applicant has ever been convicted of insurance fraud or received a sanction, including limitation, suspension, or removal from practice, imposed by any state or the federal government, and if so, an explanation; and
p. Whether the applicant, within the three years before the date of the application, has completed 45 hours in pharmacology or clinical management of drug therapy or is certified by a national commission on the certification of physician assistants or its successor;

6. A confidential questionnaire that includes answers to the following:
   a. Whether the applicant currently has a medical condition that impairs the applicant's judgment or ability to practice medicine in a competent, ethical, and professional manner;
   b. If the answer to subsection (A)(6)(a) is yes:
      i. Provide an explanation of the medical condition; and
      ii. If currently practicing under a monitoring agreement with a licensing board in another state, attach a copy of the monitoring agreement to the application; and
7. Consistent with the Board's statutory authority, other information the Board may deem necessary to evaluate the applicant fully; and
8. A sworn statement that complies with A.R.S. § 32-2522(C).

**B.** In addition to the requirements in subsection (A), an applicant shall submit the following to the Board:
1. Documentation of citizenship or alien status that conforms to A.R.S. § 41-1080;
2. Documentation of a legal name change if the applicant's legal name is different from that shown on the document submitted in accordance with subsection (B)(1);
3. A form provided by the Board and completed by the applicant that lists all current or past employment with health professionals, health professions educational institutions, or health care institutions within five years before the date of application or since graduation from a physician assistant program, if less than five years, including each health professional's, health professions educational institution's, or health care institution's name, address, and dates of employment;

4. Verification of any medical malpractice matter currently pending or resulting in a settlement or judgment against the applicant, including a copy of the complaint and either the agreed terms of settlement or the judgment and a narrative statement specifying the nature of the occurrence resulting in the medical malpractice action. An applicant who is unable to obtain a document required under this subsection may submit a written request for a waiver of the requirement. The applicant shall include the following information in a request for waiver:
   a. The document for which waiver is requested;
   b. Detailed description of efforts made by the applicant to provide the required document; and
   c. Reason the applicant's inability to provide the required document is due to no fault of the applicant; and
5. The fee required in R4-17-204.

**C.** In addition to the requirements in subsections (A) and (B), an applicant shall have the following directly submitted to the Board:
1. A copy of the applicant's certificate of successful completion of the PANCE or PANRE and the applicant's examination score provided by the NCCPA;
2. An approved program form provided by the Board, completed and signed by the director or administrator of the approved program that granted the applicant a physician assistant degree, that includes the:
   a. Applicant's full name,
   b. Type of degree earned by the applicant,
   c. Name of the physician assistant program completed by the applicant,
   d. Starting and ending dates, and
   e. Date the applicant's degree was granted.

**D.** The Board's issuance of a regular license to an applicant certifies the applicant to issue, dispense, or administer schedule II or schedule III controlled substances, subject to the limits and requirements specified in A.R.S. § 32-2532. Additionally, beginning October 1, 2018, a physician assistant previously certified by the Board for 30-day prescription privileges for schedule II or schedule III controlled substances is certified for 90-day prescription privileges for schedule II or schedule III controlled substances that are not opioids or benzodiazepine.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 25 A.A.R. 401, effective April 6, 2019 (Supp. 19-1). Amended by final rulemaking at 28 A.A.R. 1757 (July 22, 2022), effective September 4, 2022 (Supp. 22-3).

**R4-17-204. Fees and Charges**

**A.** As expressly authorized under A.R.S. § 32-2526(A)(1) through (4), the Board shall charge the following fees:
1. License application - $125.00;
2. Regular license - $370.00, prorated for each month remaining in the biennial period;
3. Regular license renewal - $370.00 if the renewal application is postmarked no later than the applicant's birthdate; and
4. Penalty for late renewal - $100.00.

**B.** Under the specific authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect the following fee to register as an out-of-state health care provider of telehealth services: $200.

**C.** The fees specified in subsections (A) and (B) are nonrefundable unless A.R.S. §§ 32-2526(B) or 41-1077 applies.

**D.** As expressly authorized under A.R.S. § 32-2526(A)(5) through (9), the Board establishes the following charges for providing the services listed:
1. Duplicate license - $25.00;
2. Copies of Board documents - $1.00 for first three pages, $.25 for each additional page;
3. Medical Directory (CD-ROM) - $30.00;
4. Data Disk - $100.00; and
5. License verification - $10.00.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section adopted effective April 22, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final exempt rulemaking at 27 A.A.R 1647, with an immediate effective date of September 22, 2021 (Supp. 21-3).

**R4-17-205. Continuing Medical Education; Request for Extension of Time**

**A.** Under A.R.S. § 32-2523(A), renewal of a license is conditioned on the licensee completing 40 hours of category I continuing medical education during each biennial license period.

**B.** During a licensee's first biennial license period, the licensee may complete a pro-rated number of continuing medical education hours established by the Board.

**C.** A licensee who is unable to complete the required hours of continuing medical education for any of the reasons in A.R.S. § 32-2523(E) may submit a written request to the Board for an extension no later than 30 days before expiration of the license that contains:

1. The name, address, and telephone number of the licensee;
2. The reason for the request;
3. The number of continuing medical education hours completed during the biennial license period;
4. The dates on which the remaining hours of continuing medical education are scheduled to be completed; and
5. The signature of the licensee.

**D.** The Board shall send a written notice of approval of the extension within seven days from the date of receipt of the request if the Board determines:

1. The extension is needed for a reason specified in A.R.S. § 32-2523(E),
2. The remaining hours of continuing medical education are scheduled to be completed within 30 days, and
3. The extension is in the best interest of the state.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-206. License Renewal**

**A.** To renew a license, a licensee shall submit a completed application to the Board that includes:

1. An application form that contains the licensee's:
   a. First, last, and middle names;
   b. Arizona license number;
   c. Office, mailing, e-mail, and home addresses;
   d. Office, mobile, and home telephone numbers;
2. A questionnaire that includes answers to the following since the last renewal date:
   a. Whether the licensee has had an application for a certificate, registration, or license refused or denied by any licensing authority, and if so, an explanation;
   b. Whether the licensee has had the privilege of taking an examination for a professional license refused or denied by any entity, and if so, an explanation;
   c. Whether the licensee has voluntarily surrendered a health care professional license, and if so, an explanation;
   d. Whether the licensee has had a health professional license suspended or revoked, or whether any other disciplinary action has been taken against a health professional license held by the licensee, and if so, an explanation;
   e. Whether the licensee has had any action taken against the applicant's privileges, including termination, resignation, or withdrawal by a health care institution or health profession regulatory authority, and if so, an explanation;
   f. Whether the licensee has had a federal or state regulatory authority take any action against the license's authority to prescribe, dispense, or administer controlled substances including revocation, suspension, or denial, or whether the applicant surrendered the authority in lieu of any of these actions, and if so, an explanation;
   g. Whether the licensee has been charged with, convicted of, pleaded guilty to, or entered into a plea of no contest to a felony or misdemeanor involving moral turpitude or an alcohol- or drug-related offense in any state, or has been pardoned or had a record expunged or vacated, and if so, an explanation;
   h. Whether the licensee has been court-martialed or discharged other than honorably from any component of the uniformed services of the United States, and if so, an explanation;
   i. Whether the licensee has been involuntarily terminated from a health professional position with any city, county, state, or federal government, and if so, an explanation;
   j. Whether the licensee has been convicted of insurance fraud or a state or the federal government has sanctioned or taken any action against the licensee, such as suspension or removal from practice, and if so, an explanation;
3. Consistent with the Board's statutory authority, other information the Board may deem necessary to evaluate the licensee fully;
4. A dated and sworn statement by the licensee verifying that during the past biennial license period, the

licensee completed at least 40 hours of Category I continuing medical education as required by A.R.S. § 32-2523;

5. The fee required in R4-17-204;
6. A confidential questionnaire that includes answers to the following:
   a. Whether the licensee currently has a medical condition that impairs the licensee's judgment or ability to practice medicine in a competent, ethical, and professional manner;
   b. If the answer to subsection (A)(6)(a) is yes:
      i. Provide an explanation of the medical condition; and
      ii. If currently practicing under a monitoring agreement with a licensing board in another state, attach a copy of the monitoring agreement to the application; and
7. If the document submitted under R4-17-203(B)(1) was a limited form of work authorization issued by the federal government, evidence that the licensee's presence in the U.S. continues to be authorized under federal law.

**B.** Under A.R.S. §32-2523(A), the Board shall randomly select at least 10 percent of renewal applications submitted by licensees who are not currently certified by a national certification organization to verify compliance with the continuing medical education requirement specified in R4-17-205(A). If selected, a licensee shall submit to the Board documents that verify compliance with the continuing medical education requirement.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 1757 (July 22, 2022), effective September 4, 2022 (Supp. 22-3).

**R4-17-207. Denial of License or Extension to Complete Continuing Education**

An applicant for a license who is denied the license or a physician assistant who is denied an extension to complete continuing medical education may request a hearing to contest the matter by filing a written notice with the Board within 30 days of receipt of notice of the Board's action. A hearing shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 6 and Article 10.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**R4-17-208. Expired**

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Section expired under A.R.S. § 41-1056(E) at 11 A.A.R. 1569, effective March 31, 2005 (Supp. 05-2).

## ARTICLE 3. DUTIES OF THE EXECUTIVE DIRECTOR

**R4-17-301. Dismissal of Complaint**

**A.** The executive director, with concurrence of the investigative staff, shall dismiss a complaint if review shows the complaint is without merit and dismissal is appropriate.

**B.** The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of physician assistants about whom complaints were dismissed since the preceding Board meeting.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-301 renumbered to R4-17-302; new Section R4-17-301 adopted effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-302. Referral to Formal Hearing**

**A.** The executive director may refer a case directly to a formal hearing if the investigative staff, medical consultant, and lead Board member concur after review of the case that a formal hearing is appropriate.

**B.** The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of the physician assistants whose cases were referred to formal hearing since the preceding Board meeting and indicate whether each case was referred because it involves revocation, suspension, out- of-state disciplinary action, or complexity.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section renumbered from R4-17-301 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-303. Non-disciplinary Consent Agreement**

The executive director may enter into a consent agreement under A.R.S. § 32-2505(C)(23) with a physician assistant to limit the physician assistant's practice or rehabilitate the physician assistant if there is evidence the physician assistant is mentally or physically unable to engage in the practice of medicine safely and the investigative staff, medical consultant, and lead Board member concur after review of the case that a consent agreement is appropriate.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section renumbered to R4-17-304; new Section R4-17-303 adopted effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-304. Request for Inactive Status and License Cancellation**

**A.** If a physician assistant requests inactive status or license cancellation, meets the requirements of A.R.S. §§ 32-2525 or 32-2528, and is not participating in the program defined under A.R.S. § 32-2552(E), the executive director shall grant the request.

**B.** The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of the individuals granted inactive or cancelled license status since the preceding Board meeting.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-304 renumbered to R4-17-305; new Section R4-17-304 renumbered from R4-17-303 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-305. Referral to Formal Interview**

The executive director shall refer a case to a formal interview on a future Board meeting agenda if the investigative staff, lead Board member, and in cases involving quality of care, the medical consultant, concur after review of the case that a formal interview is appropriate.

**Historical Note**

New Section R4-17-305 renumbered from R4-17-304 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-306. Denial of License**

**A.** The executive director shall deny a license to an applicant if the executive director, in consultation with the investigative staff and medical consultant concur after review of the application, that the applicant does not meet the statutory requirements for licensure.

**B.** The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of the physician assistants whose applications were denied since the preceding Board meeting.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-307. Appealing Executive Director Actions**

**A.** Any person aggrieved by an action taken by the executive director under the authority delegated in this Article may appeal that action to the Board. The aggrieved person shall file a written request with the Board no later than:

1. Thirty days after notification of the action, if personally served; or
2. Thirty-five days after the date on the notification, if mailed.

**B.** The aggrieved person shall provide, in the written request, evidence showing:
1. An irregularity in the investigative process or the executive director's review deprived the party of a fair decision;
2. Misconduct by Board staff, a Board consultant, or the executive director that deprived the party of a fair decision; or
3. Material evidence newly discovered that could have a bearing on the decision and that, with reasonable diligence, could not have been discovered and produced earlier.

**C.** The fact that the aggrieved party does not agree with the executive director's action is not grounds for a review by the Board.

**D.** If an aggrieved person fails to submit a written request within the time specified in subsection (A), the Board is relieved of the requirement to review actions taken by the executive director. The executive director may, however, evaluate newly provided information that is material or substantial in content to determine whether the Board should review the case.

**E.** If a written request is submitted that meets the requirements of subsection (B):
1. The Board shall consider the written request at its next regularly scheduled meeting.
2. If the written request provides new material or substantial evidence that requires additional investigation, the investigation shall be conducted as expeditiously as possible and the case shall be forwarded to the Board at the first possible regularly scheduled meeting.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1757 (July 22, 2022), effective September 4, 2022 (Supp. 22-3).

## ARTICLE 4. COLLABORATIVE PRACTICE; REGULATION

**R4-17-401. Application for Certification of Clinical Practice Hours; Waiver of Documentation**

**A.** As required under A.R.S. § 32-2536(A), a physician assistant who is licensed by the Board and in good standing may apply to the Board for certification of the clinical practice hours required to practice collaboratively with a physician or entity. A physician assistant is in good standing if the physician assistant is not:
1. Under investigation by a regulatory authority, or
2. Subject to a public or confidential probation order.

**B.** To be eligible to practice collaboratively with a physician or entity, a physician assistant shall have at least 8,000 hours of clinical practice, as described in subsection (E), obtained:
1. In the five years before the date of the application submitted under subsection (C), or
2. In the 10 years before the date of the application submitted under subsection (C) if:
   a. At least 2,000 hours of clinical practice were obtained in the three years before the date of application submitted under subsection (C); and
   b. The physician assistant is currently certified by the National Commission on Certification of Physician Assistants.

**C.** To apply for certification of clinical practice hours, a physician assistant shall submit to the Board an application form, which is available on the Board's website.

**D.** In addition to complying with subsection (C), a physician assistant applying for certification of clinical practice hours shall have submitted directly to the Board by the document custodian or an individual with direct knowledge, documentation of hours of clinical practice performed by the physician assistant. Documentation may be submitted by multiple persons.

**E.** Clinical practice includes:
1. Performing medical services related directly to patient care;
2. Providing instruction to physician assistants at an institution accredited by the Accreditation Review Commission on Education for the Physician Assistant. Time spent preparing to provide instruction or preforming administrative tasks related to providing instruction is not clinical practice.

**F.** The Board may waive the documentation requirement specified under subsection (D). To obtain a waiver of the documentation requirement, the physician assistant shall submit to the Board a written request that includes the following information:
1. The physician assistant's name and license number;
2. Date on the request for waiver;
3. Identification and an estimate of the number of clinical hours for which documentation has not been submitted under subsection (D);
4. Description of the physician assistant's efforts to have the documentation submitted as required under subsection (D);
5. Explanation of why the documentation cannot be submitted;

6. If applicable, evidence that supports the request for waiver; and
7. The physician assistant's affirmation that the physician assistant has performed the required hours of clinical practice even though documentation has not been submitted.

**G.** The Board shall waive the documentation requirement if the Board determines the documentation is unavailable for a reason beyond the control of the physician assistant requesting the waiver. In making this determination, the Board shall consider:
1. The sufficiency of the physician assistant's effort to have the documentation submitted;
2. Evidence it is not possible to have the documentation submitted because:
   a. The required document does not exist;
   b. The individual or entity responsible for maintaining and submitting the documentation is unable to do so; or
   c. Another reason beyond the control of the physician assistant; and
3. Whether the Board is able to obtain the required documentation from another source.

**H.** The Board shall document the Board's decision regarding a request for waiver submitted under subsection (F) in the official record regarding the application submitted under subsection (C). The Board's decision regarding a request for waiver is not subject to review or appeal.

**I.** The Board shall maintain on the Board's website a list of physician assistants who have at least 8,000 hours of clinical practice certified by the Board and are eligible to practice in collaboration with a physician, physician group practice, or health care institution.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-401 renumbered to R4-17-402; new Section R4-17-401 adopted effective April 22, 1998 (Supp. 98-2). Section expired under A.R.S. § 41-1056(E) at 11 A.A.R. 1569, effective March 31, 2005 (Supp. 05-2). New Section made by final exempt rulemaking at 30 A.A.R. 63 (January 12, 2024), effective December 31, 2023 (Supp. 23-4).

**R4-17-402. Practicing Collaboratively with a Physician Assistant**

**A.** Before practicing collaboratively with a physician assistant, the collaborating physician or entity shall verify that the physician assistant is qualified under A.R.S. § 32-2536 and R4-17-401 to practice collaboratively. The collaborating physician or entity shall maintain evidence of the verification as long as the physician assistant is employed by the collaborating physician or entity.

**B.** A collaborating physician or entity shall designate one or more physicians by name or position as responsible for the oversight of the physician assistant. When requested by the Board, the collaborating physician or entity shall notify the Board of the identity of the physician designated as responsible for oversight of the physician assistant.

**C.** The collaborating physician or entity shall ensure the physician assistant is competent to practice in any new area that is not substantially similar to the practice area in which the physician assistant previously practiced collaboratively, If the collaborating physician or entity determines the physician assistant needs additional education, training, and oversight, the collaborating physician or entity shall ensure additional education, training, and oversight is provided until the physician assistant acquires the necessary competence.
1. If the collaborating physician or entity determines a supervision agreement is warranted, the collaborating physician or entity shall require the physician assistant to enter a supervision agreement, as defined at A.R.S. § 32-2501, until the physician assistant acquires the education, experience, and competence necessary to practice in the practice setting or specialty in which the physician assistant has not previously practiced.
2. The collaborating physician or entity shall document all actions taken under this subsection, including any additional education, training, and oversight or the initiation or termination of a supervision agreement, to ensure the actions are recorded in the employment file of the physician assistant. When requested by the Board, the collaborating physician or entity shall provide a copy of the information required under this subsection to the Board.

**D.** The collaborating physician or entity shall make a determination required under subsection (C) in collaboration with the physician assistant.

**E.** When certified under A.R.S. § 32-2536 to practice collaboratively, a physician assistant shall continue to collaborate or consult with or refer to the appropriate health care professional according to the policies of the practice setting at which the physician assistant is employed.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-402 renumbered to R4-17-403; new Section R4-17-402 renumbered from R4-17-401 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final exempt rulemaking at 30 A.A.R. 63 (January 12, 2024), effective December 31, 2023 (Supp. 23-4). The Governor's Regulatory Review Council determined subsections (B) through (G) exceeded the agency's

statutory authority, were not authorized by statute, and therefore void under A.R.S. § 41-1033(K) at 30 A.A.R. 2665 (August 23, 2024), effective July 30, 2024; in consultation with the Arizona State Association of Physician Assistants the Board amended the voided provisions in a Notice of Final Exempt Rulemaking at 31 A.A.R. 129 (January 10, 2025), effective December 17, 2024 (Supp. 24-4).

**R4-17-403. Rehearing or Review**

**A.** Except as provided in subsection (B), a party who is aggrieved by a decision issued by the Board may file with the Board, no later than 30 days after service of the decision, a written request for rehearing or review of the decision, specifying the grounds for rehearing or review. For purposes of this Section, a decision is considered to have been served when personally delivered to the party's last known home or business address or five days after the decision is mailed by certified mail to the party or the party's attorney.

**B.** If the Board makes specific findings that the immediate effectiveness of the decision is necessary for the preservation of the public health and safety and determines that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the Board may issue the decision as a final decision without an opportunity for rehearing or review. If the Board issues the decision as a final decision, without an opportunity for a rehearing or review, the aggrieved party may make an application for judicial review within the time limits permitted for an application for judicial review of the Board's final decision under A.R.S. § 12-904.

**C.** A party filing a request for rehearing or review may amend the request at any time before it is ruled upon by the Board. Another party may file a response within 15 days after the date the request or amended request for rehearing is filed. The Board may require a party to file supplemental memoranda explaining the issues raised in the request or response and may permit oral argument.

**D.** The Board may grant a rehearing or review of a decision for any of the following causes materially affecting the requesting party's rights:

1. Irregularity in the Board's or administrative law judge's administrative proceedings or any order or abuse of discretion that deprived the party of a fair hearing;
2. Misconduct of the Board, administrative law judge, or the prevailing party;
3. Accident or surprise that could not have been prevented by ordinary prudence;
4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the original hearing;
5. Excessive or insufficient penalties;
6. Error in the admission or rejection of evidence, or other errors of law that occurred at the hearing;
7. The decision is the result of passion or prejudice; or
8. The decision or findings of fact are not justified by the evidence or are contrary to law.

**E.** The Board may affirm or modify a decision or grant rehearing or review on all or part of the issues for any of the reasons set forth in subsection (D). An order granting a rehearing or review shall specify each ground for the rehearing or review.

**F.** No later than 30 days after a decision is issued by the Board, the Board on its own initiative may order a rehearing or review for any reason in subsection (D).

**G.** When a request for rehearing or review is based on affidavits, a party shall serve the affidavits with the request. The opposing party may, within 10 days after service, serve opposing affidavits. The Board may extend the time for serving opposing affidavits for no more than 20 days for good cause shown or by written stipulation by the parties. The Board may permit reply affidavits.

**Historical Note**

New Section R4-17-403 renumbered from R4-17-402 and amended effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

As of February 13, 2025

## 32-2501. Definitions

In this chapter, unless the context otherwise requires:

1. "Active license" means a regular license issued pursuant to this chapter.

2. "Adequate records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

3. "Advisory letter" means a nondisciplinary letter to notify a physician assistant that either:

(a) While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.

(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

(c) While the licensee has demonstrated substantial compliance through rehabilitation or remediation that has mitigated the need for disciplinary action, the board believes that repetition of the activities that led to the investigation may result in further board action against the licensee.

4. "Approved program" means a physician assistant educational program accredited by the accreditation review commission on education for physician assistants, or one of its predecessor agencies, the committee on allied health education and accreditation or the commission on the accreditation of allied health educational programs.

5. "Board" means the Arizona regulatory board of physician assistants.

6. "Collaborating physician or entity" means a physician, physician group practice, physician private practice or licensed health care institution that employs or collaborates with a physician assistant who has at least eight thousand hours of clinical practice as certified by the board pursuant to section 32-2536 and does not require a supervision agreement and that designates one or more physicians by name or position who is responsible for the oversight of the physician assistant.

7. "Completed application" means an application for which the applicant has supplied all required fees, information and correspondence requested by the board on forms and in a manner acceptable to the board.

8. "Immediate family" means the spouse, natural or adopted children, father, mother, brothers and sisters of the physician assistant and the natural or adopted children, father, mother, brothers and sisters of the physician assistant's spouse.

9. "Letter of reprimand" means a disciplinary letter that is issued by the board and that informs the physician assistant that the physician assistant's conduct violates state or federal law and may

require the board to monitor the physician assistant.

10. "Limit" means a nondisciplinary action that is taken by the board and that alters a physician assistant's practice or medical activities if there is evidence that the physician assistant is or may be mentally or physically unable to safely engage in health care tasks.

11. "Medically incompetent" means that a physician assistant lacks sufficient medical knowledge or skills, or both, in performing delegated health care tasks to a degree likely to endanger the health or safety of patients.

12. "Minor surgery":

(a) Means those invasive procedures that may be performed by a physician assistant, that are consistent with the training and experience of the physician assistant, that are normally taught in courses of training approved by the board, that have been approved by the board as falling within the scope of practice of a physician assistant and that are consistent with the practice setting requirements of the physician assistant.

(b) Does not include a surgical abortion.

13. "Physician" means a physician who is licensed pursuant to chapter 13 or 17 of this title.

14. "Physician assistant" means a person who is licensed pursuant to this chapter.

15. "Regular license" means a valid and existing license that is issued pursuant to section 32-2521 to perform health care tasks.

16. "Restrict" means a disciplinary action that is taken by the board and that alters a physician assistant's practice or medical activities if there is evidence that the physician assistant is or may be medically incompetent or guilty of unprofessional conduct.

17. "Supervising physician" means a physician who holds a current unrestricted license, who supervises a physician assistant who has less than eight thousand hours of clinical practice and who assumes legal responsibility for health care tasks performed by the physician assistant.

18. "Supervision" means a physician's opportunity or ability to provide or exercise direction and control over the services of a physician assistant. Supervision does not require a physician's constant physical presence if the supervising physician is or can be easily in contact with the physician assistant by telecommunication.

19. "Supervision agreement" means a written or electronic signed agreement that both:

(a) Describes the scope of practice for a physician assistant who has less than eight thousand hours of clinical practice.

(b) Is between the physician assistant and a physician or the physician assistant's employer that employs or has on medical staff at least one physician who may provide oversight, as applicable, and who holds a current unrestricted license. For the purposes of this subdivision, "employer" means a physician, physician group practice, physician private practice or licensed health care institution.

20. "Unprofessional conduct" includes the following acts by a physician assistant that occur in

this state or elsewhere:

(a) Violating any federal or state law or rule that applies to the performance of health care tasks as a physician assistant. Conviction in any court of competent jurisdiction is conclusive evidence of a violation.

(b) Claiming to be a physician or knowingly allowing another person to represent that person as a physician.

(c) Performing health care tasks that do not meet the supervision or collaboration requirements, as applicable, pursuant to section 32-2531.

(d) Exhibiting a pattern of using or being under the influence of alcohol or drugs or a similar substance while performing health care tasks or to the extent that judgment may be impaired and the ability to perform health care tasks detrimentally affected.

(e) Signing a blank, undated or predated prescription form.

(f) Committing gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient.

(g) Representing that a manifestly incurable disease or infirmity can be permanently cured or that a disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if this is not true.

(h) Refusing to divulge to the board on demand the means, method, procedure, modality of treatment or medicine used in treating a disease, injury, ailment or infirmity.

(i) Prescribing or dispensing controlled substances or prescription-only drugs for which the physician assistant is not approved or in excess of the amount authorized pursuant to this chapter.

(j) Committing any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.

(k) Violating a formal order, probation or stipulation issued by the board.

(l) Failing to clearly disclose the person's identity as a physician assistant in the course of the physician assistant's employment.

(m) Failing to use and affix the initials "P.A." or "P.A.-C." after the physician assistant's name or signature on charts, prescriptions or professional correspondence.

(n) Procuring or attempting to procure a physician assistant license by fraud, misrepresentation or knowingly taking advantage of the mistake of another.

(o) Having professional connection with or lending the physician assistant's name to an illegal practitioner of any of the healing arts.

(p) Failing or refusing to maintain adequate records for a patient.

(q) Using controlled substances that have not been prescribed by a physician, physician assistant, dentist or nurse practitioner for use during a prescribed course of treatment.

(r) Prescribing or dispensing controlled substances to members of the physician assistant's immediate family.

(s) Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes.

(t) Dispensing a schedule II controlled substance that is an opioid, except as provided in section 32-2532.

(u) Knowingly making any written or oral false or fraudulent statement in connection with the performance of health care tasks or when applying for privileges or renewing an application for privileges at a health care institution.

(v) Committing a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

(w) Having a certification or license refused, revoked, suspended, limited or restricted by any other licensing jurisdiction for the inability to safely and skillfully perform health care tasks or for unprofessional conduct as defined by that jurisdiction that directly or indirectly corresponds to any act of unprofessional conduct as prescribed by this paragraph.

(x) Having sanctions including restriction, suspension or removal from practice imposed by an agency of the federal government.

(y) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate a provision of this chapter.

(z) Using the term "doctor" or the abbreviation "Dr." on a name tag or in a way that leads the public to believe that the physician assistant is licensed to practice as an allopathic or osteopathic physician in this state.

(aa) Failing to furnish legally requested information to the board or its investigator in a timely manner.

(bb) Failing to allow properly authorized board personnel to examine on demand documents, reports and records of any kind relating to the physician assistant's performance of health care tasks.

(cc) Knowingly making a false or misleading statement on a form required by the board or in written correspondence or attachments furnished to the board.

(dd) Failing to submit to a body fluid examination and other examinations known to detect the presence of alcohol or other drugs pursuant to an agreement with the board or an order of the board.

(ee) Violating a formal order, probation agreement or stipulation issued or entered into by the board or its executive director.

(ff) Except as otherwise required by law, intentionally betraying a professional secret or intentionally violating a privileged communication.

(gg) Allowing the use of the licensee's name in any way to enhance or allow the continuance of the activities of, or maintaining a professional connection with, an illegal practitioner of medicine or the performance of health care tasks by a person who is not licensed pursuant to this chapter.

(hh) Committing false, fraudulent, deceptive or misleading advertising by a physician assistant or the physician assistant's staff or representative.

(ii) Knowingly failing to disclose to a patient on a form that is prescribed by the board and that is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the licensee has a direct financial interest in a separate diagnostic or treatment agency or in nonroutine goods or services that the patient is being prescribed and whether the prescribed treatment, goods or services are available on a competitive basis. This subdivision does not apply to a referral by one physician assistant to another physician assistant or to a doctor of medicine or a doctor of osteopathic medicine within a group working together.

(jj) With the exception of heavy metal poisoning, using chelation therapy in the treatment of arteriosclerosis or as any other form of therapy without adequate informed patient consent or without conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a medical peer review committee, or without approval by the United States food and drug administration or its successor agency.

(kk) Prescribing, dispensing or administering anabolic or androgenic steroids for other than therapeutic purposes.

(ll) Prescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a professional relationship with the person. This subdivision does not apply to:

(i) A physician assistant who provides temporary patient care on behalf of the patient's regular treating licensed health care professional.

(ii) Emergency medical situations as defined in section 41-1831.

(iii) Prescriptions written to prepare a patient for a medical examination.

(iv) Prescriptions written or antimicrobials dispensed to a contact as defined in section 36-661 who is believed to have had significant exposure risk as defined in section 36-661 with another person who has been diagnosed with a communicable disease as defined in section 36-661 by the prescribing or dispensing physician assistant.

(mm) Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the professional relationship, was in a dating or engagement relationship with the licensee. For the purposes of this subdivision, "sexual conduct" includes:

(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual.

(ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature with a patient.

(iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

(nn) Performing health care tasks under a false or assumed name in this state.

32-2502. Arizona regulatory board of physician assistants; membership; appointment; terms; immunity

A. The Arizona regulatory board of physician assistants is established consisting of the following members:

1. Five physician assistants who hold a current regular license pursuant to this chapter. The governor may appoint these members from a list of qualified candidates submitted by the Arizona state association of physician assistants. The governor may seek additional input and nominations before the governor makes the physician assistant appointments.

2. Two public members who are appointed by the governor.

3. Two physicians who are actively engaged in the practice of medicine and who are licensed pursuant to chapter 17 of this title, one of whom supervises or collaborates with a physician assistant at the time of appointment, and who are appointed by the governor.

4. Two physicians who are actively engaged in the practice of medicine and who are licensed pursuant to chapter 13 of this title, one of whom supervises or collaborates with a physician assistant at the time of appointment, and who are appointed by the governor.

B. Before appointment by the governor, a prospective member of the board shall submit a full set of fingerprints to the governor for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

C. The term of office of members of the board is four years to begin and end on July 1.

D. Each board member is eligible for appointment to not more than two full terms, except that the term of office for a member appointed to fill a vacancy that is not caused by the expiration of a full term is for the unexpired portion of that term and the governor may reappoint that member to not more than two additional full terms. Each board member may continue to hold office until the appointment and qualification of that member's successor. The governor may remove a member after notice and a hearing on a finding of continued neglect of duty, incompetence or unprofessional or dishonorable conduct. That member's term ends when the finding is made.

E. A board member's term automatically ends:

1. On written resignation submitted to the board chairperson or to the governor.

2. If the member is absent from this state for more than six months during a one-year period.

3. If the member fails to attend three consecutive regular board meetings.

4. Five years after retirement from active practice.

F. Board members are immune from civil liability for all good faith actions they take pursuant to

this chapter.

32-2503. Organization; meetings; payment for service

A. The board shall annually elect a chairperson and vice chairperson from among its members.

B. The board shall hold a regular meeting at least quarterly on a date and at a time and place it designates. The board shall hold special meetings, including meetings using communications equipment that allows all members participating in the meeting to hear each other, as the chairperson determines are necessary to carry out the functions of the board. The board shall hold a special meeting on any day that the chairperson determines is necessary to carry out the functions of the board. The vice chairperson may call regular meetings and special meetings if the chairperson is not available.

C. Members of the board are eligible to receive up to $200 for each day of service in the business of the board and for all expenses necessarily and properly incurred in attending board meetings.

32-2504. Powers and duties; delegation of authority; rules; subcommittees; immunity

A. The board shall:

1. As its primary duty, protect the public from unlawful, incompetent, unqualified, impaired or unprofessional physician assistants.

2. License and regulate physician assistants pursuant to this chapter.

3. Order and evaluate physical, psychological, psychiatric and competency testing of licensees and applicants the board determines is necessary to enforce this chapter.

4. Review the credentials and the abilities of applicants for licensure whose professional records or physical or mental capabilities may not meet the requirements of this chapter.

5. Initiate investigations and determine on its own motion whether a licensee has engaged in unprofessional conduct or is or may be incompetent or mentally or physically unable to safely perform health care tasks.

6. Establish fees and penalties pursuant to section 32-2526.

7. Develop and recommend standards governing the profession.

8. Engage in the full exchange of information with the licensing and disciplinary boards and professional associations of other states and jurisdictions of the United States and foreign countries and a statewide association for physician assistants.

9. Direct the preparation and circulation of educational material the board determines is helpful and proper for its licensees.

10. Discipline and rehabilitate physician assistants pursuant to this chapter.

11. Certify physician assistants for thirty-day prescription privileges for schedule II, schedule III, schedule IV and schedule V controlled substances that are opioids or benzodiazepine and ninety-day prescription privileges for schedule II, schedule III, schedule IV and schedule V controlled

substances that are not opioids or benzodiazepine if the physician assistant either:

(a) Within the preceding three years of application, completed forty-five hours in pharmacology or clinical management of drug therapy or at the time of application is certified by a national commission on the certification of physician assistants or its successor.

(b) Met any other requirement established by board rule.

B. The board may delegate to the executive director the board's authority pursuant to this section or section 32-2551. The board shall adopt a substantive policy statement pursuant to section 41-1091 for each specific licensing and regulatory authority the board delegates to the executive director.

C. The board may make and adopt rules necessary or proper for the administration of this chapter.

D. The chairperson may establish subcommittees consisting of board members and define their duties as the chairperson deems necessary to carry out the functions of the board.

E. Board employees, including the executive director, temporary personnel and professional medical investigators, are immune from civil liability for good faith actions they take to enforce this chapter.

F. In performing its duties pursuant to subsection A of this section, the board may receive and review staff reports on complaints, malpractice cases and all investigations.

G. The chairperson and vice chairperson of the Arizona regulatory board of physician assistants are members of the committee on executive director selection and retention established by section 32-1403, subsection G, which is responsible for the appointment of the executive director pursuant to section 32-1405.

32-2505. Personnel; consultants; compensation

A. The executive director employed by the Arizona medical board is the executive director of the Arizona regulatory board of physician assistants. The staff of the Arizona medical board shall carry out the administrative responsibilities of the Arizona regulatory board of physician assistants.

B. The executive director is eligible to receive compensation set by the board within the range determined under section 38-611.

C. The executive director or the executive director's designee shall:

1. Employ, evaluate, dismiss, discipline and direct professional, clerical, technical, investigative and administrative personnel necessary to carry on the work of the board.

2. Set compensation for board employees within the range determined under section 38-611.

3. As directed by the board, prepare and submit recommendations for amendments to the physician assistant practice act for consideration by the legislature.

4. Appoint and employ medical consultants and agents necessary to conduct investigations, gather information and perform those duties the executive director determines are necessary and

appropriate to enforce this chapter.

5. Issue licenses, registrations and permits to applicants who meet the requirements of this chapter.

6. Manage the board's offices.

7. Prepare minutes, records, reports, registries, directories, books and newsletters and record all board transactions and orders.

8. Collect all monies due and payable to the board.

9. Pay all bills for authorized expenditures of the board and its staff.

10. Prepare an annual budget.

11. Submit a copy of the budget each year to the governor, the speaker of the house of representatives and the president of the senate.

12. Initiate an investigation if evidence appears to demonstrate that a physician assistant may be engaged in unprofessional conduct or may be medically incompetent or mentally or physically unable to safely practice as a physician assistant.

13. Issue subpoenas if necessary to compel the attendance and testimony of witnesses and the production of books, records, documents and other evidence.

14. Provide assistance to the attorney general in preparing and sign and execute disciplinary orders, rehabilitative orders and notices of hearings as directed by the board.

15. Enter into contracts to procure goods and services pursuant to title 41, chapter 23 that are necessary to carry out board policies and directives.

16. Execute board directives.

17. Represent the board in matters with the federal government, other states or jurisdictions of the United States, this state, political subdivisions of this state, the news media and the public.

18. Enter into stipulated agreements on behalf of the board with persons under the jurisdiction of the board for the treatment, rehabilitation or monitoring of chemical substance abuse or misuse.

19. Review all complaints filed pursuant to section 32-2551. If delegated by the board, the executive director may also dismiss a complaint if the complaint is without merit.

20. If delegated by the board, directly refer cases to a formal hearing.

21. If delegated by the board, close cases resolved through mediation.

22. If delegated by the board, issue advisory letters.

23. If delegated by the board, enter into a consent agreement if there is evidence of danger to the public health and safety.

24. If delegated by the board, grant uncontested requests for inactive status and cancellation of a

license pursuant to this chapter.

25. If delegated by the board, refer cases to the board for a formal interview.

26. Perform all other administrative, licensing or regulatory duties required by the board.

D. Medical consultants and agents appointed pursuant to subsection C, paragraph 4 of this section are eligible to receive compensation determined by the executive director in an amount not to exceed two hundred dollars for each day of service.

E. A person who is aggrieved by an action taken by the executive director may request the board to review that action by filing with the board a written request within thirty days after that person is notified of the executive director's action by personal delivery, or if mailed to that person's last known residence or place of business, within thirty-five days after the date on the notification. At the next regular board meeting, the board shall review the executive director's action. On review, the board shall approve, modify or reject the executive director's action.

32-2506. Arizona medical board fund

(L24, Ch. 222, sec. 35. Eff. until 7/1/28)

A. Pursuant to sections 35-146 and 35-147, the board shall deposit fifteen percent of all monies collected pursuant to this chapter in the state general fund and deposit the remaining eighty-five percent in the Arizona medical board fund.

B. Monies deposited in the fund pursuant to this section are subject to section 35-143.01.

32-2506. Arizona medical board fund

(L24, Ch. 222, sec. 36. Eff. 7/1/28)

A. Pursuant to sections 35-146 and 35-147, the board shall deposit ten percent of all monies collected pursuant to this chapter in the state general fund and deposit the remaining ninety percent in the Arizona medical board fund.

B. Monies deposited in the fund pursuant to this section are subject to section 35-143.01.

32-2507. Licensee profiles; civil penalty

A. The board shall make available to the public a profile of each licensee. The board shall make this information available through an internet website and, if requested, in writing. The profile shall contain the following information:

1. A description of any conviction of a felony or a misdemeanor involving moral turpitude within the last five years. For the purposes of this paragraph, a licensee is deemed to be convicted of a

crime if the licensee pled guilty or was found guilty by a court of competent jurisdiction.

2. A description of any felony charges or misdemeanor charges involving moral turpitude within the last five years to which the licensee pled no contest.

3. The number of pending complaints and final board disciplinary and nondisciplinary actions within the last five years. Information concerning pending complaints shall contain the following statement:

Pending complaints represent unproven allegations. On investigation, many complaints are found to be without merit and are dismissed.

4. All medical malpractice court judgments and all medical malpractice awards or settlements in which a payment is made to a complaining party within the last five years. Information concerning malpractice actions shall contain the following statement:

The settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician assistant. A payment in settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.

5. The name and location of the licensee's training and the date of graduation.

6. The licensee's primary practice location.

B. Each licensee shall submit the information required pursuant to subsection A of this section as directed by the board. An applicant for licensure shall submit this information at the time of application. The applicant and licensee shall submit the information on a form prescribed by the board. A licensee shall submit immediately any changes in information required pursuant to subsection A, paragraphs 1, 2 and 4 of this section. The board shall update immediately its internet website to reflect changes in information relating to subsection A, paragraphs 1, 2, 3 and 4 of this section. The board shall update the internet website information after receipt of the renewal application pursuant to section 32-2523.

C. The board shall provide each licensee with a copy of the licensee's profile and give the licensee reasonable time to correct the profile before it is available to the public.

D. It is an act of unprofessional conduct for a licensee to provide erroneous information pursuant to this section. In addition to other disciplinary action, the board may impose a civil penalty of not more than one thousand dollars for each erroneous statement.

32-2508. Preceptorship awareness campaign; definitions

A. The board shall develop a preceptorship awareness campaign that educates medical professionals who are licensed pursuant to this chapter on how to become and the benefits of being a medical preceptor for students.

B. For the purposes of this section:

1. "Medical preceptor" means a medical professional who is licensed pursuant to this chapter and who maintains an active practice in this state.

2. "Preceptorship":

(a) Means a mentoring experience in which a medical preceptor provides a program of personalized instruction, training and supervision to a student to enable the student to obtain a medical professional degree to become licensed pursuant to this chapter.

(b) Does not include mentoring for medical services that are prescribed in section 36-2301.01, subsection C, paragraph 1.

3. "Student" means an individual who is matriculating at the graduate level at an accredited institution of higher education in this state and who is seeking a medical professional degree to become licensed pursuant to this chapter.

32-2521. Qualifications

A. An applicant for licensure shall:

1. Have graduated from a physician assistants educational program approved by the board.

2. Pass a certifying examination approved by the board.

3. Be physically and mentally able to safely perform health care tasks as a physician assistant.

4. Have a professional record that indicates that the applicant has not committed any act or engaged in any conduct that constitutes grounds for disciplinary action against a licensee pursuant to this chapter. This paragraph does not prevent the board from considering the application of an applicant who was the subject of disciplinary action in another jurisdiction if the applicant's act or conduct was subsequently corrected, monitored and resolved to the satisfaction of that jurisdiction's regulatory board.

5. Not have had a license to practice revoked by a regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter.

6. Not be currently under investigation, suspension or restriction by a regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter. If the applicant is under investigation by a regulatory board in another jurisdiction, the board shall suspend the application process and may not issue or deny a license to the applicant until the investigation is resolved.

7. Not have surrendered, relinquished or given up a license in lieu of disciplinary action by a regulatory board in another jurisdiction in the United States for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter. This paragraph does not prevent the board from considering the application of an applicant who surrendered, relinquished or gave up a license in lieu of disciplinary action by a regulatory board in another jurisdiction if that regulatory board subsequently reinstated the applicant's license.

8. Have submitted verification of all hospital affiliations and employment for the five years preceding application. Each hospital must verify the applicant's affiliation or employment on the hospital's official letterhead or the electronic equivalent.

B. The board shall require an applicant to have all credentials submitted from the primary source

where the document originated, either electronically or by hard copy, except that the board may accept primary-source verified credentials from a credentials verification service approved by the board.

C. The board may make investigations it deems necessary to advise itself with respect to the qualifications of the applicant, including physical examinations, mental evaluations, written competency examinations or any combination of these examinations and evaluations.

D. If the board finds that the applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action in this state, before issuing a license the board must determine to its satisfaction that the act or conduct has been corrected, monitored and resolved. If the act or conduct has not been resolved, before issuing a license the board must determine to its satisfaction that mitigating circumstances exist that prevent its resolution.

E. If another jurisdiction has taken disciplinary action against an applicant, before issuing a license the board must determine to its satisfaction that the cause for the action was corrected and the matter was resolved. If the other jurisdiction has not resolved the matter, before issuing a license the board must determine to its satisfaction that mitigating circumstances exist that prevent its resolution.

F. The board may delegate to the executive director the authority to deny licenses to applicants who do not meet the requirements of this section.

32-2522. Applications; interview; withdrawal

A. Each applicant shall file a verified completed application in the form required and supplied by the board that is accompanied by the prescribed application fee.

B. The application shall be designed to require the submission of evidence, credentials and other proof necessary to satisfy the board that the applicant qualifies for licensure.

C. The application shall contain the oath of the applicant that:

1. All information contained in the application and evidence submitted with it are true and correct.

2. The credentials submitted were not procured by fraud or misrepresentation or any mistake of which the applicant is aware.

3. The applicant is the lawful holder of the credentials.

D. All applications submitted to the board and any attendant evidence, credentials or other proof submitted with an application are the property of the board and part of the permanent record of the board and shall not be returned to an applicant.

E. After the board has received a completed application the board either shall grant or deny a license to the applicant. If an applicant has submitted an incomplete application, the board shall promptly notify an applicant, in writing, of the deficiencies, if any, in the application that prevent it from being a completed application.

F. The board or its representatives may interview an applicant to determine whether the application is sufficient.

G. Applications are considered withdrawn on any of the following conditions:

1. Written request of the applicant.

2. Failure of the applicant to appear for an interview with the board unless good cause is shown.

3. Failure to submit a completed application within one year from the date of the mailing by the board of a statement to the applicant of the deficiencies in the application pursuant to subsection E of this section.

H. On request of an applicant who disagrees with the statement of deficiency, the board shall grant a hearing before the board at its next regular meeting if there is time at that meeting to hear the matter. The board shall not delay this hearing beyond one regularly scheduled meeting. At any hearing granted pursuant to this subsection, the burden of proof is on the applicant to demonstrate that the alleged deficiencies do not exist.

I. The board may deny a license to an applicant who does not meet the requirements of this article.

J. If an applicant does not meet the requirements of section 32-2521, subsection A, paragraph 3, the board may issue a license subject to any of the following probationary conditions:

1. Restrict the licensee's practice.

2. Require the licensee to continue medical or psychiatric treatment.

3. Require the licensee to participate in a specified rehabilitation program.

4. Require the licensee to abstain from alcohol and other drugs.

K. If the board offers a probationary license to an applicant pursuant to subsection J of this section, it shall notify the applicant in writing of the following:

1. The applicant's specific deficiencies.

2. The probationary period.

3. The applicant's right to reject the terms of probation.

4. If the applicant rejects the terms of probation, the applicant's right to a hearing on the board's denial of the application.

32-2523. Licensure; renewal; continuing education; audit; penalty fee; expiration

A. Except as provided in section 32-4301, each holder of a regular license shall renew the license every other year on or before the licensee's birthday by paying the prescribed renewal fee and supplying the board with information it deems necessary, including proof of having completed, before the renewal date, forty hours of category I continuing medical education approved by the American academy of physician assistants, the American medical association, the American osteopathic association or any other accrediting organization acceptable to the board. The board shall verify continuing medical education compliance and shall randomly audit at least ten percent of physician assistants who are renewing their license within the calendar year and who

do not hold a current national certification from a national certification organization for physician assistants that is approved by the board.

B. Except as provided in section 32-4301, a holder of a regular license who fails to renew the license within thirty days after the licensee's birthday shall pay a penalty fee as set forth in rule for late renewal.

C. Except as provided in section 32-4301, if a holder of a regular license fails to renew the license within ninety days after the licensee's birthday, the license automatically expires. It is unlawful for a person to perform health care tasks of a physician assistant after the license expires.

D. A person whose license expires may reapply for licensure pursuant to this chapter.

E. If a licensee does not meet the requirements of subsection A of this section because of that person's illness, religious missionary activity or residence in a foreign country or any other extenuating circumstance, the board may grant an extension of the deadline if it receives a written request to do so from the licensee that details the reasons for this request.

F. The continuing medical education requirement in subsection A of this section is deemed satisfied if, at the time of renewal, the licensee holds a certification in good standing from a certifying body approved by the board.

32-2524. Exemption from licensure

This chapter does not require licensure of:

1. A student who is enrolled in a physician assistant education program approved by the board.

2. A physician assistant who is an employee of the United States government and who works on land or in facilities owned or operated by the United States government.

3. A physician assistant who is a member of the armed forces of the United States and who is on official orders or performing official duties as outlined in the appropriate regulation of that branch of military service.

32-2525. Cancellation of license

A. A person who holds an active regular license as a physician assistant, who is not presently under investigation by the board as the result of a complaint or information received by it, and against whom the board has not commenced any disciplinary proceedings may request and the board shall grant cancellation of the license.

B. The board may accept the request to cancel the active regular license of a physician assistant who has been charged with a violation of this chapter or rules adopted pursuant to this chapter if the physician assistant admits the charges and stipulates this admission for the record.

32-2526. Fees

A. By a vote at its annual fall meeting, the board shall establish nonrefundable fees and penalties that do not exceed the following:

1. Processing an application for an active license, four hundred dollars.

2. Issuing an active license, four hundred dollars.

3. Annual renewal of a regular license, four hundred dollars.

4. Penalty fee for late renewal of a regular license, three hundred fifty dollars.

5. Issuance of a duplicate license, twenty-five dollars.

6. Verification of a license, ten dollars.

7. Copying records, documents, letters, minutes, applications and files, one dollar for the first three pages and twenty-five cents for each additional page.

8. The sale of computerized tapes or diskettes that do not require programming, one hundred dollars.

9. Services not required to be provided by this chapter, but that the board deems appropriate to carry out the intent and purpose of this chapter, a fee of not to exceed the actual cost of providing the services. Notwithstanding section 32-2506, the board shall deposit, pursuant to sections 35-146 and 35-147, all of the monies collected under this paragraph in the Arizona medical board fund established by section 32-1406.

B. Notwithstanding subsection A of this section, on written request the board may return the license renewal fee for good cause shown.

C. The board may collect from a drawer of a dishonored check, draft, order or note an amount allowed pursuant to section 44-6852.

32-2527. Change of address; penalty

A. A person holding an active license as a physician assistant in this state shall inform the board in writing within thirty days of that person's current residence address, office address and telephone number and of each change in residence and office address or telephone number that occurs. A residential address is not available to the public unless it is the only address of record.

B. The board may assess its costs incurred in locating a physician assistant who fails to comply with subsection A of this section within thirty days after the date of change. The board may also assess a penalty of not to exceed one hundred dollars against the physician assistant. Notwithstanding section 32-2506, monies collected pursuant to this subsection shall be deposited, pursuant to sections 35-146 and 35-147, in the Arizona medical board fund established by section 32-1406.

32-2528. Inactive license; application; prohibited activities

A. A person who holds a regular license pursuant to this chapter may request an inactive license from the board if both of the following are true:

1. The licensee is not under investigation by the board.

2. The board has not begun disciplinary proceedings against the licensee.

B. The board may grant an inactive license and shall waive the annual renewal fee and

requirements for continuing medical education if the person certifies total retirement from the performance of health care tasks in this state, any jurisdiction of the United States and any foreign country and is current on all fees required by this chapter.

C. An inactive licensee shall not perform health care tasks.

D. The board may convert an inactive license to a regular license on payment of the annual renewal fee and presentation of evidence to the board that the holder possesses the medical knowledge and the physical and mental ability to safely engage in the performance of health care tasks. The board may require any combination of physical examination, psychiatric or psychological evaluation, oral competency examination or a board qualified written examination or interview it believes necessary to assist it in determining the ability of a physician assistant who holds an inactive license to return to regular licensure.

32-2531. Physician assistant scope of practice; health care tasks; supervision agreements; supervising physician duties; civil penalty

A. Except as prohibited in subsection E of this section, a physician assistant may provide any legal medical service for which the physician assistant has been prepared by education, training and experience and that the physician assistant is competent to perform, including:

1. Obtaining comprehensive health histories and performing physical examinations.

2. Evaluating and diagnosing patients and managing and providing medical treatment and therapeutic interventions.

3. Ordering, performing and interpreting diagnostic studies and therapeutic procedures.

4. Educating patients on health promotion and disease prevention and providing counseling and education to meet patient needs.

5. Providing consultation on request.

6. Writing medical orders.

7. Obtaining informed consent.

8. Assisting in surgery.

9. Delegating and assigning therapeutic and diagnostic measures to and supervising licensed or unlicensed personnel.

10. Making appropriate referrals.

11. Ordering, prescribing, dispensing and administering drugs and medical devices.

12. Prescribing prescription-only medications.

13. Prescribing schedule IV or schedule V controlled substances as defined in the controlled substances act (P.L. 91-513; 84 Stat. 1242; 21 United States Code section 802).

14. Prescribing schedule II and schedule III controlled substances as defined in the controlled

substances act.

15. Performing minor surgery.

16. Performing nonsurgical health care tasks that are normally taught in courses of training approved by the board and that are consistent with the physician assistant's education, training and experience.

17. Certifying the health or disability of a patient as required by any local, state or federal program.

18. Ordering home health services.

B. Pursuant to the requirements of this chapter and the standard of care, a physician assistant who has at least eight thousand hours of clinical practice certified by the board pursuant to section 32-2536 is not required to practice pursuant to a supervision agreement but shall continue to collaborate with, consult with or refer to the appropriate health care professional as indicated by the patient's condition and by the physician assistant's education, experience and competencies. The level of collaboration required by this subsection is determined by the policies of the practice setting at which the physician assistant is employed, including a physician employer, physician group practice or health care institution. Collaboration, consultation or a referral pursuant to this subsection may occur through electronic means and does not require the physical presence of the appropriate health care professional at the time or place the physician assistant provides medical services. This subsection does not prohibit a physician assistant who has at least eight thousand hours of clinical practice certified by the board pursuant to section 32-2536 from practicing pursuant to a supervision agreement.

C. A physician assistant who has less than eight thousand hours of clinical practice certified by the board shall work in accordance with a supervision agreement that describes the physician assistant's scope of practice. A physician assistant may not perform health care tasks until the physician assistant has completed and signed a supervision agreement. Under a supervision agreement, supervision may occur through electronic means and does not require the physical presence of the supervising physician at the time or place the physician assistant provides medical services. The supervision agreement must be kept on file at the main location of the physician assistant's practice and, on request, be made available to the board or the board's representative. On receipt of board certification of the physician assistant's completion of at least eight thousand hours of clinical practice, a physician assistant is no longer subject to the requirements of this subsection. The board may count practice hours earned in another jurisdiction toward the hours of clinical practice required by this subsection.

D. A physician assistant who does not practice pursuant to a supervision agreement is legally responsible for the health care services performed by the physician assistant.

E. A physician assistant shall not perform surgical abortions as defined in section 36-2151.

F. A physician assistant may pronounce death and may authenticate, by the physician assistant's signature, certification, stamp, verification, affidavit or endorsement, any form that may be authenticated by a physician's signature, certification, stamp, verification, affidavit or endorsement.

G. The board by rule may prescribe a civil penalty for a violation of this article. The penalty shall

not exceed $50 for each violation. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it receives from this penalty in the state general fund. A physician assistant and the supervising physician or collaborating physician or entity may contest the imposition of this penalty pursuant to board rule. The imposition of a civil penalty is public information, and the board may use this information in any future disciplinary actions.

32-2532. Prescribing, administering and dispensing drugs; limits and requirements; notice

A. Except as provided in subsection G of this section, a physician assistant shall not prescribe, dispense or administer:

1. A schedule II or schedule III controlled substance as defined in the controlled substances act (P.L. 91-513; 84 Stat. 1242; 21 United States Code section 802) without board approval and United States drug enforcement administration registration. If the physician assistant has less than eight thousand clinical practice hours, the supervision agreement shall specify the physician assistant's ability to prescribe, dispense or administer a schedule II or schedule III controlled substance.

2. A schedule IV or schedule V controlled substance as defined in the controlled substances act without United States drug enforcement administration registration. If the physician assistant has less than eight thousand clinical practice hours, the supervision agreement shall specify the physician assistant's ability to prescribe, dispense or administer a schedule IV or schedule V controlled substance.

3. Prescription medication intended to perform or induce an abortion.

B. If the physician assistant has less than eight thousand clinical practice hours, the supervision agreement shall specify the physician assistant's ability to prescribe, dispense or administer prescription-only medication.

C. All prescription orders issued by a physician assistant shall contain the name, address and telephone number of the physician assistant. A physician assistant shall issue prescription orders for controlled substances under the physician assistant's own United States drug enforcement administration registration number.

D. If the physician assistant is certified for prescription privileges pursuant to section 32-2504, subsection A, initial prescriptions by the physician assistant for schedule II controlled substances that are opioids are subject to the limits prescribed in sections 32-3248 and 32-3248.01. For each schedule IV or schedule V controlled substance, the physician assistant may not prescribe the controlled substance more than five times in a six-month period for each patient.

E. A prescription by a physician assistant for a schedule III controlled substance that is an opioid or benzodiazepine is not refillable without the written consent of a physician.

F. A physician assistant may not dispense, prescribe or refill prescription-only drugs for a period exceeding one year for each patient.

G. Except in an emergency, a physician assistant may dispense schedule II or schedule III controlled substances for a period of use of not to exceed seventy-two hours with board approval or any other controlled substance for a period of use of not to exceed ninety days and may administer controlled substances without board approval if it is medically indicated in an emergency dealing with potential loss of life or limb or major acute traumatic

pain. Notwithstanding the authority granted in this subsection, a physician assistant may not dispense a schedule II controlled substance that is an opioid, except for an implantable device or an opioid that is for medication-assisted treatment for substance use disorders or as provided in section 32-3248.03.

H. Except for samples provided by manufacturers, all drugs dispensed by a physician assistant shall be labeled to show the name of the physician assistant.

I. A physician assistant shall not obtain a drug from any source other than a physician or a pharmacist. A physician assistant may receive manufacturers' samples.

J. If a physician assistant is approved by the board to prescribe, administer or dispense schedule II and schedule III controlled substances, the physician assistant shall maintain an up-to-date and complete log of all schedule II and schedule III controlled substances the physician assistant administers or dispenses. The board may not grant a physician assistant the authority to dispense schedule II controlled substances that are opioids, except for implantable devices or opioids that are for medication-assisted treatment for substance use disorders.

K. The Arizona regulatory board of physician assistants shall advise the Arizona state board of pharmacy and the United States drug enforcement administration of all physician assistants who are authorized to prescribe or dispense drugs and any modification of their authority.

L. The Arizona state board of pharmacy shall notify all pharmacies at least quarterly of physician assistants who are authorized to prescribe or dispense drugs.

32-2533. Supervising physicians; responsibilities

A. A supervising physician is responsible for all aspects of the performance of a physician assistant who has less than eight thousand hours of clinical practice, whether or not the supervising physician actually pays the physician assistant a salary. The supervising physician is responsible for supervising the physician assistant and ensuring that the health care tasks performed by a physician assistant are within the physician assistant's scope of training and experience and have been properly delegated by the supervising physician.

B. Each physician-physician assistant team must ensure that:

1. The physician assistant's scope of practice is identified.

2. The delegation of medical tasks is appropriate to the physician assistant's level of competence.

3. The relationship of, and access to, the supervising physician is defined.

4. A process for evaluating the physician assistant's performance is established.

C. A supervising physician shall not supervise more than six physician assistants who work at the same time.

D. A supervising physician shall develop a system for recording and reviewing all instances in which the physician assistant prescribes schedule II or schedule III controlled substances.

32-2534. Billing; direct payment

A physician assistant may bill and receive direct payment for the professional services provided by the physician assistant.

32-2535. Emergency medical care

A. Notwithstanding the requirements of this article, in response to a natural disaster, accident or other emergency, a physician assistant who is licensed pursuant to this chapter, licensed or certified by another regulatory jurisdiction in the United States or credentialed as a physician assistant by a federal employer may provide medical care at any location, and the physician assistant is not required to have completed eight thousand clinical practice hours pursuant to section 32-2531.

B. A physician who supervises a physician assistant who is providing medical care pursuant to this section is not required to comply with the requirements of this article relating to supervising physicians.

32-2536. Physician assistants; documentation; certification; rules

A. A physician assistant who is licensed pursuant to this chapter, who is in good standing, who has graduated from an accredited physician assistant program in the United States and who has at least eight thousand clinical practice hours within the previous five years in this state or another jurisdiction shall provide the board with documentation of having completed at least eight thousand hours of clinical practice in order to meet the requirements of section 32-2531, subsection B. The board shall develop:

1. A policy that sets forth the process of attestation or documentation required as proof of completion of at least eight thousand clinical practice hours and issuance of certification of completion of the eight thousand clinical practice hours.

2. An alternative comparable standard for certification of eight thousand hours of clinical practice for physician assistants who have been actively practicing for more than five years.

B. The board shall adopt rules establishing additional certification standards or requirements for physician assistants who previously completed eight thousand clinical practice hours certified by the board and who are seeking employment with a collaborating physician or entity for a position that is not substantially similar to the practice setting or specialty in which the physician assistant was previously certified. The certification standards or requirements shall ensure appropriate training and oversight, including a supervision agreement if warranted, for the physician assistant's new practice setting or specialty.

32-2551. Grounds for disciplinary action; duty to report; immunity; proceedings; board action; notice; civil penalty

A. The board on its own motion may investigate any evidence that appears to show that a physician assistant is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable to carry out approved health care tasks. Any physician, physician assistant or health care institution as defined in section 36-401 shall, and any other person may, report to the board any information the physician, physician assistant, health care institution or other person has that appears to show that a physician assistant is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable to carry out approved health care tasks. If the board begins an investigation

pursuant to this section, it may require the physician assistant to promptly provide the name and address of the supervising physician or collaborating physician or entity, as applicable. The board or the executive director shall notify the physician assistant of the content of the reported information in writing within one hundred twenty days after the board's receipt of the information. Any physician, physician assistant, health care institution or other person that reports or provides information to the board in good faith is not subject to an action for civil damages as a result of reporting or providing information, and, if requested, the name of the reporter shall not be disclosed unless the information is essential to proceedings conducted pursuant to this section.

B. The board or, if delegated by the board, the executive director may require a mental, physical or medical competency examination or any combination of those examinations or may make investigations, including investigational interviews, between representatives of the board and the physician assistant and the supervising physician, the collaborating physician or a physician representative of the collaborating entity, as applicable, as the board deems necessary to fully inform itself with respect to any information reported pursuant to subsection A of this section. These examinations may include biological fluid testing and other examinations known to detect the presence of alcohol or other drugs. The board or, if delegated by the board, the executive director may require the physician assistant, at the physician assistant's expense, to undergo assessment by a board-approved rehabilitative, retraining or assessment program.

C. If the board finds, based on the information it receives under subsections A and B of this section, that the public safety imperatively requires emergency action and incorporates a finding to that effect in its order, the board may restrict a license or order a summary suspension of a license pending proceedings for revocation or other action. If the board acts pursuant to this subsection, the physician assistant shall also be served with a written notice of complaint and formal hearing, setting forth the charges, and is entitled to a formal hearing before the board or an administrative law judge on the charges within sixty days pursuant to title 41, chapter 6, article 10.

D. If, after completing its investigation, the board finds that the information provided pursuant to subsection A of this section is not of sufficient seriousness to merit disciplinary action against the physician assistant's license, the board may take the following actions:

1. Dismiss if, in the opinion of the board, the complaint is without merit.

2. File an advisory letter. The licensee may file a written response with the board within thirty days after receiving the advisory letter.

3. Require the licensee to complete designated continuing medical education courses.

E. If the board finds that it can take rehabilitative or disciplinary action without the presence of the physician assistant at a formal interview it may enter into a consent agreement with the physician assistant to limit or restrict the physician assistant's practice or to rehabilitate the physician assistant, protect the public and ensure the physician assistant's ability to safely practice. The board may also require the physician assistant to successfully complete a board-approved rehabilitative, retraining or assessment program at the physician assistant's own expense.

F. The board shall not disclose the name of the person who provided the information regarding a licensee's drug or alcohol impairment or the name of the person who files a complaint if that person requests anonymity.

G. If, after completing its investigation, the board believes that the information is or may be true and that the information may be of sufficient seriousness to merit direct action against the physician assistant's license, it may request a formal interview with the physician assistant and the supervising physician, the collaborating physician or a physician representative of the collaborating entity, as applicable. If the physician assistant refuses the invitation for a formal interview, the board may issue a formal complaint and order that a hearing be held pursuant to title 41, chapter 6, article 10. The board shall notify the physician assistant in writing of the time, date and place of the formal interview at least twenty days before the interview. The notice shall include the right to be represented by counsel and shall fully set forth the conduct or matters to be discussed.

H. After the formal interview, the board may take the following actions:

1. Dismiss if, in the opinion of the board, the information is without merit.

2. File an advisory letter. The licensee may file a written response with the board within thirty days after receiving the advisory letter.

3. Enter into a stipulation with the physician assistant to restrict or limit the physician assistant's practice or medical activities or to rehabilitate, retrain or assess the physician assistant, in order to protect the public and ensure the physician assistant's ability to safely perform health care tasks. The board may also require the physician assistant to successfully complete a board-approved rehabilitative, retraining or assessment program at the physician assistant's own expense as prescribed in subsection E of this section.

4. File a letter of reprimand.

5. Issue a decree of censure. A decree of censure is a disciplinary action against the physician assistant's license and may include a requirement for restitution of fees to a patient resulting from violations of this chapter or rules adopted under this chapter.

6. Fix a period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the physician assistant. Failure to comply with any terms of probation is cause for initiating formal proceedings pursuant to title 41, chapter 6, article 10. Probation may include:

(a) Restrictions on the health care tasks the physician assistant may perform.

(b) Temporary suspension for not more than twelve months.

(c) Restitution of patient fees.

(d) Education or rehabilitation at the licensee's own expense.

7. Require the licensee to complete designated continuing medical education courses.

I. If the board finds that the information provided pursuant to subsection A of this section warrants suspension or revocation of a physician assistant's license, the board shall immediately initiate formal proceedings to suspend or revoke the license as provided in title 41, chapter 6, article 10. The notice of complaint and hearing is fully effective by mailing a true copy of the notice of complaint and hearing by certified mail addressed to the physician assistant's last known

address of record in the board's files. The notice of complaint and hearing is complete at the time of its deposit in the mail.

J. A physician assistant who after a formal hearing pursuant to title 41, chapter 6, article 10 is found to be medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely carry out the physician assistant's approved health care tasks, or any combination of these, is subject to censure, probation, suspension or revocation, or any combination of these, for a period of time or permanently and under conditions the board deems appropriate to protect the public health and safety.

K. In a formal interview pursuant to subsection G of this section or in a hearing pursuant to subsection I of this section, the board in addition to any other action may impose a civil penalty in the amount of at least $300 but not more than $10,000 for each violation of this chapter or a rule adopted under this chapter.

L. An advisory letter is a public document and may be used in future disciplinary actions against a physician assistant.

M. The board may charge the costs of a formal hearing to the licensee if it finds the licensee in violation of this chapter.

N. If the board acts to modify a physician assistant's prescription writing privileges, the Arizona regulatory board of physician assistants shall immediately notify the Arizona state board of pharmacy and the United States drug enforcement administration of this modification.

O. If during the course of an investigation the board determines that a criminal violation may have occurred involving the physician assistant's performance of health care tasks, the board shall provide evidence of the violation to the appropriate criminal justice agency.

P. The board may accept the surrender of an active license from a person who admits in writing to any of the following:

1. Being unable to safely engage in the practice of medicine.

2. Having committed an act of unprofessional conduct.

3. Having violated this chapter or a board rule.

Q. In determining the appropriate disciplinary action under this section, the board shall consider all previous nondisciplinary and disciplinary actions against a licensee.

32-2552. Right to examine and copy evidence; subpoena authority; right to counsel; confidentiality of records

A. In connection with an investigation conducted by the board on its own motion or as the result of information received pursuant to section 32-2551, subsection A, the board or its duly authorized agent or employee at all reasonable times shall have access to, for the purpose of examination, and the right to copy any documents, reports, records or other physical evidence of any person being investigated or the reports, the records and any other documents maintained by and in the possession of any hospital, clinic, physician's office, physician assistant's office, laboratory, pharmacy, health care institution as defined in section 36-401 or other public or private agency if the documents, reports, records or evidence relate to a physician assistant's

medical competence, unprofessional conduct or mental or physical ability to safely engage in the physician assistant's approved health care tasks.

B. For the purpose of all investigations and proceedings conducted by the board:

1. On its own motion or on application of a person involved in an investigation, the board may issue subpoenas compelling the attendance and testimony of witnesses or demanding the production of documents or any other physical evidence for examination or copying if the evidence relates to the medical incompetence, unprofessional conduct or mental or physical ability of a physician assistant to safely perform health care tasks. Within five days after service of a subpoena requiring the production of evidence in the person's possession or under the person's control, the person may petition the board to revoke, limit or modify the subpoena. The board shall do so if it believes that the evidence required does not relate to violations of this chapter, is not relevant to the subject matter of the hearing or investigation or does not describe with sufficient particularity the physical evidence requested.

2. A person appearing before the board may be represented by counsel.

3. A board member or agent designated by the board may administer oaths or affirmations, examine witnesses and receive evidence.

4. On application by the board or by the person subpoenaed, the superior court has jurisdiction to issue an order to do either of the following:

(a) Require a person to appear before the board or its authorized agent to produce evidence relating to the investigation.

(b) Revoke, limit or modify a subpoena if the court determines that the evidence does not relate to a violation of this chapter, is not relevant to the hearing or investigation or does not describe with sufficient particularity the physical evidence requested.

C. The following items are not available to the public:

1. Patient records, including clinical records, medical reports and laboratory statements and reports.

2. Files, films, reports or oral statements relating to diagnostic findings or treatment of patients.

3. Any information from which a patient or the patient's family might be identified.

4. Information received and records kept by the board in its investigations.

D. This section and any other provision of law that makes communications between a physician or a physician assistant and the physician assistant's patient a privileged communication does not apply to investigations or proceedings conducted pursuant to this chapter. The board and its employees, agents and representatives shall keep in confidence the names of any patients whose records are reviewed during the course of investigations and proceedings pursuant to this chapter.

E. Hospital records, medical staff records, medical staff review committee records, testimony concerning those records and proceedings related to the creation of those records are not available to the public, shall be kept confidential by the board and are subject to the same provisions of law concerning discovery and use in legal actions as are the original records in the possession and

control of hospitals, medical staffs and medical staff review committees.

32-2553. Judicial review

Except as provided in section 41-1092.08, subsection H, final decisions of the board are subject to judicial review pursuant to title 12, chapter 7, article 6.

32-2554. Violation; classification

A. A person who does any of the following is guilty of a class 6 felony:

1. Performs a health care task if that person is not licensed pursuant to this chapter or is not exempt from licensure pursuant to this chapter.

2. Secures a license to perform health care tasks by fraud or deceit.

3. Impersonates a member of the board.

B. A person who is not licensed pursuant to this chapter shall not use the designation "P.A.", "P.A.-C." or "Physician assistant" or use any other words, initials or symbols in a way that leads the public to believe that the person is licensed pursuant to this chapter. A person who violates this subsection is guilty of a class 2 misdemeanor.

32-2555. Injunctions

A. The superior court may issue an injunction to enjoin:

1. A person who is not licensed pursuant to this chapter or who is not exempt from licensure pursuant to this chapter from performing health care tasks.

2. A physician assistant from performing health care tasks if the court determines that the licensee will or may cause irreparable damage to the public health and safety before the board has an opportunity to act pursuant to section 32-2551.

3. An act proscribed in section 32-2554, subsection B.

B. In a petition for an injunction pursuant to subsection A, paragraph 1 of this section, it is sufficient for the petitioner to charge that the respondent on a day certain in a named county engaged in the performance of health care tasks without being licensed or exempt from licensure pursuant to this chapter. It is not necessary for the petitioner to show damage or injury.

C. In a petition for an injunction pursuant to subsection A, paragraph 2 of this section, the petitioner shall specify the facts regarding the licensee's threat to the public health and safety.

D. The board shall file the petition in the superior court in Maricopa county or in the county where the respondent resides or is found.

32-2556. Human immunodeficiency virus; disclosure; immunity; definition

A. It is not an act of unprofessional conduct for a licensee to report to the department of health services the name of a patient's spouse, sex partner or person with whom the patient has shared hypodermic needles or syringes if the licensee knows that the patient tests positive for the human immunodeficiency virus and that the patient has not or will not notify these people and refer them

to testing. Before reporting this information to the department of health services the licensee shall ask the patient to release this information voluntarily.

B. It is not an act of unprofessional conduct for a licensee who knows or who has reason to believe that a significant exposure has occurred between a patient who tests positive for the human immunodeficiency virus and a health care worker or a public safety employee to inform the worker or employee of the exposure. Before disclosing this information the licensee shall ask the patient to disclose this information voluntarily. If the patient does not agree to do this the licensee may disclose the information in a manner that does not identify the patient.

C. This section does not impose a duty to disclose information. A licensee is not subject to civil or criminal liability for either disclosing or not disclosing information.

D. If a licensee decides to make a disclosure pursuant to this section the licensee may request the department of health services to make the disclosure on the licensee's behalf.

E. For the purposes of this section, "significant exposure" means contact of a person's ruptured or broken skin or mucous membranes with another person's blood or body fluid, other than tears, saliva or perspiration, of a magnitude that the centers for disease control of the United States public health service have epidemiologically demonstrated can result in the transmission of the human immunodeficiency virus.

32-2557. Disciplinary action; reciprocity

A. The board shall initiate an investigation pursuant to section 32-2551 if a professional regulatory board in another jurisdiction in the United States has taken disciplinary action against a licensee for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter.

B. The board shall order the summary suspension of a license pending proceedings for revocation or other action if a professional regulatory board in another jurisdiction in the United States has taken the same action because of its belief that the public health, safety or welfare imperatively required emergency action.

32-2558. Reinstatement of revoked or surrendered license

A. On written application, the board may issue a new license to a physician assistant whose license was previously revoked by the board or surrendered if the applicant demonstrates to the board's satisfaction that the applicant is completely rehabilitated with respect to the conduct that was the basis for the revocation or surrender. In making its decision, the board shall determine:

1. That the applicant has not engaged in any conduct during the revocation or surrender period that would have constituted a basis for revocation or surrender pursuant to section 32-2551.

2. If a criminal conviction was a basis of the revocation or surrender, that the applicant's civil rights have been fully restored pursuant to statute or any other applicable recognized judicial or gubernatorial order.

3. That the applicant has made restitution to any aggrieved person as ordered by a court of competent jurisdiction.

4. That the applicant demonstrates any other standard of rehabilitation the board determines is

appropriate.

B. Except as provided in subsection C of this section, a person shall not submit an application for reinstatement less than two years after the date of revocation or surrender.

C. The board shall vacate its previous order to revoke or accept the surrender of a license if that revocation or surrender was based on a conviction of a felony or an offense involving moral turpitude and that conviction has been reversed on appeal. The physician assistant may submit an application for reinstatement as soon as the court enters the reversal.

D. An applicant for reinstatement shall comply with all initial licensing requirements prescribed by this chapter.

**DEPARTMENT OF REVENUE**
Title 15, Chapter 12, Articles 1-3

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** June 3, 2025, July 1, 2025

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** May 20, 2025, June 17, 2025

**SUBJECT:** **DEPARTMENT OF REVENUE**
Title 15, Chapter 12 Articles 1-3

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**Staff Update**

As a reminder, this Five-Year Review Report from the Department of Revenue was tabled at the June 3, 2025 Council meeting in order for the Department to determine a proposed course of action timeline. Any supplemental information received will be forward to the Council Members.

**Summary**

This Five-Year Review Report (5YRR) from the Arizona Department Revenue ("Department") covers twenty-four (24) rules in Title 15, Chapter 12, Articles 1-3 relating to the Property Tax Oversight Commission. Article 1 covers general provisions, Article 2 covers property tax levy limits, and Article 3 covers hearing and appeal procedures. The purposes of the Property Tax Oversight Commission is to: (1) further the public confidence in property tax limitations; (2) provide a uniform methodology for determining those limitations; and (3) provide a continuing review of practices for ensuring a fair and equitable administration of the property tax laws.

The Department has not completed the proposed course of action from both their previous three reports approved by the Council in July 2010, July 2015 and February 2020, respectively.

In the 2010 report, the Department proposed to amend 14 rules but this was not completed because the Department did not qualify for an exemption to the executive order concerning the Rulemaking Moratorium. In the 2015 report, the Department proposed to amend 14 rules but did not provide a timeline because of active litigation. In the 2020 report, the Department indicated that they did not complete this proposed course of action from the 2015 report because the Department was named as a defendant to a lawsuit on June 8, 2015. In the 2020 report, the Department indicated this lawsuit was resolved and the Department intended on completing a rulemaking by September 1, 2020.

In this 5YRR now before the Council, the Department has indicated that the course of action from the 2020 report was not completed as a result of litigation started in June 2024. The Department stated that they do not want to make any substantive changes to the rules prior to final adjudication in that matter, which concerns the calculation of levy limits.

**Proposed Action**

The Department indicates that they still intend on amending the 14 rules identified in the previous reports. The amendments are necessary to incorporate 2009 statutory changes and to update the rules to conform to modern rulewriting standards. Given the on-going litigation, the Department has not proposed any timeline for when they intend on completing a rulemaking.

1. **Has the agency analyzed whether the rules are authorized by statute?**

   The Department cites both general and specific statutory authority for these rules.

2. **Summary of the agency's economic impact comparison and identification of stakeholders:**

   The Property Tax Oversight Commission was created by Laws 1987, Ch, 204. The Department indicates that the original economic impact statement estimated that the Department of Revenue, Property Tax Oversight Commission, the Attorney General's Office and political subdivisions would all experience cost savings due to the standardization of the Property Tax Oversight Commission's practices and procedures. The Department believes that the economic impacts projected in the original adoptions of the rules and in the subsequent amendments in 1997, 2000, and 2006 are generally accurate. However, the Department believes that one aspect that may generate costs that outweigh benefits is in the engagement of the Commission members and staff as well as a political subdivision, special taxing district or fire district that disputes the Commission's findings in a rehearing process that is unnecessary prior to the petitioner's appeal of the matter to tax court.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department states that after analysis, the probable benefits of the rules outweigh the probable costs and the rules impose the least burden and costs to persons regulated by them, including paperwork and other costs necessary to achieve the underlying regulatory objective.

4. **Has the agency received any written criticisms of the rules over the last five years?**

The Department indicates it received no written criticisms of the rules in the last five years.

5. **Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rules are mostly clear, concise, and understandable but that the following 7 rules need to be amended to conform with modern rulewriting standards, such as improving terminology and removing passive voice.

- R15-12-201
- R15-12-301
- R15-12-302
- R15-12-303
- R15-12-304
- R15-12-306
- R15-12-312

6. **Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rules are generally consistent with other rules and statutes, with the exception of the following. The following rules are not compliant with the statutes that govern the Property Tax Oversight Commission because of laws 2009, Ch 118 which included fire districts.

- R15-12-106
- R15-12-201
- R15-12-203
- R15-12-204
- R15-12-205
- R15-12-301
- R15-12-302
- R15-12-303
- R15-12-305
- R15-12-306
- R15-12-308
- R15-12-311

- R15-12-312

7. **Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rules are effective in achieving their objectives with the exception of R15-12-312. The Department indicates that the current rehearing process could result in repetitive or unnecessary actions prior to the ability to take the matter to tax court.

8. **Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rules are enforced as written outside of those listed that are not compliant with statute, in which the statutes would govern.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates there are no corresponding federal laws.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department has indicated that the rules do not require a permit or a license.

11. **Conclusion**

This Five-Year Review Report (5YRR) from the Arizona Department Revenue ("Department") covers twenty-four (24) rules in Title 15, Chapter 12, Articles 1-3 relating to the Property Tax Oversight Commission. The Department has not completed their previous courses of action from the Department's last three 5YRR as a result of litigation. The Department is proposing to amend 14 rules but have not identified a timeframe for when they expect to complete the rulemaking, as a result of litigation filed in 2024.

The Department has not provided a course of action with a date and year in accordance with R1-6-301. Council staff recommends the Council ask the Department to clarify when the Department intends to complete a rulemaking.

**DEPARTMENT OF REVENUE**

**5 YEAR REVIEW REPORT**

**A.A.C. Title 15 Revenue**

**Chapter 12 Department of Revenue**

**Property Tax Oversight Commission**

**Articles 1, 2, and 3**

**December 31, 2024**

## 1. Authorization of the rule by existing statutes

All of the rules are generally authorized by A.R.S. § 42-1005, which provides that the Director ("Director") of the Department of Revenue ("Department") may make administrative rules as he deems necessary and proper to effectively administer the Department and enforce Arizona Revised Statutes ("A.R.S.") Title 42 and Title 43. Additionally, A.R.S § 42-17002(A) establishes the Property Tax Oversight Commission ("Commission") to: (1) further the public confidence in property tax limitations; (2) provide a uniform methodology for determining those limitations; and (3) provide a continuing review of practices for ensuring a fair and equitable administration of the property tax laws. A.R.S. § 42-17002(B) states that the Director or the Director's designee is to serve as chairman of the Commission and A.R.S. § 42-17002(D) states that the Department shall provide secretarial and staff support services to the Commission. The Commission is required "to make rules of practice setting forth the nature and requirements of "those hearing procedures. A.R.S. §41-1003.

**Specific Authorization for the Rules:**

1. A.R.S. §§ 42-17001 through 42-17003 are the specific statutes upon which the following rules are based:

   R15-12-101. Definitions

   R15-12-102. Principal Office of the Property Tax Oversight Commission

   R15-12-103. Quorum

   R15-12-104. Hearings

R15-12-104. Voting

R15-12-106. Decisions

R15-12.107. Copying and Recording Costs

2. A.R.S. §§ 42-17003 and 42-17051 are the specific statutes upon which the following rules are based:

R15-12-201. Primary Property Tax Calculations

R15-12-202. Involuntary Tort Judgments

3. A.R.S. §§ 42-17003 and 42-17054 are the specific statutes upon which the following rules are based:

R15-12-203. Primary Property Tax Calculations

R15-12-204. Involuntary Tort Judgments

R15-12-205. Actual Levies

4. A.R.S. §§ 42-17002 and 42-17004 are specific statutes upon which the following rules are based:

R15-12-301. Notice of Violation

R15-12-302. Petition

R15-12-303. Grounds for Petition

R15-12-304. Manner of Filing

R15-12-305. Supplementing the Petition

R15-12-306. Withdrawal of Petition

R15-12-307. Rescheduling of Hearing

R15-12-308. Evidence

R15-12-309 Subpoena

R15-12-310. Post Hearing Memoranda

R15-12-311. Prehearing Issue Resolution

R15-12.312. Rehearing

**2. <u>The objective of each rule</u>:**

| Rule | Objective |
|---|---|
| **R15-12-101** | *Definitions:*<br>The objective of this rule is to define words and phrases used throughout the chapter. |
| **R15-12-102** | *Principal Office of the Property Tax Oversight Commission:*<br>The objective of this rule is to provide the location of the principal office of the Property Tax Oversight Commission and where inquiries, correspondence, and filings are to be sent and the meeting and hearing are to be held. |
| **R15-12-103** | *Quorum*:<br>The objective of this rule is to require a quorum of the Commission to make orders and decisions and conduct official business. |
| **R15-12-104** | *Hearings:*<br>The objective of this rule is to provide that a quorum of the Commission shall directly conduct all hearings before the Commission regarding contested cases. Under A.R.S. §41-1092.02(F), a commission that directly conducts an administrative hearing is not required to use the services of the Office of Administrative Hearings. |
| **R15-12-105** | *Voting*:<br>The objective of this rule is to provide when Commission members may vote and allows dissenting members to state the reason for their dissent. |
| **R15-12-106** | *Decisions*:<br>The objective of this rule is to explain when Commission decisions are rendered and to whom these decisions must be sent. |

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| **R15-12-107** | *Copying and Recording Costs*:<br>The objective of this rule is to provide who will bear the costs of copying and the costs of employing a court reporter. |
| **R15-12-201** | *Primary Property Tax Calculations*:<br>The objective of this rule is to expound on the proper calculations for determining the maximum allowable primary property tax levy limit and the allowable primary property tax rate. |
| **R15-12-202** | *Involuntary Tort Judgments*:<br>The objective of this rule is to provide when the Commission shall recognize an involuntary tort judgment paid by a political subdivision and what the political subdivision may do with the involuntary tort judgment. |
| **R15-12-203** | *Levy Limit Worksheets*:<br>The objective of this rule is to provide when and to whom the counties should submit a copy of the final levy limit worksheets. The rule also provides that the County Assessor must certify the copies as true and correct. |
| **R15-12-204** | *Political Subdivision Agreement*:<br>The objective of this rule is to provide the procedure and deadlines for a political subdivision to disagree with the county's levy limit worksheet calculations. The rule also provides that the Commission may allow additional time to present objections to specific items if good cause is shown or on motion by the Commission. |
| **R15-12-205** | *Actual Levies*:<br>The objective of this rule is to require the chief county fiscal officers in each county to certify and submit to the Commission the actual amount of primary property tax levied by each political subdivision in their counties within a certain time frame. |
| **R15-12-301** | *Notice of Violation*:<br>The objective of this rule is to provide what kind of information must be contained on a notice of violation issued by the Commission |
| **R15-12-302** | *Petition*:<br>The objective of this rule is to provide that all objections to the notice of violation must be made by way of a written petition to the Commission. The rule further explains the |

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| | proper form of the petition and what information it must contain. |
| **R15-12-303** | *Grounds for Petition*:<br>The objective of this rule is to require that objections to notices of violations be limited to factual findings and conclusions of law reached by the Commission |
| **R15-12-304** | *Manner of Filing*:<br>The objective of this rule is to provide the manner for filing the petition. The rule specifies the number of copies of the petition that must be filed, that the Commission shall record the petition and supporting memorandum, and that no fee shall be charged for filing. |
| **R15-12-305** | *Supplementing the Petition*:<br>The objective of this rule is to provide that the Commission may allow additional time, not to exceed 15 days, to supplement the petition |
| **R15-12-306** | *Withdrawal of Petition*:<br>The object of this rule is to provide the procedure for withdrawal of a petition and the result of such a withdrawal. |
| **R15-12-307** | *Rescheduling of Hearing*:<br>The objective of this rule is to allow the Commission to postpone or recess a hearing upon a showing of good cause. The Commission must then state the date, time, and place for the hearing to continue. |
| **R15-12-308** | *Evidence*:<br>The objective of this rule is to describe the kinds of evidence that may be presented at a hearing before the Commission. The rule also provides guidance for admitting evidence and hearing oral evidence. |
| **R15-12-309** | *Subpoena*:<br>The objective of this rule is to allow the Commission to issue subpoenas upon request of a party or its own initiative. |
| **R15-12-310** | *Post-Hearing Memoranda*:<br>The objective of this rule is to provide information concerning the submission of post-hearing memoranda. |
| **R15-12-311** | *Prehearing Issue Resolution*:<br>The objective of this rule is to explain the treatment of any agreement or resolution of issues prior to hearing between |

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| | the Commission and a political subdivision. |
| **R15-12-312** | *Rehearing*:<br>The objective of this rule is to provide a rehearing process and the circumstances under which a rehearing may be granted. The rules also provide the proper time frame for the Commission to grant or order a rehearing. |

**3. <u>Are the rules effective in achieving their objectives</u>? Yes _<u>X</u>_ No ____**

| Rule | Explanation |
|---|---|
| **R15-12-312** | *Rehearing*:<br>The Department believes the rehearing process and the circumstances under which a rehearing is necessary may create scenarios in which both the Commission and petitioner are engaged in repetitive or unnecessary actions before the petitioner is able to appeal the matter to the tax court. |

**4. <u>Are the rules consistent with other rules and statutes</u>? Yes ___ No _<u>X</u>_**

The following rules identified below are not consistent with other rules and statutes as written.

| Rule | Explanation |
|---|---|
| **R15-12-106** | *Decisions*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-201** | *Primary Property Tax Calculations*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-203** | *Levy Limit Worksheets*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include |

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| | fire districts. |
| **R15-12-204** | *Political Subdivision Agreement*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-205** | *Actual Levies*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-301** | *Notice of Violation*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-302** | *Petition*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-303** | *Grounds for Petition*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-305** | *Supplementing the Petition*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-306** | *Withdrawal of Petition*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-308** | *Evidence*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include |

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|---|---|
| | fire districts. |
| **R15-12-311** | *Prehearing Issue Resolution*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |
| **R15-12-312** | *Rehearing*:<br>The Department proposes to amend this rule to comply with the Secretary of State's guidelines and to reflect statutory changes made by Laws 2009, Ch. 118 to include fire districts. |

**5. <u>Are the rules enforced as written</u>? Yes _X_ No ___**

**6. <u>Are the rules clear, concise, and understandable</u>? Yes ___ No _X_**

| Rule | Explanation |
|---|---|
| **R15-12-201** | *Primary Property Tax Calculations*:<br>This rule contains language that does not conform to existing rulewriting standards. |
| **R15-12-301** | *Notice of Violation*:<br>This rule contains language that does not conform to existing rulewriting standards. |
| **R15-12-302** | *Petition*:<br>This rule contains language that does not conform to existing rulewriting standards. |
| **R15-12-303** | *Grounds for Petition*:<br>This rule contains language that does not conform to existing rulewriting standards. |
| **R15-12-304** | *Manner of Filing*:<br>This rule contains language that does not conform to existing rulewriting standards. |
| **R15-12-306** | *Withdrawal of Petition*:<br>This rule contains language that does not conform to existing rulewriting standards. |
| **R15-12-312** | *Rehearing*:<br>This rule contains language that does not conform to existing rulewriting standards. |

**7. <u>Has the agency received written criticisms of the rules within the last five years</u>? Yes___ No __<u>X</u>_**

**8. <u>Economic, small business, and consumer impact comparison</u>:**

All of the rules in this chapter with the exception of R15-12-104 were adopted in one package in 1990. R15-12-104 was added in 1997 to replace the old R15-12-104 that was repealed. In addition, ten of the rules in this chapter were amended in 1997. Two more rules were amended in 2000. And, finally, two rules were amended in 2006.

The Property Tax Oversight Commission was created by Laws 1987, Ch. 204. Prior to the original adoption of these rules in 1990, the Property Tax Oversight Commission did not have any rules. Therefore, the original economic impact statement estimated that the Department of Revenue, Property Tax Oversight Commission, the Attorney General's Office and the political subdivisions would all experience cost savings due to the standardization of the Property Tax Oversight Commission's practices and procedures. A cost savings was also expected because of the streamlining and increased definitiveness of the contested issues and facts required by the rules. In addition, by placing the responsibility for arranging for special services on the party that makes the request, the burden on Department of Revenue clerical support is reduced, thereby reducing the costs to the Department and possibly increasing the costs of the political subdivision that makes the special request. These amounts could not be quantified. The Department also estimated minimal costs associated with the publishing of the rules and the public hearing process. Political subdivisions, other state agencies and the public would incur costs in obtaining copies of the rules.

On October 7, 1997, the Governor's Regulatory Review Council approved the amendment of R15-12-105, R15-12-202, R15-12-203, R15-12-305, and R15-12-307 through R15-12-312. In addition, a new R15-12-104 was added to replace the old R15-12-104 that was repealed. The economic impact statement estimated decreased costs from increased clarity of the rules to operate the Commission. This would eliminate the need to provide individual instruction to each representative of the 72 political subdivisions governed by the Commission. The Department of Revenue would decrease costs by not having to provide a hearing officer to the Commission. The Commission would save by not having to pay the Office of Administrative Hearings to administer the hearings. The only increased costs were the result of the rulemaking process and were estimated to be minimal. "Minimal" is defined as an impact of less than $1,000 in costs.

On October 4, 2000, the Department amended R15-12-101 and R15-12-103. The economic impact statement expected that the benefits of the rules would be greater than the costs. The amendment of these rules would benefit the political subdivisions that deal with the Property Tax Oversight Commission and the public by making the rules more accurate as well as clearer and easier to understand. The Department would incur the costs associated with the

rulemaking process. The political subdivisions and the public were not expected to incur any expense in the amendment of these rules other than the cost of obtaining copies.

On May 13, 2006, the Department amended R15-12-101 and R15-12-204. The economic impact statement expected minimal costs in amending the rules to conform to current rule writing standards and statutory changes. The Department and the Commission expected to benefit from time saved by customer service and taxpayer assistance personnel in answering questions from the political subdivisions on issues that are addressed by each rule. The political subdivisions would experience cost savings due to the increased clarity and correctness of the rules. The public was not expected to incur any expense in the amendment of these rules other than the cost of obtaining copies.

The Department of Revenue believes that the economic impacts projected in the original adoption of the rules and in the subsequent amendments in 1997, 2000 and 2006 are generally accurate. However, the Department believes that one aspect that may generate costs that outweigh benefits is in the engagement of the Commission members and staff as well as a political subdivision, special taxing district or fire district that disputes the Commission's findings in a rehearing process that is unnecessary prior to the petitioner's appeal of the matter to tax court.

**9. Has the agency received any business competitiveness analyses of the rules?**

No analysis regarding the property tax commission rules' impact on business competitiveness in this state compared with the impact on businesses in other states has been submitted to the Department within the last five years.

**10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

The 2019 five-year report stated that the Department would amend thirteen (13) rules. However, since June 2024, the Commission was named in a lawsuit, *Coconino Community College v. Property Tax Oversight Commission* (No. TX2024-000143), in regards to the interpretation of the language in the Arizona Constitution Art. IX, § 19 and A.R.S. §§ 42-17051 and 17056 and how those statutes relate to the calculation of the levy limits by the Commission. Accordingly, the Department has held off on making any substantive changes to the rules, pending a final adjudication of the court case.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

After analysis, the probable benefits of the rules outweigh the probable costs and the rules impose the least burden and costs to persons regulated by them, including paperwork and other costs necessary to achieve the underlying regulatory objective.

**12. Are the rules more stringent than corresponding federal laws? Yes __ No __X_**

There are no corresponding federal laws. The rules are based on state law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

None of the rules were adopted after July 29, 2010 and none of the rules being reviewed require the issuance of a regulatory permit, license or agency authorization.

**14. Proposed course of action**

The 2019 five-year report stated that the Department would amend thirteen (13) rules. However, since June 2024, the Commission was named in a lawsuit, *Coconino Community College v. Property Tax Oversight Commission* (No. TX2024-000143), in regards to the interpretation of the language in the Arizona Constitution Art. IX, § 19 and A.R.S. §§ 42-17051 and 17056 and how those statutes relate to the calculation of the levy limits by the Commission. While the Department has not prioritized making substantive changes to the rules pending final adjudication of the court case, it may do so if it becomes apparent that the rulemaking will neither create confusion for the public nor adversely impact the case.

At that time the Department would include the following rules:

| Rule | Explanation |
|---|---|
| **R15-12-106** | *Decisions* |
| **R15-12-201** | *Primary Property Tax Calculations* |
| **R15-12-203** | *Levy Limit Worksheets* |
| **R15-12-204** | *Political Subdivision Agreement* |

| | |
|---|---|
| **R15-12-205** | *Actual Levies* |
| **R15-12-301** | *Notice of Violation* |
| **R15-12-302** | *Petition* |
| **R15-12-303** | *Grounds for Petition* |
| **R15-12-304** | *Manner of Filing* |
| **R15-12-305** | *Supplementing the Petition* |
| **R15-12-306** | *Withdrawal of Petition* |
| **R15-12-308** | *Evidence* |
| **R15-12-311** | *Prehearing Issue Resolution* |
| **R15-12-312** | *Rehearing* |

# TITLE 15. REVENUE

## CHAPTER 12. DEPARTMENT OF REVENUE
## PROPERTY TAX OVERSIGHT COMMISSION

### ARTICLE 1. GENERAL PROVISIONS

Section


### ARTICLE 2. PROPERTY TAX LEVY LIMITS

Section


### ARTICLE 3. HEARING AND APPEAL PROCEDURE

Section


### ARTICLE 1. GENERAL PROVISIONS

**R15-12-101. Definitions**

Unless the context requires otherwise, the following definitions shall apply:

1. "Excess collections" means the amount collected during the previous fiscal year in excess of the previous fiscal year's maximum allowable primary property tax levy.
2. "Excess expenditures" means the amount under A.R.S. § 42-17051(C) that is certified by the Auditor General's office.
3. "Quorum" means a majority of the members of the Commission.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended by final rulemaking at 6 A.A.R. 4114, effective October 4, 2000 (Supp. 00-4). Amended by final rulemaking at 12 A.A.R. 1096, effective May 13, 2006 (Supp. 06-1).

**R15-12-102. Principal Office of the Property Tax Oversight Commission**

The principal office of the Property Tax Oversight Commission shall be the Department of Revenue Building, 1600 West Monroe, Phoenix, Arizona 85007. All inquiries, correspondence, and filings shall be delivered to the Property Tax Oversight Commission at this location. All meetings and hearings shall be held at this location unless designated in writing by the Commission.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-103. Quorum**

The Commission shall have a quorum for making orders and decisions or transacting other official business, as delineated in A.R.S. § 42-17003.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended by final rulemaking at 6 A.A.R. 4114, effective October 4, 2000 (Supp. 00-4).

**R15-12-104. Hearings**

A quorum of the Commission shall directly conduct all hearings regarding contested cases before the Commission.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Section repealed; new Section adopted effective October 10, 1997 (Supp. 97-4).

**R15-12-105. Voting**

A. A Commission member may vote on decisions if:
   1. The member was present at all hearings during which the matter being voted on was discussed;
   2. The member was not present at all hearings but the member reviewed the evidence submitted at the hearings and attended or listened to tape recordings of all hearings during which the matter being voted on was discussed; or
   3. The parties submitted the matter for a decision based on a joint stipulation of facts.

B. Any member who dissents may state the reasons for the member's dissent.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Section amended effective October 10, 1997 (Supp. 97-4).

**R15-12-106. Decisions**

A. A Commission decision is rendered when signed by the Chairman.

B. Decisions of the Commission shall be sent to the affected political subdivision and the affected County Board of Supervisors.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-107. Copying and Recording Costs**

A. The costs of copying shall be paid by the person making the request.

B. Court reporting arrangements and costs shall be the responsibility of the person employing the court reporter.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3).

## ARTICLE 2. PROPERTY TAX LEVY LIMITS

**R15-12-201. Primary Property Tax Calculations**

A. The Commission shall calculate the maximum allowable primary property tax levy limits for political subdivisions as follows:
   1. The maximum allowable primary property tax rate shall equal the resulting value of the following rounded to four decimal places:
      a. 102% of the sum of the previous fiscal year's maximum primary property tax levy divided by;
      b. the sum of the values provided by the County Assessor's office and the Department for the current year's value of the previous year's centrally assessed, locally assessed real, locally assessed secured personal, and locally assessed unsecured personal property, divided by 100.
   2. The maximum allowable primary property tax levy limit shall equal the sum of the current value of the current year's property as provided by the County Assessor and the Department including centrally assessed, locally real, locally assessed secured personal, and locally assessed unsecured personal property, divided by 100 and multiplied by the maximum allowable primary property tax rate.
   3. Political subdivisions may request that a specific alternative methodology be considered by the Commission. If the Commission determines the alternative methodology will more accurately calculate the levy limit of the political subdivision, such alternative methodology shall be used.

B. The Commission shall calculate the allowable primary property tax levy limit by reducing the maximum allowable primary property tax levy limit by the sum of the amount of excess levies, excess collections and excess expenditures.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-202. Involuntary Tort Judgments**

A. A political subdivision that paid an involuntary tort judgment may only use the judgment to:
   1. Offset excess collections from the previous fiscal year; or
   2. Justify a primary property tax levy limit being set above the maximum allowable rate in the current fiscal year.

B. The Commission shall recognize an involuntary tort judgment if:
   1. The judgment is pursuant to a court order or settlement agreement;
   2. The judgment is approved for payment by the political subdivision's governing board;
   3. The Attorney General certifies that the judgment is an involuntary tort judgment; and
   4. The political subdivision submits copies of the court order or settlement agreement and the minutes of the governing board's pay approval to the Commission on or before the 1st Monday of July.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Spelling of the word "tort" in subsection (A) corrected (Supp. 94-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-203. Levy Limit Worksheets**

A. The counties shall simultaneously submit copies of the final levy limit worksheets for all political subdivisions in their respective counties to the Commission and the affected political subdivision. The County Assessor shall verify that the copies are true and correct and, if so, certify the copies.

B. The counties shall deliver the worksheets to affected political subdivisions and the Commission on or before the 2nd Monday of August.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-204. Political Subdivision Agreement**

A. If a political subdivision disagrees with the county's final levy limit worksheet calculations, the political subdivision shall, within 10 days of receipt of the county's calculations, file in writing with the Commission a statement of disagreement and the figures it deems appropriate. Failure to act within the 10 days shall be deemed agreement by the political subdivision.

B. Upon timely petition of the political subdivision for good cause shown, or on its own motion, the Commission may permit the political subdivision to present objections to specific items at a later date.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended by final rulemaking at 12 A.A.R. 1096, effective May 13, 2006 (Supp. 06-1).

**R15-12-205. Actual Levies**

The chief county fiscal officers shall certify and submit to the Commission the amount of the primary property tax levied for each political subdivision within their counties within three days after each levy is determined.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3).

## ARTICLE 3. HEARING AND APPEAL PROCEDURE

**R15-12-301. Notice of Violation**

The notice of violation shall specify the violations found and the monetary amount in dispute. The notice shall inform the political subdivision of the right to petition on or before October 1 for a hearing on the Commission's finding of violation.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-302. Petition**

A. All objections to the Commission's notice of violation shall be by written petition to the Commission. The petition shall include the following information:
   1. Name, title, address, and phone number of the political subdivision's contact person;
   2. A particularized statement of the errors allegedly committed by the Commission in its findings;
   3. A statement of facts upon which the political subdivision relies to support the assignment of errors alleged to have been committed by the Commission;
   4. The relief sought; and
   5. Whether an oral hearing is requested.

B. The petition shall be addressed to the Chairman of the Commission.

C. The petition shall be in a form that can readily be duplicated on standard office equipment.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-303. Grounds for Petition**
A. Objections to notices of violation shall be limited to disputing the factual findings and conclusions of law of the Commission.
B. The Commission shall refuse all petitions not based on a dispute of its factual findings or conclusions of law. Financial impacts on the political subdivision shall not be considered by the Commission in its decision-making.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-304. Manner of Filing**
A. An original and six copies of the petition and any supporting memoranda shall be filed with the Chairman.
B. No fee shall be charged for the filing of any petition or supporting memoranda.
C. Upon receipt of a petition, the Commission staff shall record the filing of the petition and supporting memoranda.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-305. Supplementing the Petition**
The Commission may grant a political subdivision's request for an additional period of time, not to exceed 15 days, within which to supplement a timely filed petition. The Commission shall not consider a supplement to the petition that the political subdivision files after the additional period of time granted.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-306. Withdrawal of Petition**
A. The petition may be withdrawn at the written request of the political subdivision before a final decision by the Commission is issued.
B. When the petition is withdrawn, the Commission's finding shall be deemed final and shall not be subject to any further appeal.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-307. Rescheduling of Hearing**
The Commission may postpone or recess the hearing for good cause shown. The Commission shall specify the date, time, and place for the hearing to continue.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3).

**R15-12-308. Evidence**
A. The political subdivision and the Commission may:
1. Call and examine witnesses,
2. Introduce exhibits,
3. Cross-examine opposing witnesses on any matter relevant to the issues, even though the matter was not covered in the direct examination,
4. Impeach any witness regardless of which party first called the witness to testify,
5. Rebut the evidence against it, and
6. Call and examine as if under cross-examination a party or its employees, agents, or officers.
B. The Commission shall be liberal in admitting evidence, but the Commission shall consider objections to the admission of and comments on the weakness of evidence in assigning weight to the evidence.
C. The Commission shall take oral evidence only on oath or affirmation.
D. Legible copies may be admitted into evidence or substituted in place of the original documents.
E. The original records and files of the Commission or the Department of Revenue shall not be removed from their offices for use as evidence or for other purposes.
F. The Commission may take official notice of the records maintained by the Department of Revenue.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-309. Subpoena**
The Commission may, on request of a party or on its own initiative, issue subpoenas.

**Historical Note**
Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-310. Post-Hearing Memoranda**

If the Commission desires the submission of post-hearing memoranda or information, the Commission shall, at the time of the hearing, direct the parties to submit the post-hearing memoranda or information within a period of time set by the Commission.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-311. Prehearing Issue Resolution**

If the Commission and a political subdivision agree as to the resolution of some or all of the issues prior to the hearing, the Commission shall stipulate to the agreed issues in the record and shall consider those issues withdrawn. The Commission shall then issue an order of partial resolution that becomes part of the Commission's record. The Commission shall forward copies of the order to the political subdivision, County Assessor and the Department of Revenue.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

**R15-12-312. Rehearing**

A. Any party in a contested case before the Commission may file a petition for rehearing or review with the Commission within 30 days after receiving the final decision. The party shall attach a supporting memorandum, specifying the grounds for the petition.

B. The party who filed the petition for rehearing or review may amend it at any time before the Commission rules. Any other party to the original hearing may file a response within 5 days after the Commission's receipt of the petition for rehearing or review. The party shall support the response with a memorandum discussing the legal and factual issues. Either party or the Commission may request oral argument.

C. The Commission may grant a rehearing or review of the decision for any of the following causes that materially affect a party's rights:

1. Irregularity in the administrative proceedings, or any order or abuse of discretion which deprived a party of a fair hearing;
2. Misconduct of the Commission, its staff, or the prevailing party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
5. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceeding; or
6. The decision is not justified by the evidence or is contrary to law.

D. The Commission shall not consider the financial impact to the political subdivision as a cause for rehearing.

E. The Commission may grant a rehearing or review within 15 days after its receipt of the petition for rehearing or review. The Commission may grant a petition for rehearing or review for a reason not stated in the petition. An order modifying a decision or granting a rehearing shall specify the ground or grounds for the order, and any rehearing shall only cover those matters. If the Commission fails to take action on a petition for rehearing or review within 15 days of the Commission's receipt of the petition, the petition shall be deemed denied.

F. The Commission may on its own initiative order a rehearing or review within 15 days after its decision is rendered for any reason set forth in subsection (C) of this rule. The order shall specify the grounds for rehearing or review.

G. The petitioner shall include all affidavits with the petition for rehearing or review when the petition for rehearing is based upon affidavits. An opposing party may, within 5 days after the petition for rehearing or review is filed, submit opposing affidavits. The Commission may extend this period for an additional period of time not to exceed 5 days for good cause shown. Reply affidavits may be permitted.

**Historical Note**

Adopted effective September 14, 1990 (Supp. 90-3). Amended effective October 10, 1997 (Supp. 97-4).

## General and Specific Authorizing Statutes:

42-1005. Powers and duties of director

A. The director shall be directly responsible to the governor for the direction, control and operation of the department and shall:

1. Make such administrative rules as he deems necessary and proper to effectively administer the department and enforce this title and title 43.

2. On or before November 15 of each year issue a written report to the governor and legislature concerning the department's activities during the year. In any election year a copy of this report shall be made available to the governor-elect and to the legislature-elect.

3. On or before December 15 of each year issue a supplemental report which shall also contain proposed legislation recommended by the department for the improvement of the system of taxation in the state.

4. In addition to the report required by paragraph 2 of this subsection, on or before November 15 of each year issue a written report to the governor and legislature detailing the approximate costs in lost revenue for all state tax expenditures in effect at the time of the report. For the purpose of this paragraph, "tax expenditure" means any tax provision in state law which exempts, in whole or in part, any persons, income, goods, services or property from the impact of established taxes including deductions, subtractions, exclusions, exemptions, allowances and credits.

5. Annually, on or before January 10, prepare and submit to the legislature a report containing a summary of all the revisions made to the internal revenue code during the preceding calendar year.

6. Provide such assistance to the governor and the legislature as they may require.

7. Delegate such administrative functions, duties or powers as he deems necessary to carry out the efficient operation of the department.

B. The director may enter into an agreement with the taxing authority of any state which imposes a tax on or measured by income to provide that compensation paid in that state to residents of this state is exempt in that state from liability for income tax, the requirement for filing a tax return and withholding tax from compensation. Compensation paid in this state to residents of that state is reciprocally exempt from the requirements of title 43.

42-17001. Definitions

In this chapter, unless the context otherwise requires:

1. "Commission" means the property tax oversight commission established by section 42-17002.

2. “Fire district” means a fire district established pursuant to title 48, chapter 5.

2. "Political subdivision" means a county, charter county, city, charter city, town, community college district or school district.

42-17002. Property tax oversight commission

A. The property tax oversight commission is established to:

1. Further the public confidence in property tax limitations.

2. Provide a uniform methodology for determining those limitations.

3. Provide a continuing review of practices for ensuring a fair and equitable administration of the property tax laws.

B. The commission consists of:

1. The director of the department of revenue, who serves as chairman.

2. Four persons who are knowledgeable in the area of property tax assessment and levy, one appointed by the governor and three appointed jointly by the president of the senate and the speaker of the house of representatives. The appointive members' terms are three years.

C. An appointment to fill a vacancy on the commission resulting from other than expiration of a term is for the unexpired portion of the term only.

D. The department shall provide secretarial and staff support services to the commission.

E. The private citizen members of the commission shall receive fifty dollars per day for time spent in performing their duties.

F. The commission shall meet at least annually and, in addition, at the call of the chairman. The commission shall meet at such other times and places as convenient or necessary to conduct its affairs and shall render its findings, reports and recommendations in writing to the governor, to the director of the department of revenue and to the legislature.

42-17003. Duties

A. The commission shall:

1. Establish procedures for deriving the information required by sections 15-905.01, 15-1461.01 and 42-17107 and article 2 of this chapter, section 48-254 and paragraph 4 of this subsection.

2. Review the primary property tax levy of each political subdivision to determine violations of sections 15-905.01, 15-1461.01 and 42-17107 and article 2 of this chapter.

3. Beginning in tax year 2017, review the secondary property tax levy of each special taxing district to determine violations of section 48-254.

4. Review the secondary property tax levy of each county, city, town and community college district to identify violations of constitutional and statutory requirements.

5. Review the secondary property tax levy of each fire district to determine violations of section 48-807.

6. Review for accuracy the tax levy and rate as prescribed by section 15-992.

7. Review the reports made by the department concerning valuation accuracy.

8. Hold hearings to determine the adequacy of compliance with articles 2 and 3 of this chapter.

9. Upon the request of a county, city, town or community college district, hold hearings as prescribed in section 42-17004 regarding the calculation of the maximum allowable primary property tax levy limits prescribed in section 42-17051, subsection A.

B. If the commission determines that a political subdivision has violated section 15-905.01, 15-1461.01 or 42-17107 or article 2 of this chapter, that a special taxing district has violated section 48-254, that a fire district has violated section 48-807 or that a school district incorrectly calculated the tax levy and rate as prescribed by section 15-992, on or before September 15 the commission shall notify the political subdivision or district, and the county board of supervisors, in writing, of:

1. The nature of the violation.

2. The necessary adjustment to:

(a) The primary property tax levy and tax rate to comply with section 15-905.01, 15-1461.01 or 42-17107 or article 2 of this chapter.

(b) The secondary property tax levy and tax rate to comply with sections 48-254 and 48-807.

(c) For school districts, the tax levy and rate to comply with section 15-992.

C. If the commission determines that a county, city, town or community college district has levied a secondary property tax in violation of constitutional or statutory law, on or before December 31 the commission shall notify in writing the affected political subdivision, the county board of supervisors, the county attorney and the attorney general of the violation.

42-17004. Hearing and appeals of commission findings

A. If the commission notifies a political subdivision of a violation of section 15-905.01, 15-1461.01 or 42-17107 or article 2 of this chapter, notifies a special taxing district of a violation of section 48-254, notifies a fire district of a violation of section 48-807 or notifies a school district of an incorrect calculation of the tax levy and rate as prescribed by section 15-992, and the political subdivision, special taxing district or fire district disputes the commission's findings, then on or before October 1 the political subdivision, special taxing district or fire district may request a hearing before the commission to attempt to resolve the dispute.

B. A governing body of a county, city, town, community college district, school district or fire district may request a hearing before the commission regarding the calculation of the maximum allowable primary or secondary property tax levy limits prescribed in section 42-17051 or 48-807 or the calculation of the tax levy and rate as prescribed in section 15-992, as applicable. The commission may resolve any disputes.

C. The commission shall conduct the hearing as prescribed in title 41, chapter 6, article 10.

D. If the dispute is resolved at the hearing, the commission shall immediately notify the county board of supervisors of the proper primary or secondary tax levy and tax rate.

E. If a political subdivision, special taxing district or fire district continues to dispute the commission's findings after the hearing under this section, the political subdivision, special taxing district or fire district may:

1. Appeal the matter to tax court within thirty days after the commission renders the decision.

2. Levy primary or secondary property taxes in the amount that the political subdivision, special taxing district or fire district considers to be proper, pending the outcome of the appeal.

42-17005. Adjustments to levy

A. If a governing body of a political subdivision or a fire district receives written notice of a violation of its allowable levy limit or truth in taxation limit under section 42-17003, and has not appealed the commission's decision pursuant to section 42-17004, the governing body shall correct its property tax levy and tax rate to properly reflect the

allowable levy for the current year. The county board of supervisors shall make the necessary adjustments to the political subdivision's or district's property tax levy and tax rate to ensure that the corrected information is contained in the assessment and tax roll that is transmitted to the county treasurer pursuant to section 42-18003. If the governing body receives the notice after it is too late to correct the levy in the current year, the difference between the amount actually levied and the allowable property tax levy shall be set aside in a special fund and used to reduce the property taxes levied in the following year.

B. If, after a hearing under section 42-17004, the commission determines that errors were made in the calculation of the maximum allowable primary property tax levy limit pursuant to section 42-17051, subsection A, the primary property tax levy pursuant to section 15-992 or the secondary property tax levy limit pursuant to section 48-807, the commission shall have five days to notify the governing body of the county, city, town, community college district, school district or fire district of the corrected levy limit. The commission shall also notify the county board of supervisors within five days. The corrected maximum allowable primary property tax levy shall be used in section 42-17051, subsection A, paragraph 1 in determining the following year's levy limit. The corrected maximum allowable secondary property tax levy shall be used in section 48-807 in determining the following year's levy limit.

C. If, after a hearing under section 42-17004, it is impossible for the board of supervisors to correct a property tax levy in the current year, the political subdivision or fire district shall hold the difference between the amount the political subdivision or district actually levied and the allowable property tax levy prescribed by the commission in a separate fund to be used to reduce the property taxes levied by the political subdivision or district in the following year.

D. If the commission discovers that it has made an error in computing the levy limit after September 15, it shall notify the political subdivision's or fire district's governing body about the error. The error shall be corrected as prescribed in subsection A of this section. If the error results in the maximum allowable property tax levy being raised:

1. The corrected maximum allowable primary property tax levy shall be used in section 42-17051, subsection A, paragraph 1 in determining the following year's levy limit.

2. The corrected maximum allowable secondary property tax levy shall be used for the purposes of section 48-807 in determining the following year's levy limit.

E. If, on appeal under section 42-17004, subsection E, the ruling of the court provides for a property tax levy in an amount that is less than the amount levied by the political subdivision or fire district, the political subdivision or district shall hold the difference between the amounts in a separate fund to be used to reduce the property taxes levied by the political subdivision or district in the following year.

42-17051. Limit on county, municipal and community college primary property tax levy

A. In addition to any other limitation that may be imposed, a county, charter county, city, charter city, town or community college district shall not levy primary property taxes in any year in excess of an aggregate amount computed as follows:

1. Determine the maximum allowable primary property tax levy limit for the jurisdiction for the preceding tax year.

2. Multiply the amount determined in paragraph 1 of this subsection by 1.02.

3. Determine the assessed value for the current tax year of all property in the political subdivision that was subject to tax in the preceding tax year.

4. Divide the dollar amount determined in paragraph 3 of this subsection by one hundred and then divide the dollar amount determined in paragraph 2 of this subsection by the resulting quotient. The result, rounded to four decimal places, is the maximum allowable tax rate for the political subdivision.

5. Determine the finally equalized valuation of all property, less exemptions, appearing on the tax roll for the current tax year including an estimate of the personal property tax roll determined pursuant to section 42-17053.

6. Divide the dollar amount determined in paragraph 5 of this subsection by one hundred and then multiply the resulting quotient by the rate determined in paragraph 4 of this subsection. The resulting product is the maximum allowable primary property tax levy limit for the current year for all political subdivisions.

7. The allowable levy of primary property taxes for the current fiscal year for all political subdivisions is the maximum allowable primary property tax levy limit less any amounts required to reduce the levy pursuant to subsections B and C of this section.

B. Any monies that a political subdivision received from primary property taxation in excess of the sum of the amount of taxes collectible pursuant to section 42-15053, subsection G, paragraph 2 and the allowable levy determined under subsection A of this section shall be maintained in a separate fund and used to reduce the primary property tax levy in the following year. Monies that are received and that are attributable to the payment of delinquent taxes that were properly assessed in prior years shall not be applied to reduce the levy in the following year.

C. If, pursuant to section 41-1279.07, the auditor general determines that in any fiscal year a county has exceeded its expenditure limitation, the allowable levy of primary property taxes of the county determined under subsection A of this section shall be reduced in the fiscal year following the auditor general's hearing by the amount of the expenditures that exceeded the county's expenditure limitation.

D. The limitations prescribed by this section do not apply to levies made pursuant to article 5 of this chapter.

E. The levy limitation for a political subdivision is considered to be increased each year to the maximum permissible limit under subsection A of this section regardless of whether the county, city, town or district actually levies taxes in any year up to the maximum permissible amount.

F. For purposes of determining a county's levy limit under this article, remote municipal property, as defined in section 42-15251, is considered to be taxable property in the county.

## 42-17054. Levy limit worksheet

A. When the county assessor transmits valuations under section 42-17052, the assessor shall prepare and transmit a final levy limit worksheet to each city, town and community college district that imposes a primary property tax, to each fire district that imposes a secondary property tax and to the property tax oversight commission.

B. Each city, town, community college district and fire district shall notify the property tax oversight commission in writing within ten days of its agreement or disagreement with the final levy limit worksheet.

# STATE OF ARIZONA

*Department of Revenue*

*Katie Hobbs*
**Governor**

*Robert Woods*
**Director**

December 31 , 2024

*Via e-mail:* grrc@azdoa.gov

Ms. Jessica Klein, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Department of Revenue, Title 15 Revenue, Chapter 12 Department of Revenue, Property Tax Oversight Commission, Five Year Review Report

Dear Ms. Klein:

Please find enclosed the Five-Year Review Report of the Department of Revenue for Title 15 Revenue, Chapter 12 Department of Revenue, Property Tax oversight Commission, which is due on December 31, 2024.

The Department of Revenue hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Ranjana Burke or Rburke@azdor.gov.

Sincerely,

Hsin Pai (Dec 30, 2024 17:31 MST)

Hsin Pai
General Counsel

**DEPARTMENT OF CHILD SAFETY**
Title 21, Chapter 5, Article 1

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 9, 2025

**SUBJECT:** **DEPARTMENT OF CHILD SAFETY**
Title 21, Chapter 5, Article 1

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**Summary**

This Five-Year Review Report (5YRR) from the Department of Child Safety (Department) relates to seven (7) rules in Title 21, Chapter 5, Article 1 regarding Interstate Compact on the Placement of Children. Specifically, these rules cover the Interstate Compact on the Placement of Children (ICPC). ICPC is a contract between and among the 50 states, District of Columbia, and the Virgin Islands, which provides standard national procedures to ensure suitable placement and supervision for children placed across state lines. Additionally, ICPC ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement.

In the prior 5YRR for these rules, which was approved by the Council in May 2025, the Department indicated the rules were clear, concise, understandable, consistent, effective, and enforced as written. As such, the Department did not propose to take any action regarding these rules.

**Proposed Action**

In the current report, the Department does not propose to take any action regarding the rules.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

The rules in Title 21, Chapter 5, Article 1 cover the Interstate Compact on the Placement of Children (ICPC). The ICPC is a contract between and among the 50 states, District of Columbia, and the Virgin Islands, which provides standard national procedures to ensure suitable placement and supervision for children placed across state lines. Additionally, ICPC ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement. Any costs related to the implementation of these rules are associated with running and monitoring the operations of the program, and the Department—as a result of this five-year review—does not plan any rulemaking activity for these rules.

There are four full-time employees in the ICPC Office. This includes the ICPC Administrator and three ICPC Coordinators. In addition, the Department of Child Safety has two statewide contracts in place with two agencies to conduct home studies and provide supervision for children placed in Arizona from another state.

Funding for Arizona's ICPC Program is approximately $6.4 million annually. The funding source is both state General Fund and Federal funds. There are no fees charged between Compact States. However, there is an annual fee to the state of Arizona of $2,000 to participate in the national ICPC and an additional $25,000 to participate with the national electronic system known as the "National Electronic Interstate Compact Enterprise (NEICE)." This electronic system allows for a quick and secure exchange of data and documents between states.

Stakeholders are identified as children in out-of-home care, adoptive children, children requiring placement in a residential treatment facility, the Department, and other compact states.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes that the current rules pose the minimum cost and burden to the persons regulated by these rules. It is the Department's belief that any costs associated with the rules are offset by the greater benefit of partnering with other states in the placement of children outside their state's jurisdiction and ensuring the children's safety and protection.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Department indicates it has not received any written criticisms of the rule in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rule is clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rule is consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rule is effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rule is currently enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates the following federal laws correspond to the rules:

- 42 U.S.C. 622
- 42 U.S.C. 671
- 42 U.S.C. 675
- 42 U.S.C. 5113

The Department indicates the rules in this Article are not more stringent than these corresponding federal laws.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates the rules do not request the issuance of a permit, license, or agency authorization. As such, A.R.S. § 41-1037 does not apply.

**11. Conclusion**

This 5YRR from the Department relates to seven (7) rules in Title 21, Chapter 5, Article 1 regarding Interstate Compact on the Placement of Children. The ICPC is a contract between and among the 50 states, District of Columbia, and the Virgin Islands, which provides standard national procedures to ensure suitable placement and supervision for children placed across state lines. Additionally, ICPC ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement. The Department indicates the rules are clear, concise, understandable, consistent, effective, and enforced as written. As such, the Department does not propose to take any action regarding these rules.

Council staff recommends approval of this report.

ARIZONA DEPARTMENT OF CHILD SAFETY

Kathryn Ptak, Director
Katie Hobbs, Governor

February 25, 2025

VIA EMAIL: grrc@azdoa.gov
Jessica Klein, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Arizona Department of Child Safety, A.A.C. Title 21, Chapter 5, Article 1 Five-Year-Review Report

Dear Chairperson Klein:

Please find enclosed the updated Five-Year-Review Report of the Arizona Department of Child Safety (DCS) for A.A.C. Title 21, Chapter 5, Article 1 due on February 28, 2025.

DCS hereby certifies compliance with A.R.S. § 41-1091.

For questions about this report, please contact Karen Wouters at Karen.Wouters@azdcs.gov.

Sincerely,

Kathryn Ptak
Director

Enclosure


P.O. Box 6030 ♦ Site Code C010-23 ♦ Phoenix, AZ 85005-6030
Telephone (602) 255-2500

**ARIZONA DEPARTMENT OF CHILD SAFETY**

**Five-Year-Review Report**

**Title 21. Child Safety**

**Chapter 5. Department of Child Safety - Permanency and Support services**

**Article 1. Interstate Compact on the Placement of Children**

**February 2025**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 8-453(A)(5)

Specific Statutory Authority: A.R.S. §§ 8-548 through 8-548.06, and A.R.S. § 8-453 (A)(9)(a)

**2. The objective of each rule:**

| Rule | Objective |
|---|---|
| R21-5-101. Definitions | The objective of this rule is to provide a uniform set of definitions used throughout this Article. |
| R21-5-102. Authority | The objective of this rule is to provide the statutory authority for the rules in this Article. |
| R21-5-103. Conditions of Placement | The objective of this rule is to clearly state who and when someone can place a child in another Compact State. |
| R21-5-104. Financial Responsibility | The objective of this rule is to establish who is financially responsible for a child sent to another state. |
| R21-5-105. Applicability | The objective of this rule is to indicate when ICPC applies and when ICPC does not apply. |
| R21-5-106. Placement Approval | The objective of this rule is to establish the requirement for approval from both states before placing children across state lines. |
| R21-5-107. Operations | The objective of this rule is to establish that services are provided in accordance with federal and state law and indicate that interpreters will be made available. |

**3. Are the rules effective in achieving their objectives?** **Yes _X__** **No ___**

**4. Are the rules consistent with other rules and statutes?** **Yes _X__** **No ___**

**5. Are the rules enforced as written?** **Yes _X__** **No ___**

**6. Are the rules clear, concise, and understandable?** **Yes _X_** **No ___**

**7. Has the agency received written criticisms of the rules within the last five years?** **Yes ___** **No _X_**

**8. Economic, small business, and consumer impact comparison:**

The rules in Title 21, Chapter 5, Article 1 cover the Interstate Compact on the Placement of Children (ICPC). ICPC is a contract between and among the 50 states, District of Columbia, and the Virgin Islands, which provides standard national procedures to ensure suitable placement and supervision for children placed across state lines. Additionally, ICPC ensures that the individual or entity placing the child remains legally and financially responsible for the child following placement.

Four types of placements are covered:

1. Placements preliminary to an adoption;
2. Placements into foster care; including foster homes, group homes, and residential treatment facilities;
3. Placement with parents and relatives with court oversight; and
4. Placements of adjudicated delinquents into institutions in other states.

The persons directly affected by, bear the costs of, or directly benefit from the rules in this Article include children in out-of-home care or adoptive children who need to be placed across state line for permanency or placed in another state in a residential treatment facility, DCS, and other compact states. When children in foster care, adoptive children, and children requiring placement in a residential treatment facilities require placement in a state other than their state jurisdiction, placement must be approved by the ICPC.

During State Fiscal Year 2024, there were approximately 2238 children served by the Department's ICPC Program. Approximately 58% of the children are children who leave Arizona and the other 42% of the children who are coming to Arizona from another state.

DCS ICPC Office

Services include foster and adoptive home studies and the supervision of the placements approved by ICPC for children residing in a state other than their state of jurisdiction. ICPC also approves the placement of children in residential treatment facilities outside of the child's state of jurisdiction.

The ICPC Office also facilitates services and communication with the Interstate Compact for Juveniles (ICJ). When a child is in DCS care due to runaway status from another state, DCS must coordinate with the Interstate Compact for Juveniles (ICJ) in order to return the child to their home state.

In addition, the ICPC Office facilitates a connection to International Social Services USA, which coordinates the placement of an Arizona child a parent, relative or kinship caregiver in another country.

There are four (4) FTEs (Full-Time Employees) in the ICPC Office. This includes the ICPC Administrator, three (3) ICPC Coordinators. In addition, DCS has two (2) statewide contracts in place with two (2) agencies to conduct home studies and provide supervision for children placed in Arizona from another state. This office is responsible for the following functions:

- Interpret and provide support to internal and external stakeholders regarding the Interstate Compact and Placement of Children (ICPC).
- Develop policies, procedures, forms and booklets relating to compliance with ICPC regulations.
- Evaluate and make determinations on ICPC applications for placements to/from Arizona of foster children or adoptive children.
- Ensure compliance with ICPC law through monitoring case actions and progress.
- Communicate and problem solve with other state ICPC administrations.
- Provide technical assistance and educational training to attorneys, private child welfare and adoption agency staff, and DCS staff.
- Ensures that DCS and contracted vendors follow the ICPC protocols.
- Coordinates, develops, and identifies training activities for DCS staff.

Funding

Funding for Arizona's ICPC Program is approximately $6.4 million annually. The funding source is both state General Fund and Federal funds. This funding includes ICPC operations (staffing, supplies, overhead, etc.) and contracted services. There are no fees charged between Compact States. However, there is an annual fee to the state of Arizona of $2,000.00 to participate in the national ICPC and an additional $25,000.00 to participate with the national electronic system known as the "National Electronic Interstate Compact Enterprise (NEICE)". This electronic system allows for a quick and secure exchange of data and documents between states.

**9. Has the agency received any business competitiveness analyses of the rules? Yes ___ No _X_**

**10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

The Department did not propose any course of action in the agency's previous five-year-review report.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department believes that the current rules pose the minimum cost and burden to the persons regulated by these rules. Any costs related to the implementation of these rules are associated with running and monitoring the operations of the program. It is the Department's belief that any costs associated with the rules are offset by the greater benefit of partnering with other states in the placement of children outside their state's jurisdiction and ensuring the children's safety and protection. The purpose of ICPC is to place children with relatives, kin, or caregivers who are safe, suitable and able to meet the child's needs.

**12. Are the rules more stringent than corresponding federal laws? Yes ___ No _X_**

Federal laws 42 U.S.C. 622, U.S.C. 671, U.S.C 675, and U.S.C. 5113 apply to the rules of this Article. The rules in this Article are not more stringent than federal law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

The Department has determined that A.R.S. § 41-1037 does not apply to these rules. The rules in this Article do not require the issuance of a regulatory permit, license, or agency authorization.

**14. Proposed course of action**

The Department has reviewed the current rules and does not plan any rulemaking activity for these rules at this time.

Arizona Administrative CODE
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Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION



# TITLE 21. CHILD SAFETY

## CHAPTER 5. DEPARTMENT OF CHILD SAFETY - PERMANENCY AND SUPPORT SERVICES

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
July 1, 2022 through September 30, 2022



**Questions about these rules? Contact:**

| | |
|---|---|
| Department: | Department of Child Safety |
| Address: | 3003 N. Central Ave.<br>Phoenix, AZ 85012 |
| Website: | https://dcs.az.gov/about/dcs-rules-rulemaking |
| Name: | Angie Trevino, Rule Development Specialist |
| Telephone: | (602) 619-3163 |
| Fax: | (602) 255-3262 |
| Email: | Angelica.Trevino@azdcs.gov |


**The release of this Chapter in Supp. 22-3 replaces Supp. 20-2, 1-20 pages.**
Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State's website, www.azsos.gov under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*


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# TITLE 21. CHILD SAFETY

## CHAPTER 5. DEPARTMENT OF CHILD SAFETY - PERMANENCY AND SUPPORT SERVICES

Authority: A.R.S. § 8-453(A)(5)

**Supp. 22-3**

***Editor's Note: Chapter 5 contains rules which were exempt from the regular rulemaking process under Laws 2014, 2nd Special Session, Ch. 1, Sec. 158. The law required the Department to post on its website proposed exempt rulemakings for a minimum of 30 days, at which time the public could provide written comments. In addition, at least two public hearings were held prior to the filing of the final exempt rules. Because the Department solicited comments on its proposed exempt rules, the rules filed with the Office of the Secretary of State are considered final exempt rules (Supp. 15-4).***

### CHAPTER TABLE OF CONTENTS

## ARTICLE 1. INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

**R21-5-101. Definitions**

The definitions contained in A.R.S. § 8-548 and the following definitions apply in this Article:

1. "Child" means any person less than the age of 18 years.
2. "Compact" or 'ICPC" means the Interstate Compact on the Placement of Children.
3. "Compact Administrator" means the same as A.R.S. § 8-548.
4. "Compact State" means a state that is a member of the Interstate Compact on the Placement of Children.
5. "Department" or "DCS" means the Arizona Department of Child Safety.
6. "Interstate placement" means any movement of a child from one state to another state for the purpose of establishing a suitable living environment and providing necessary care.
7. "Intra-state placement" means the placement of a child within a state by an agency of that state.
8. "Placement" means the same as in A.R.S. § 8-548.
9. "Receiving state" means the same as in A.R.S. § 8-548.
10. "Sending agency" means the same as in A.R.S. § 8-548.
11. "Sending state" means the state where the sending agency is located, or the state in which the court holds exclusive jurisdiction over a child, which causes, permits, or enables the child to be sent to another state.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-102. Authority**

The ICPC is governed by A.R.S. §§ 8-548 through 8-548.06 and the ICPC regulations. ICPC regulations are posted on the Association of Administrators of the Interstate Compact on the Placement of Children website. These regulations supplement those authorities and must be read in conjunction with them.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-103. Conditions of Placement**

No person, court, or public or private agency in a Compact State shall place a child in another Compact State until the Compact Administrator in the receiving state has notified the Compact Administrator in the sending state, on a prescribed form, that such placement does not appear to be contrary to the interests of the child and does not violate any applicable laws of the receiving state.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-104. Financial Responsibility**

The sending person, court, or public or private agency shall be held financially responsible for:

1. Sending the child to the receiving state;
2. Returning the child to the sending state; and
3. Treatment of the child during the period of placement.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-105. Applicability**

**A.** Except as listed in subsection (B), the ICPC applies to the placement of:

1. Children in another Compact State by an agency, court or person, which has care or custody of the children.
2. Foreign-born children who are brought under the jurisdiction of a Compact State by an international child placing agency.

**B.** In addition to the children listed in statute that are not subject to ICPC, the ICPC does not apply:

1. When a child is placed in an institution caring for the mentally ill, mentally impaired, epileptic, or in any institution primarily educational in character or in any hospital or other medical facility.
2. To the placement of children into and out of the United States when the other jurisdiction involved is a foreign country.
3. When a sending court or agency seeks an independent (not ICPC related) courtesy check for placement with a parent from whom the child was not removed, the responsibility for credentials and quality of the courtesy check rests directly with the sending court or agency and the person or party in the receiving state who agrees to conduct the courtesy check without invoking the protection of the ICPC home study process. This does not prohibit a sending state from requesting an ICPC.
4. The Compact does not apply in court cases of paternity, divorce, custody, and probate pursuant to which or in situations where children are being placed with parents or relatives or non-relatives.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-106. Placement Approval**

Sending and receiving states must obtain approval from the Compact Administrator in both the sending and receiving states prior to the placement of a child in another Compact State.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-107. Operations**

In providing services provided under this Article, the sending and the receiving state shall:

1. Maintain all information required by state and federal law.
2. Comply with all federal and their respective state laws and regulations regarding the disclosure and use of confidential health and personal information.
3. Comply with all federal and their respective state nondiscrimination laws and regulations.
4. Ensure that interpreters, including assistance for the visually or hearing impaired, are available to those receiving services at no cost.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

## ARTICLE 2. INDEPENDENT LIVING AND TRANSITIONAL INDEPENDENT LIVING PROGRAMS

**R21-5-201. Definitions**

The following definitions apply to this Article:

1. "Active participation" means the foster youth is demonstrating efforts toward completion of case plan goals such as regular attendance at school or employment that results in school credits or earned wages.
2. "Aftercare services" means assistance and support available to eligible, former foster youth living in Arizona after the Department, tribal foster care, or other state foster care case is dismissed, and includes services available through the Transitional Independent Living Program.
3. "Age of majority" means that a person is at least 18 years old.
4. "Approved living arrangement" means a residence that has been reviewed by the assigned Child Safety Worker or other responsible agency staff and approved within the individual case plan.
5. "Arizona Young Adult Program" means a group of programs and services designed to assist eligible youth to make a successful transition to adulthood. The programs and services include Independent Living Services, the Independent Living Subsidy Program, Voluntary Out-of-home Care for Foster Youth 18 through 20 Years of Age, and the Transitional Independent Living Program.
6. "Child placing agency" means the same as in A.R.S. § 8-501(A)(1)(a)(iii), and includes a Child Welfare Agency that OLR licenses as a Placing Agency to place a child in a licensed foster home, or facility.
7. "Child Welfare Agency" means the same as in A.R.S. § 8-501.
8. "Child Safety Worker" means the same as in A.R.S. § 8-801.
9. "Custody of the Department" means that the foster youth:
   a. Is in out-of-home care under the supervision of the Department while the subject of a dependency petition, as an adjudicated dependent, or placed voluntarily under A.R.S. § 8-806; or
   b. Is 18, 19, or 20 years of age, a resident of Arizona, and has signed an individual case plan agreement for voluntary out-of-home care. This includes foster youth who were dually adjudicated (dependent and delinquent) and released from a secure setting prior to, or on the foster youth's 19th birthday.
10. "Department" or "DCS" means the Arizona Department of Child Safety.
11. "Eligible youth" means a person who meets the qualifications in A.R.S. § 8-521 for the Independent Living Program, the qualifications in A.R.S. § 8-521.01 for the Transitional Independent Living Program, or is a person who was formerly in another state's child welfare program who would otherwise be eligible.
12. "Employment" means:
    a. Paid employment;
    b. Participation in employment-readiness activities, which include career assessment and exploration, and part time enrollment in an employment or career readiness education program;
    c. Volunteer positions;
    d. Job-shadowing;
    e. Internship; or
    f. Other paid or unpaid employment-related activities.
13. "Extraordinary purchase" means an expenditure by an eligible youth that impedes an eligible youth's ability to meet the financial obligations outlined in the eligible youth's budget.
14. "Foster youth" means a person in the custody of the Department.
15. "Full-time student" means an eligible youth enrolled in an education program identified by the program as being full-time due to the number of credits, credit hours, or other measure of enrollment.
16. "Independent Living Program" means the program authorized by A.R.S § 8-521 to provide an Independent Living Subsidy and educational case management to a foster youth.
17. "Independent Living Services" or "IL Services" means an array of assistance and support services, including those provided under the Independent Living Program, that the Departments provides, contracts, refers, or otherwise arranges that are designed to help a foster youth transition to adulthood by building skills and resources necessary to ensure personal safety, well-being, and permanency into adulthood.
18. "Independent Living Subsidy" or "IL Subsidy" means a monthly stipend provided under the Independent Living Program to a foster youth, to assist in meeting monthly living expenses. This stipend replaces any foster care maintenance payment from the Department for support of the foster youth's daily living expenses.
19. "Individual case plan" means an agreement between an eligible foster youth and the Department, directed by the foster youth that documents specific services and assistance that support the foster youth's goals in relation to:
    a. Natural supports including permanent connections to and relationships with family and community, including peer and community mentors;
    b. A safe, stable, desired living arrangement, which may include a permanent arrangement such as guardianship or adoption;
    c. Daily living skills;
    d. Secondary and postsecondary education and training;
    e. Employment and career planning;
    f. Physical health, including reproductive health;
    g. Life care planning;
    h. Emotional health;
    i. Mental health;
    j. Spiritual or faith needs;
    k. Interpersonal relationships; and
    l. Age-appropriate extra-curricular, enrichment, and social activities.
20. "Individual service plan" means an agreement that is directed by an eligible youth in the TIL Program that documents specific services and assistance to support the eligible youth's goals including, as applicable:
    a. Financial,
    b. Housing,
    c. Counseling,
    d. Employment,
    e. Education, and
    f. Other appropriate support and services.
21. "Life skills assessment" means a measure of an eligible youth's ability to function in a variety of areas such as daily living skills, knowledge of community resources, and budgeting, as determined by a validated assessment tool.
22. "Medical professional" means a doctor of medicine or osteopathy, physician's assistant, or registered nurse practitioner licensed in A.R.S. Title 32, or a doctor of medi-

cine licensed and authorized to practice in another state or foreign country. A medical professional from another state or foreign country must provide verification of valid and current licensure in that state or country.

23. "Misuse of funds" means that an eligible youth has expended money provided by the Department for specific purposes (such as education or living expenses) on an item that is not permitted by law (such as illegal drugs and alcohol), or on an extraordinary purchase that is not included in an approved budget or individual case or service plan, to the degree that the funds are not available for necessary items and purchases approved within the case plan, service plan, or budget.
24. "Natural supports" means relationships and connections that occur in everyday life, independent of formal services, with people or groups who provide personal or other support during a person's lifetime.
25. "Out-of-home care" means a placement approved by the Department such as a licensed foster home, residential group care facility operated by a Child Welfare Agency, therapeutic residential facility, independent living setting, approved unlicensed independent living setting, or in a relative or non-relative placement. Out-of-home care excludes a detention facility, forestry camp, training school, or any other facility operated primarily for the detention of a child who is determined delinquent.
26. "Personal Crisis" means an unexpected event or series of events in an eligible youth's life that prevents or impedes participation in scheduled services or activities.
27. "Residential group care facility" means a Child Welfare Agency that is licensed to receive more than five children for 24-hour social, emotional, or educational supervised care and maintenance at the request of a child, child placing agency, law enforcement agency, parent, guardian, or court. A residential group care facility provides care in a residential setting for children for an extended period of time.
28. "Responsible agency staff" means the assigned Child Safety Worker, another identified Department employee, or contracted staff.
29. "Service team members" means the eligible youth, the youth's attorney(s), the Guardian ad Litem (GAL), the Court Appointed Special Advocate (CASA), tribal child welfare staff, other parties to the dependency case, contract, or other service providers, responsible agency staff, and other adults involved with the youth or supporting the youth's activities or employment.
30. "Substantial non-compliance" means an eligible youth's:
    a. Termination from an educational, vocational, or employment program due to lack of attendance or failure to make satisfactory progress as defined by the program for reasons unrelated to physical health including pregnancy, emotional, or mental health;
    b. Persistent lack of communication during a 60-day period with the assigned Child Safety Worker or other responsible agency staff known to the youth that results in a loss of contact with the eligible youth, or interferes with the Department's ability to provide services and supervision or to document individual case plan or service plan progress;
    c. Persistent misuse of funds provided to support individual case plan or service plan goals; or
    d. For an eligible foster youth, failure to communicate unexpected changes in the living arrangement as agreed to in the individual case plan or the Independent Living Subsidy agreement.
31. "Transitional Independent Living Program" or "TIL Program" means a program of services for residents of Arizona who are eligible youth under A.R.S. § 8-521.01, that provides assistance and support in counseling, education, vocation, employment, and the attainment or maintenance of housing.
32. "Transitional Independent Living Services" or "TIL Services" means those services the Department provides through the Transitional Independent Living Program under A.R.S. § 8-521.01, and may include assistance and support with health care, money management, housing, counseling, education, vocational training, and employment. The Department or its contractors provide services through a written agreement with the eligible youth.
33. "Validated assessment tool" means a written or verbal survey tool that can demonstrate empirical evidence for reliability and validity.
34. "Work day" means Monday through Friday, excluding Arizona state holidays.
35. "Young Adult Transitional Insurance" means a category of health care coverage under the state Medicaid program (Arizona Health Care Cost Containment System or AHCCCS) for Medicaid eligible youth who have reached the age of majority in foster care.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Amended by emergency rulemaking at 25 A.A.R. 771, effective March 21, 2019, for 180 days (Supp. 19-1). Emergency amendments renewed at 25 A.A.R. 2485, for an additional 180 days effective September 18, 2019 (Supp. 19-3). Emergency expired; amended by final rulemaking at 26 A.A.R. 241, effective March 15, 2020 (Supp. 20-1).

**R21-5-202. Provision of Services**

**A.** The Department shall provide services and stipends for the IL Services, IL Subsidy, and TIL services to eligible youth in a manner that is fair and equitable.

**B.** The Department shall provide Independent Living Services to eligible foster youth based on needs identified by the eligible foster youth, by service team recommendations, or the findings of a life skills assessment. The services shall address needs identified in the eligible foster youth's individual case plan and may include one or more of the following, depending on the individual case plan goals:
1. Information and assistance to create and maintain a network of natural supports;
2. Independent living skills training;
3. Program incentives;
4. Information and assistance in life care and health care planning, including enrollment in a health plan;
5. Educational, career, and vocational planning;
6. Financial assistance for post-secondary education and training;
7. Out-of-home care for foster youth 18 through 20 years of age; or
8. Aftercare services through the Transitional Independent Living Program.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-203. Denial of Services**

The Department shall deny services if a person does not meet the eligibility requirements of A.R.S. §§ 8-806, 8-521, 8-521.01, and R21-5-204.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-204. Eligibility**

**A.** Independent Living Services. In order to be eligible for IL Services a person shall:
1. Be at least 16 years of age and less than 21 years of age;
2. Be in the custody of the Department or tribal child welfare agency;
3. Reside in out-of-home care;
4. Be referred by the eligible youth's assigned Child Safety Worker, other Department staff, or a tribal social services representative; and
5. Be a resident of Arizona if 18, 19, or 20 years of age.

**B.** Independent Living Subsidy.
1. In order to be eligible for the IL Subsidy, a person shall:
   a. Be at least 17 years of age, in the custody of the Department, and employed or a full-time student.
   b. With the assistance of the responsible agency staff, complete the Independent Living Subsidy Agreement or other approved forms designated by the Department.
2. Conditions for approval and continuation in the Independent Living Subsidy Program include:
   a. Active participation in activities outlined in the individual case plan;
   b. Adherence to the terms of the IL Subsidy Agreement, including:
      i. Communication with the Child Safety Worker;
      ii. Maintenance of a Department-approved living arrangement, including approval of a roommate, except those assigned by school or work; and
      iii. Participation in scheduled meetings to review progress and update the individual case plan and IL Subsidy Agreement.
3. Eligible youth 18, 19, and 20 years of age who are temporarily residing out of state for the purpose of education or vocational training, and who maintain Arizona residency, may receive the Independent Living Subsidy under the same conditions as above.

**C.** Transitional Independent Living Program. Under A.R.S. § 8-521.01, in order to be eligible for the Transitional Independent Living Program, a person must be less than 21 years of age and have been in out-of-home care and in the custody of the Department, a licensed residential group care facility, or a tribal child welfare agency while 16, 17, or 18 years of age. Persons who were in another state's child welfare agency under the same conditions are also eligible.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-205. Out-of-home Care Services for Foster Youth 18 through 20 Years of Age**

**A.** The Department may provide out-of-home care services and supervision to a foster youth less than 21 years of age, who reached the age of 18 years while in the custody of the Department, and was either in out-of-home care or in secure care, as defined by A.R.S. § 8-201, through a delinquency action, when the foster youth:
1. Requests out-of-home care;
2. Has residency in the state of Arizona;
3. Participates in developing an individual case plan agreement for out-of-home care; and
4. Demonstrates acceptance of personal responsibility for his or her part of the agreement through active participation in the individual case plan.

**B.** The foster youth, Child Safety Worker, and involved service team members shall develop the individual case plan for out-of-home care:
1. Within the 90-day period prior to the foster youth's 18th birthday for foster youth continuing in out-of-home care past 18 years of age;
2. Within ten work days for foster youth who enter out-of-home care during the 90-day period prior to the foster youth's 18th birthday; and
3. For eligible youth re-entering foster care at 18 years of age or older, within seven work days of the eligible youth's return to Department care and supervision.

**C.** The individual case plan shall outline the services and supports to be provided under R21-5-202(B) and include at least one of the following activities:
1. Completion of secondary education or a program leading to an equivalent credential;
2. Enrollment in an institution that provides post-secondary education or vocational education;
3. Participation in a program or activity designed to promote or remove barriers to employment; or
4. Employment of at least 80 hours per month.

**D.** Foster youth participating in out-of-home care shall demonstrate acceptance of personal responsibility by actively participating in an individual case plan, unless prevented by a documented behavioral health or medical condition, or other personal crisis or life event, such as pregnancy, birth, necessary maternity leave as determined by a medical professional, adoption, or guardianship of a child.

**E.** The Child Safety Worker shall support the foster youth to address any documented condition, crisis, or life event listed in subsection (D), by:
1. Facilitating a youth led discussion that includes a review of the supports and services available as intervention strategies, to assist in resolving the condition, crisis, or concern;
2. Documenting the foster youth's preferred intervention strategy for addressing the condition, crisis, or concern; and
3. Expeditiously providing or otherwise arranging the preferred intervention strategy.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Amended by emergency rulemaking at 25 A.A.R. 771, effective March 21, 2019, for 180 days (Supp. 19-1). Emergency amendments renewed at 25 A.A.R. 2485, for an additional 180 days effective September 18, 2019 (Supp. 19-3). Emergency expired; amended by final rulemaking at 26 A.A.R. 241, effective March 15, 2020 (Supp. 20-1).

**R21-5-206. Transitional Independent Living Program**

**A.** The Transitional Independent Living Program provides services to eligible youth, under A.R.S. § 8-521.01 that comple-

ments their own efforts toward becoming self-sufficient. The Department may provide the following assistance, depending on individual service plan goals:

1. Financial,
2. Housing,
3. Counseling,
4. Employment,
5. Education, and
6. Other appropriate support and services.

**B.** The eligible youth requesting services through the Transitional Independent Living Program shall provide the following information to the responsible agency staff:

1. Identifying information including:
   a. Name (and any aliases); and
   b. Date of birth;
2. Information regarding the eligible youth's former foster care status such as the state or tribal child welfare system where the youth was in care, and approximate dates of care, if known; and
3. Any available contact information for the youth, including:
   i. Phone number,
   ii. Friend or family phone number,
   iii. Email address, and
   iv. Any other communication method identified by the youth.

**C.** An eligible youth and responsible agency staff shall develop an individual service plan for the eligible youth to receive these services.

**D.** The individual service plan shall address the level of need based on the items noted in subsection (A).

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-207. Re-entry Into Out-of-home Care**

**A.** The Department shall facilitate re-entry into out-of-home care for eligible youth participating in the Transitional Independent Living Program.

**B.** On request for re-entry by the eligible youth, the Department shall confirm the eligible youth's request to receive out-of-home care, supervision, and other services with the youth and within ten work days:

1. Facilitate a meeting with the eligible youth to review the requirements under R21-5-205;
2. Assist the eligible youth to develop an individual case plan that includes an effective date for reopening the Department case;
3. Identify the name and contact information of the Child Safety Worker or responsible agency staff assigned to the case;
4. Identify the out-of-home care type selected such as, foster home, residential group care facility, Independent Living Program, or other arrangement;
5. Notify the identified Child Safety Worker or responsible agency staff assigned to the case; and
6. Complete all necessary authorizations for out-of-home care and other services to reasonably ensure a smooth transition from the TIL Services to the IL Services.

**C.** If the eligible youth reports he or she is in crisis and unsafe, the Department shall immediately assess the youth's safety and assist the youth to secure a safe living arrangement and to manage the crisis.

**D.** An eligible youth may request to postpone re-entry, decline re-entry at any time, or re-initiate the request any time prior to the eligible youth's 21st birthday. The responsibilities of the Department to process the request for re-entry shall begin upon the Department's receipt of the eligible youth's request for re-entry under subsection (B).

**E.** Supports and services shall continue for youth who re-enter out-of-home care, as outlined in R21-5-205.

**F.** If the Department denies re-entry, the Department shall provide the youth with written notification of the reason for this decision and the youth's grievance and appeal rights within 15 work days of the request for re-entry.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-208. Termination of Services**

**A.** The Department may terminate IL Services, including out-of-home care for foster youth 18 through 20 years of age, and TIL services if the eligible youth:

1. Reaches the age of 21 years;
2. Reaches the age of 18 years and does not desire continued services;
3. Makes a voluntary decision to terminate services; or
4. Demonstrates substantial non-compliance or otherwise refuses to meet the requirements of the individual case plan or individual service plan after the responsible agency staff or designee has made active efforts to engage the eligible youth in identifying and resolving issues, including assessing the effectiveness of current services, and identifying and providing additional or different support services.

**B.** The Department shall deny IL Services, including out-of-home care for foster youth age 18 through 20 years, and TIL services if the Department determines the person is:

1. Not eligible;
2. Unwilling to create an individual case or service plan; or
3. Not participating in the individual case or service plan.

**C.** The Child Safety Worker or responsible agency staff shall notify the person in writing of the Department's decision to terminate or deny services within ten work days of the person's application for services.

**D.** The notice shall include information on the person's right to grieve any decision to terminate or deny services.

**E.** Within ten work days of the notice to terminate or deny services, the Child Safety Worker or responsible agency staff shall contact the person to:

1. Assist the person through the grievance process including the completion and submittal of any required Department forms; or
2. Identify and engage a personal advocate to assist the person through the grievance process, including the completion and submittal of any required Department forms.

**F.** When termination of services to a foster youth is planned due to one of the reasons outlined in (A)(1) through (3) of this Section, the Child Safety Worker or responsible agency staff shall schedule a discharge staffing with the foster youth within ten work days of the foster youth's 21st birthday or the Department's receipt of the foster youth's notice to discontinue services to provide any necessary documents not previously provided, such as a birth certificate, social security card, state identification card, credit report, and a copy of the foster youth's health and education records.

**G.** The Department shall not terminate services for substantial non-compliance under subsection (A)(4) until the Child Safety Worker or responsible agency staff satisfies all responsibilities including:
1. Staffing of the individual case or service plan;
2. Adhering to the grievance process described in R21-5-209; and
3. Developing and implementing a discharge plan that provides information on available community resources, and connects the person to those resources.

**H.** Services shall remain in effect until the reasons for termination are resolved or the grievance or appeal process is completed.

**I.** For Independent Living Subsidy only, if the Department determines that continuation of the Independent Living Subsidy would place the foster youth at risk of immediate harm, the Child Safety Worker or responsible agency staff shall:
1. Document this fact in the case file progress notes, and
2. Arrange for a safe living arrangement and sufficient support services to reasonably ensure the foster youth's safety in the interim.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-209. Grievance Process**

**A.** A person eligible for services under R21-5-204 who disagrees with a Department adverse action decision to reduce, terminate, or deny services for that person may:
1. File a grievance under this Section;
2. Choose not to file a grievance and appeal the adverse action under A.A.C. Title 21, Chapter 1, Article 3 by filing a notice of appeal within 20 days after receipt of the adverse action decision reducing, terminating, or denying services; or
3. File a grievance, and if the person is dissatisfied with the results of the grievance process, appeal under A.A.C. Title 21, Chapter 1, Article 3 by filing a notice of appeal within 20 days after receipt of the grievance response letter.

**B.** In the event that a person disagrees with a Department decision to reduce, terminate, or deny services, the Child Safety Worker or responsible agency staff shall:
1. Inform the person of the formal grievance process;
2. Provide the person with the Department's grievance form and directions for submittal to the designated Department staff, such as the Department's Ombudsman's Office; and
3. Offer to assist the person in completing and submitting the form, or referring the person to the appropriate Department staff, such as the Department's Ombudsman, for assistance in completing and submitting the form.

**C.** Upon receipt of the grievance form, the Department shall:
1. Schedule a face-to-face meeting with the person who filed the grievance within seven work days from the date the grievance was received by the Department, or schedule a teleconference if a face-to-face meeting is not possible;
2. Evaluate the grievance to determine if the grievance can be resolved by the Department to the satisfaction of the person;
3. Mail a grievance response letter to the person within three work days of the meeting; and
4. Include an appeal form with the grievance response letter so the person may appeal the adverse action.

**D.** If the person agrees with the Department's decision to terminate services, the Child Safety Worker or responsible agency staff shall proceed with case closure including completing a discharge plan with the person that includes information on aftercare services and other community based support.

**E.** The Department shall retain documentation of all grievances in the case file according to the Department's retention schedule.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

## ARTICLE 3. DEPARTMENT ADOPTION SERVICES

**R21-5-301. Definitions**

In addition to the definitions in A.R.S. § 8-101, the following definitions apply in this Article, Article 4 of this Chapter, and 21 A.A.C. 9:
1. "Adoptable child" means a child who is legally available for adoption but who has not been placed for adoption.
2. "Adoptee" means a child who is the subject of a legal petition for adoption.
3. "Adoption agency" means an individual or entity, including a corporation, company, partnership, firm, association, or society, other than the Department, licensed by the Department to place a child for adoption.
4. "Adoption entity" or "entity" means the Department and includes an adoption agency, but does not include a private attorney who is licensed to practice law in the state of Arizona and who is only assisting in a direct placement adoption to the extent allowed by A.R.S. § 8-130(C).
5. "Adoption placement" or "placement" means the act of placing an adoptable child in the home of an adoptive parent who has filed, or is contemplating filing, a petition to adopt the child.
6. "Adoption Registry" means the electronic database described in A.R.S. § 8-105.
7. "Adoption services" means activities conducted in furtherance of an adoption and includes the activities listed in A.A.C. R21-5-303 and R21-9-201(B).
8. "Adoptive parent" means an individual who has successfully completed the application process and has been certified by the court to adopt. An adoptive parent includes an individual who does not have a child placed in their home.
9. "Agency placement" means the child is placed in an adoptive home chosen by the adoption agency.
10. "AHCCCS" means the Arizona Health Care Cost Containment System, which is the State's program for medical assistance available under Title XIX of the Social Security Act and state public insurance statutes under A.R.S. Title 36, Chapter 29.
11. "Applicant" means an individual who has applied to become an adoptive parent.
12. "Birth parent" means the biological mother or father of a child.
13. "Central Registry" means the information maintained by the Department of substantiated reports of child abuse or neglect for the purposes of A.R.S. § 8-804.
14. "Certification application" means the form that an applicant submits to an adoption entity or to the court to request a certification investigation to become certified as an adoptive parent.
15. "Certification investigation" means the process referred to in A.R.S. § 8-105(C) by which an adoption entity

determines if an applicant is a fit and proper person to adopt.

16. "Certification order" means a judicial determination that an applicant is acceptable to adopt children.
17. "Certification report" or "adoptive home study" means the written report described in A.R.S. § 8-105, in which an adoption entity summarizes the results of a certification investigation and makes a recommendation for or against certification of an applicant.
18. "Child with special needs" means a child who has one of the special needs listed in A.R.S. § 8-141.
19. "Department" or "DCS" means the Arizona Department of Child Safety.
20. "Developmentally appropriate" means an action that takes into account:
    a. A child's age and family background;
    b. The predictable changes that occur in a child's physical, emotional, social, cultural, and cognitive development; and
    c. A child's pattern and history of growth, personality, and learning style.
21. "Direct placement" means the child is placed in an adoptive home by the birth parent or legal parent.
22. "Final report to the court" means a written report that includes a social study under A.R.S. § 8-112, in which an adoption entity advises the court of the entity's assessment and recommendations about the finalization of a particular adoption.
23. "Foster parent" means the same as in A.R.S. § 8-501.
24. "ICPC" means the Interstate Compact on the Placement of Children described in A.R.S. § 8-548.
25. "ICWA" means the Indian Child Welfare Act described in 25 U.S.C. 1901 et seq.
26. "Legally available" means a child whose birth or legal parents are deceased, have voluntarily relinquished their parental rights, or whose parental rights have been terminated by the court.
27. "License" means a permission granted by the Department to an adoption agency authorizing the adoption agency to perform adoption services in A.A.C. R21-9-201(B).
28. "Open adoption" means an adoption in which the adoptive parent and the birth or legal parent agree to share varying degrees of each other's personal information for future contact.
29. "Out-of-state agency" means any person or entity that is authorized or licensed by a state other than Arizona, or a foreign country, to perform adoption services.
30. "Placed child" means an adoptable child who has been placed with an adoptive parent, and the adoptive parent has not yet filed a petition to adopt the child.
31. "Placement supervision period" means the time period from the date of adoption placement until the court enters a final order of adoption, during which the adoptive parent has the rights under A.R.S. § 8-113.
32. "Reasonable fee" means
    a. A fee commensurate with:
        i. The actual cost of providing a specific adoption service or item to a specific individual, or
        ii. The average cost of a service or item if the adoption entity routinely uses an averaging method to determine the cost of a particular service or item.
    b. A reasonable fee may include reasonable compensation for officers and employees and a reasonable profit margin above actual or averaged costs.
33. "Service plan" means a written document of developmentally appropriate pre-placement and post-placement services necessary to facilitate a child's transition to an adoptive home.
34. "Social study" means the written report described in A.R.S. § 8-112, after a petition for adoption has been filed, where the adoption entity summarizes the results of its investigation, and makes a definite recommendation for or against the proposed adoption and the reasons for that recommendation.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-302. Adoption Registry: Information Maintained; Confidentiality**

**A.** The Department shall maintain and keep current the Adoption Registry with the information required under A.R.S. § 8-105. The Adoption Registry shall include the following current information for each child or adoptive parent listed on the Adoption Registry:
1. The child's availability for adoptive placement,
2. The adoptive parent's certification status,
3. The adoptive parent's availability for adoptive placement, and
4. The type of child the adoptive parent is open to considering for adoption including:
    a. Age;
    b. Sex; or
    c. Special needs.

**B.** Upon request, the Department shall provide personally identifiable Adoption Registry information to:
1. The court;
2. An adoption agency, including a private attorney;
3. Under a court order, a National or Regional Adoption registry and exchange; and
4. An out-of-state agency.

**C.** Before providing information, the Department shall obtain, from the person requesting the information, the following:
1. The name and affiliation of the person requesting the information;
2. The reason for the request; and
3. If the requesting party is other than a court representative, a signed statement acknowledging that the information is confidential and promising not to release the information to anyone except as allowed by A.R.S. §§ 8-120, 8-121, and 8-105.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-303. Department Adoption Services**

**A.** The Department provides the following adoption services for families and children in accordance with the limitations and provisions of A.R.S. Title 8, Chapter 1, Article 1:
1. For families:
    a. Recruiting adoptive parents;
    b. Informing persons interested in adopting a child about the adoption process;
    c. Conducting certification investigations of applicants under A.R.S. § 8-105;

d. Preparing certification reports under A.R.S § 8-105; and
e. Submitting the names and profiles of adoptive parents for listing in the Adoption Registry.

2. For children:
a. Accepting adoption consents from birth parents;
b. Preparing non-identifying, pre-placement information on adoptive children for adoptive parents, as required in A.R.S. § 8-129;
c. Submitting the name and profile of an adoptive child for listing in the Adoption Registry;
d. Preparing a child for adoptive placement;
e. Matching an adoptable child with an adoptive parent;
f. Placing an adoptable child in the home of an adoptive parent;
g. Investigating and reporting to the court on the acceptability of an adoptive parent under A.R.S. § 8-105(H);
h. Monitoring an adoption placement during the placement supervision period;
i. Providing services to a child placed for adoption and the adoptive family to assist with adjustment to the adoption placement;
j. Conducting a social study under A.R.S. § 8-112 and preparing a final report to the court determining suitability of placement; and
k. Assisting an attorney by providing legal documents to enable an adoptive parent to complete the adoption process.

**B.** When performing adoption services, the Department shall adhere to the standards established for an adoption agency in 21 A.A.C. 9.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-304. Department Procedures for Processing Certification Applications**

**A.** Upon review of a certification application, the Department shall notify the applicant in writing that the application is either complete or incomplete. An application is complete when it contains the information and supporting documentation described in R21-5-404. If the application is incomplete, the notice shall specify what information is missing.

**B.** An applicant with an incomplete application has 30 days from the date of the notice to provide the missing information. If the applicant fails to do so, the Department may close the file. An applicant whose file has been closed and who later wishes to apply for certification may reapply.

**C.** Upon review of a complete application, the Department shall decide whether to accept the application, according to the priority schedule listed in R21-5-305, and the availability of the Department's resources. If the Department cannot accept the application, the Department shall return the original application and all supporting documentation to the applicant. The applicant may reapply.

**D.** After the Department accepts the completed application, the Department shall provide the applicant written notice of the acceptance. The Department shall complete the certification investigation as specified in R21-5-405 within 90 days of the date of the notice. The Department shall prepare a certification report under R21-5-406.

**E.** The Department shall process a renewal application under this Section and R21-5-407.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-305. Department Priorities for Receipt of Services**

The Department shall accept and process certification applications and render adoption services according to the following priority schedule:

1. An applicant for whom the court has ordered the Department to do a certification investigation and report;
2. An applicant seeking to adopt a particular adoptable child with special needs;
3. An applicant wishing to adopt a child with special needs;
4. An applicant considering adopting a child with special needs; and
5. All other applicants.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-306. Department Recruitment Efforts**

The Department shall actively recruit persons to adopt children with special needs by:

1. Publicizing the need for such adoptive parents;
2. Registering adoptable children, as appropriate, with the Adoption Registry or other local, state, regional and national adoption resources;
3. Advising prospective adoptive parents of:
a. The availability of children with special needs,
b. The procedures involved in adopting such children, and
c. The support services and subsidies that may be available to persons adopting such children; and
4. Other measures similar to those described in this Section.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-307. Expired**

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 1322, effective June 3, 2020 (Supp. 20-2).

**R21-5-308. Termination of Adoption Services**

**A.** The Department may terminate services to an applicant or adoptive parent when:

1. The adoption is finalized;
2. The applicant or adoptive parent requests closure before receiving a child for placement;
3. The applicant or adoptive parent ceases to be a resident of Arizona before receiving a child for placement;
4. The court declines to certify the applicant or adoptive parent;
5. The applicant or adoptive parent refuses to comply with the requirements in A.R.S. Title 8, Chapter 1, Article 1, or this Chapter, Articles 3 and 4;
6. The applicant fails to submit a completed certification application within 90 days of the date on which the Department sent the person an application form;

7. The adoptive parent is no longer willing to be an adoptive parent; or.
8. The adoptive parent is no longer certified to adopt.

**B.** The Department may terminate adoption services to an adoptive child when:
1. The court issues a final adoption order; or
2. The court determines that adoption is no longer the most appropriate case plan for the child, and the Department provides alternate services consistent with the child's new case plan.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

## ARTICLE 4. ADOPTION ENTITY SERVICES

**R21-5-401. Definitions**

The definitions in R21-5-301 apply in this Article.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-402. Recruitment**

**A.** When recruiting applicants, an adoption entity shall comply with the requirements of this Section.

**B.** The adoption entity shall conduct recruitment efforts pursuant to a written plan, which shall describe:
1. Specific recruitment goals, including:
   a. The number and composition of adoptive parents the entity will serve; and
   b. The children the entity will accept for placement and any limitations such as:
      i. Age;
      ii. Medical special needs;
      iii. Developmental special needs;
      iv Mental health; or behavioral health special needs.
2. Methods of recruitment;
3. The number and professional qualifications of staff designated to handle recruitment; and
4. The means by which the adoption entity shall fund the agency's recruitment efforts.

**C.** The adoption entity's recruitment efforts shall be consistent with the personal characteristics of the children the entity has available for adoption and reasonably expects will become available for adoption through the entity.

**D.** An adoption entity shall not:
1. Promise to place more children than the adoption entity's prior history shows it can reasonably expect to place;
2. Promise to place a child in less time than the average waiting period demonstrated by the adoption entity's past practice;
3. Promise adoption subsidy prior to the formal approval and receipt of an adoption assistance agreement that meets the requirements of A.R.S. Title 8 Chapter 1 Article 2; or
4. Make any other statements or promises the entity knows or reasonably should know are false, misleading, or inaccurate.

**E.** The Department may take an adverse licensing action against an adoption agency that does not comply with this Section.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-403. Orientation: Persons Interested in Adoption**

**A.** Prior to accepting a certification application from a person considering the adoption of a child, or an application for placement from a person who intends to seek a placement through the adoption entity, an adoption entity shall provide the person with an adoption orientation, which shall explain the following:
1. The adoption process, including all legally mandated procedures, and estimated time-frames for completion of such procedures;
2. The adoption entity's policies and procedures that directly affect services to adoptive parents;
3. The adoption entity's fee structure and written fee agreement;
4. The types and number of children the agency typically has had and reasonably expects to have available for adoption placement and the average length of time between certification and placement;
5. The Department's responsibility for licensing and monitoring agencies, and the public's right to register a complaint about an agency as prescribed in 21 A.A.C. 9, Article 2;
6. The function of the Adoption Registry and the adoptive parent's right to decide whether to be included in the Adoption Registry; and
7. Confidentiality requirements, open adoptions, and the confidential intermediary program described in A.R.S. § 8-134.

**B.** A person who is already knowledgeable about all or part of the matters listed in subsection (A) may waive orientation on those matters, with the approval of the adoption entity. A person may be knowledgeable due to a prior adoption through an Arizona adoption entity, employment in adoption services, or for other similar reasons.

**C.** An adoption entity shall maintain written documentation showing that any person who has applied to the entity for certification or for placement of a child has received the orientation described in subsection (A), required by R21-9-227, or has obtained a waiver described in subsection (B). If some or all of the adoption orientation is waived, the adoption entity shall document the matters waived and the reasons for the waiver.

**D.** An adoption entity shall not charge a person for anything other than a certification application fee, or enter into an adoption fee agreement with a person, until the person has received the orientation in subsection (A).

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-404. Application for Certification**

An applicant who wishes to become certified as an adoptive parent shall apply for certification as provided in A.R.S. § 8-105. An adoption entity shall require an applicant to provide at least the following information:
1. Personally identifying information for each prospective adoptive parent, including:
   a. Name and date of birth;
   b. Social Security number;
   c. Race and ethnicity;
   d. Physical description;
   e. Current address and duration of Arizona residency;
   f. Marital history; and

g. The name, address, and phone number of immediate family members, including emancipated adult children;
2. The name, date of birth, and social security number of any person currently residing with the applicant;
3. A listing of the applicant's insurance policies, including:
a. Any insurance that may be available to cover the medical expenses of a birth mother or adoptive child; and
b. The name of the insured, the insurance policy number, and the effective dates of coverage;
4. A current financial statement describing the applicant's assets, income, debts, and financial obligations;
5. A physician's statement as to the applicant's current physical and mental health;
6. A medical and psychological history on the applicant and the applicant's household members. The history may be a declaration by the applicant of past physical and mental illness for the applicant and any household member;
7. The applicant's employment history;
8. The applicant's social history;
9. A statement from the applicant as to the type of child the applicant seeks to adopt and whether the applicant desires to adopt or would consider adopting a child with special needs;
10. Information on the following legal proceedings in which the applicant has been a party:
a. Dependency proceedings,
b. Severance or termination of parental rights proceedings,
c. Child support enforcement proceedings,
d. Proceedings involving allegations of child abuse or neglect,
e. Adoption proceedings, or
f. All criminal proceedings;
11. The applicant's prior history of adoption certification, including prior applications for certification and the dates of any certification denials;
12. Whether the applicant wishes to be listed on the Adoption Registry;
13. A fingerprint card or fingerprints processed through the Court, meeting the requirements of A.R.S. § 41.1758.07 on each applicant and each adult residing in the home more than the age of 18 years; and
14. The names, addresses, and phone numbers of five personal references; two references from family members related to the applicant by blood or marriage, and three other references, who have known the applicant at least two years and who can attest to the applicant's character and fitness to adopt.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-405. Certification Investigation**

**A.** Following acceptance of a completed certification application, the adoption entity shall conduct a certification investigation that includes:
1. Personal interviews with the adoptive family. Such interviews shall:
a. Occur on at least two separate occasions, at least one of which shall be at the adoptive parent's residence;
b. Comprise no less than four hours of in person contact, and at least one hour shall take place at the adoptive parent's residence;
c. Include at least one separate interview with each member of the adoptive parent's household who is more than the age of five; and
d. Include at least one joint interview with both adoptive parents if they are married;
2. Written statements from and personal contact (either a face-to-face meeting or a telephone call) with at least three of the applicant's personal references;
3. An inquiry as to whether the applicant wishes to be listed in the Adoption Registry;
4. Verification of the applicant's financial condition through a review of one or more of the documents listed in subsection (A)(7)(g) below;
5. A request to the Department for a check of the Central Registry to determine if the applicant has a past record of substantiated allegations of child abuse or neglect;
6. An evaluation of the success of the placement of other children adopted by the applicant;
7. A review of any supporting documentation the adoption entity reasonably deems necessary to determine an applicant's fitness to adopt, including:
a. A physician's statement regarding the physical health of other adult household members and the applicant's children living in the home;
b. A statement from a psychiatrist or psychologist regarding the mental health of the applicant and the applicant's other household members;
c. Birth certificates;
d. Marriage certificate;
e. Dissolution of marriage or divorce papers and orders, including child support documentation;
f. Military discharge papers;
g. Financial statements, tax returns, pay stubs, and W-2 statements;
h. Bankruptcy papers;
i. Insurance policy information; and
j. Documentation showing Arizona residency.

**B.** A person who meets the qualifications listed in 21 A.A.C. 9, Article 2, shall perform the certification investigation and shall document all personal contacts made and all information reviewed and considered during the investigation.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-406. Certification Report and Recommendation**

**A.** Upon completion of the certification investigation, the adoption entity shall prepare a certification report under A.R.S. § 8-105.

**B.** In determining whether to recommend certification of an applicant, the adoption entity shall consider all factors bearing on fitness to adopt, including, but not limited to:
1. The factors listed in A.R.S. § 8-105;
2. The length and stability of the applicant's marital relationship, if applicable;
3. The applicant's age and health;
4. Past, significant disturbances, or events in the applicant's immediate family, such as:
a. Involuntary job separation,
b. Divorce, or death of spouse, child, or parent, and
c. History of child abuse or neglect;

5. The applicant's ability to financially provide for an adopted child; and
6. The applicant's history of providing financial support to the applicant's other children, including compliance with court-ordered child support obligations.

**C.** The certification report shall specifically note any instances where an applicant has:
1. Been charged with, been convicted of, pled no contest to, or is awaiting trial, on charges of an offense listed in A.R.S. § 41-1758.07; or
2. Been a party to a dependency, guardianship, or termination of parental rights action.

**D.** If the report recommends denial of certification, the adoption entity shall send the applicant written notice of the unfavorable recommendation, the reason for the denial, and an explanation of the applicant's right under A.R.S. § 8-105, to petition the court for review. The adoption entity shall mail the notice to the applicant at least five work days prior to filing the certification report with the Court.

**E.** The adoption entity may notify the adoptive parent of the Court's certification decision if the Court fails to do so.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-407. Renewal of Certification**

**A.** A certified adoptive parent who has not filed a petition for adoption within one year of the original certification order, may apply for an extension of certification, as provided in A.R.S. § 8-105.

**B.** If the Court directs an adoption entity to investigate a certified adoptive parent who has requested a renewal of certification, the entity shall obtain from the adoptive parent seeking renewal:
1. A copy of the request for renewal of certification;
2. An updated profile of any changes in the certified adoptive parent's social, family, medical, and financial circumstances;
3. New fingerprint clearance per Court requirements, following original certification;
4. A current physical health statement for all members of the adoptive parent's household at least every third year following original certification; and
5. Other information as the Court may request.

**C.** When investigating a request for a renewal of certification, the adoption entity shall, at a minimum, complete the following:
1. Conduct an in person interview at the applicant's home with the applicant and the applicant's other household members more than the age of five years,
2. Investigate any change in circumstances described in the request for renewal as necessary to determine continuing fitness to adopt, and
3. Document all actions.

**D.** Upon completion of the renewal investigation, the adoption entity shall prepare and file with the Court a certification investigation that shall contain a recommendation for or against renewal of certification.

**E.** If the adoption entity recommends that certification not be renewed, the entity shall send the adoptive parent the notice in R21-5-406(D).

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-408. Communication with Adoptive Parents Awaiting Placement**

Upon request, an adoption entity shall inform an adoptive parent awaiting placement of a child of the following:
1. The status of the adoptive parent's case;
2. The number of children the adoption entity currently has available for adoption;
3. The number of times the adoptive parent has been considered for the placement of a child;
4. The number of approved adoptive parents awaiting placement of a child through the adoption entity; and
5. The number of placements the adoption entity made in the prior year, the number of placements the adoption entity has made to date in the current year, and the number of placements the adoption entity anticipates making during the remainder of the current year.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-409. Prohibitions Regarding Birth Parents**

An adoption entity shall not:
1. Promise a birth parent that the birth parent shall have future contact with the child or the adoptive parent but may explain the concept of open adoption;
2. Promise a birth parent that the child will be placed with a specific adoptive parent or type of adoptive parent, except in a direct placement adoption. The adoption entity may advise the parent that it will use the entity's best efforts to honor any placement preferences the birth parent may have, to the extent that such preferences are consistent with the best interests of the child;
3. Promise a birth parent any financial or other consideration prohibited by law; or
4. Do or say anything to coerce or pressure a birth parent to sign a consent to adopt.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-410. Information about Birth Parents**

**A.** Before accepting a child for placement, the adoption entity shall make a good faith effort to obtain the following information described in this Section from the child's birth parent, or person having custody of the child:
1. Information about each birth parent including:
   a. Name and any aliases used;
   b. Address, phone number, and residential history;
   c. Date and place of birth;
   d. Social security number;
   e. Race, citizenship, and any Native American tribal affiliation or membership;
   f. Physical description;
   g. Name of current employer and employment history;
   h. Educational history;
   i. Marital history and status;
   j. Record of other births and children born to the birth parent;
   k. Hobbies;
   l. Future plans;
   m. Record of arrests or convictions;
   n. Medical, psychological, and substance use history;

o. For the birth mother, history of prenatal care, gestational substance or drug abuse, pregnancy, and delivery;
p. Immediate family relationships; and
q. Significant family events.

2. An explanation of the birth parent's decision to place the child for adoption, the factors that influenced the decision, and a record of any counseling the birth parent received concerning the decision.
3. A record of the birth parent's contact with the child.
4. A statement of the birth parent's feelings about future contact with the child.
5. A list of the birth parent's preferences regarding an adoptive home for the child.
6. Medical or psychological history on the birth parent's own parents, siblings, grandparents, aunts, uncles, and first cousins.
7. Information on the child being surrendered for adoption, as appropriate to the age of the child and the child's:
   a. Developmental history,
   b. Medical and psychological history,
   c. Family background,
   d. Educational history, and
   e. Membership in or affiliation with any Native American tribe.
8. A listing of the birth parent's insurance policies, including:
   a. Any insurance that may be available to cover the medical expenses of the birth mother or adoptive child; and
   b. The name of the insured, the insurance policy number, and the effective dates of coverage.

**B.** The adoption entity shall document all statements and information in a permanent record.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-411. Pre-consent Conference with Birth Parents**

**A.** The adoption entity shall have a pre-consent conference with each birth parent who must provide consent to adoption under A.R.S. § 8-106, to explain in a language and form that each birth parent can understand the following:
1. The legal and practical consequences of executing a consent, including:
   a. Applicable ICWA provisions; and
   b. The fact that the consent, and all other affidavits executed in connection with an adoption, are executed under penalty of perjury;
2. The irrevocability and inalterability of a consent;
3. The legal prohibition against paying the birth parent to execute a consent;
4. The fact that the birth parent has no obligation to sign the consent; and
5. The provisions of A.R.S. § 8-106, regarding an affidavit of any potential father.

**B.** The pre-consent conference shall occur:
1. No earlier than 12 hours after the birth of a child if the conference was not held before the birth under subsection (B)(2);
2. No earlier than 60 days before the anticipated due date, if the conference is held before the child's birth;
3. At least 24 hours before presenting a birth parent with the consent form for signature; and
4. At a time that takes into account the known medical and emotional condition of each available birth parent.

**C.** The person conducting the pre-consent conference shall provide the birth parent with a sample consent form and shall convey the information described in subsection (A) in a language and form that the birth parent can understand.

**D.** The person conducting the pre-consent conference shall document that the information was given and understood and shall obtain the birth parent's signature on the documentation. If the conference is by telephone under subsection (E), the person may obtain the signature through the mail at a later date. If the conference is not held, the person shall document the reason under subsection (E).

**E.** The pre-consent conference may be by telephone and is not required if the birth parent cannot be located or refuses to participate in the conference. The adoption entity shall document the reason why the conference did not occur.

**F.** If required to obtain a consent from a birth father under A.R.S. § 8-106, the adoption entity shall, prior to obtaining the birth father's signature, advise the birth father of the matters listed in subsection (A) in a form and language the birth father can understand. The adoption entity shall include the advice listed in subsection (A) on the consent form.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-412. Consent to Adopt; Unknown Birth Parent**

**A.** A person who obtains a birth parent's signature on a consent shall not do so until the person reasonably determines:
1. That the requirements of R21-5-411 have been met;
2. That the birth parent is not acting under duress;
3. That the birth parent is physically and mentally capable of exercising informed consent; and
4. That the birth parent has revealed all information known about the identity and location of the other birth parent.

**B.** No one shall advise a birth parent to falsely state that he or she does not know the identity or location of the other birth parent.

**C.** When a birth parent professes not to know the identity or location of the other birth parent, the person taking the consent shall explain the risks and consequences of this response, including the following:
1. Potential invalidation of the adoption;
2. Potential detriment to the child's social and physical well-being, due to lack of information concerning the unidentified birth parent's social and medical history; and
3. Potential penalties for perjury.

**D.** When a birth parent knows, but refuses to disclose, the identity or location of the other birth parent, the adoption entity shall advise the birth parent as provided in subsection (C) and shall also explain that the Court may refuse to finalize the adoption.

**E.** The adoption entity shall document all action taken in compliance with this Section.

**F.** The adoption entity shall give the birth parent a copy of the consent and retain a copy in the permanent adoption file.

**G.** The adoption entity shall request a search of the confidential putative fathers registry of information that the Arizona Department of Health Services maintains under A.R.S. § 8-106.01 when:
1. A birth father's identity is unknown or undisclosed, and
2. The adoption entity believes that a search of the putative fathers registry may prevent disruption of a placement or an adoption.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-413. Adoptable Child: Assessment and Service Plan**

**A.** Prior to selecting an adoptive placement for an adoptable child, the adoption entity shall:
1. Assess the child's medical, psychological, social, and developmental needs;
2. Design an adoptive family profile consistent with the child's needs and best interests;
3. Develop a written service plan; and
4. Assess whether the child is a potential candidate for an adoption subsidy.

**B.** The service plan shall, at a minimum, include:
1. Placing the child on the Adoption Registry if there is no adoptive parent readily available to adopt the child;
2. Giving the child a developmentally appropriate explanation of the adoption process.

**C.** The adoption entity shall provide the child with services in accordance with the child's service plan.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-414. Placement Determination**

**A.** An adoption entity shall have and follow a written policy for making placement recommendations and decisions in both direct placement and adoption placement adoptions.

**B.** Except as otherwise provided in subsection (C), in an agency placement adoption a team shall make the placement decision. The team shall at a minimum, include:
1. The case manager or person who assessed the adoptable child, and
2. The case manager or person who is knowledgeable about the potential adoptive parents for the adoptable child.

**C.** In international adoptions, where the case manager or person who assessed the child is out of the country and unavailable, the adoption team shall include the person who is most familiar with the adoptable child's needs.

**D.** In an agency placement adoption, an adoption entity shall place an adoptable child in the adoptive setting that best meets the child's safety, social, emotional, physical and mental health needs. In determining who can best meet the needs, the adoption entity shall consider ICWA placement preferences if applicable and the following relevant factors in no order of preference:
1. The marital status, length and stability of the marital relationship of the adoptive parent;
2. The family's ability to meet the child's emotional, physical, mental, and social needs;
3. The family's ability to financially provide for the child;
4. The wishes of a child who is 12 years of age or more;
5. Family relationships between the child and the adoptive parent's family members;
6. The placement of the child's siblings;
7. The availability of relatives, the adoptable child's former foster parents, or other significant persons to provide support to the adoptive parent and child;
8. The wishes of the child's birth parent; and
9. All information in the case files of the child and the adoptive parent.

**E.** The adoption entity shall document the placement decision.
1. For adoptions conducted pursuant to the ICPC, the documentation shall comply with the requirements of the ICPC under A.R.S. § 8-548 et seq.
2. For all other adoptions, the documentation shall include the following:
   a. The adoptive child's critical needs and characteristics that weigh most heavily in the placement determination,
   b. The names and general characteristics of those adoptive parents who most closely match the child's needs and who are seriously considered for placement, and
   c. The reasons why a particular adoptive parent chosen for placement best meets the child's needs.

**F.** For adoptions not covered by the ICPC, the adoption entity may document the placement decision in a file or placement log that is separate from the clients' case files.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-415. Provision of Information on a Placed Child**

After selecting an adoptive placement for a child, and before placing the child with the chosen adoptive parent, the adoption entity shall provide the adoptive parent with all non-identifying information available on the child, including, without limitation, the following:
1. All records concerning the child's medical, psychological, social, legal, family, and educational background;
2. All records concerning the birth parents' medical, psychological, social, legal, family, and educational background;
3. The medical and social background on the child's other immediate family members, including siblings and birth grandparents;
4. The child's plan for adoption services, as described in R21-4-413; and
5. Information on adoption subsidy that may be available for the child.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-4-416. Transportation**

An adoption entity that transports an adoptive child shall:
1. Ensure that any person who transports an adoptive child is informed of the child's medical needs and is capable of meeting any medical needs that are reasonably likely to arise during transport;
2. Not leave an adoptive child unattended during transportation if the adoptive child:
   a. Is less than seven years of age;
   b. Has a developmental disability; and
   c. Is more than seven years of age if the adoption entity has determined, and documented in the child's record, that the child is physically and emotionally incapable of traveling alone;
3. Require all persons who provide transport to carry personal identification and a written statement from the adoption entity describing the person's authority and responsibilities while performing transport duties;
4. Require proof of driver's license from any person accepting temporary or permanent responsibility for transporting an adoptive child during the course of placement;

5. Document all transportation plans and actual transportation events in the child's record;
6. All vehicles used in transporting adoptive children shall be insured;
7. Ensure that an adoptive child is properly secured in a child restraint system that meets the requirements listed in R21-9-224(E).

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-417. Placement Services**

**A.** An adoption entity shall make counseling services available to the adoptive parents' family as the entity deems reasonable and necessary to facilitate the child's acceptance into the adoptive parent's family and to preserve stability. The adoption entity may make such services available by advising the adoptive family that such services may be beneficial and referring the adoptive parent and his or her family to community resources and providers.

**B.** The adoption entity shall make information on adoption related educational and supportive resources available to adoptive parents.

**C.** The adoptive parent must sign a document stating if he or she is declining any form of adoption counseling.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-418. Post-placement Supervision: Non-foster Parent Placement**

**A.** When a child is placed for adoption with a person who is not the child's foster parent, a case manager from the adoption entity shall visit the home within 30 calendar days of the date of adoptive placement to:
1. Ensure that the adoptive parent received all available non-identifying information from the adoption entity on the child;
2. Address any questions or concerns the adoptive parent or child may have about the adoption process or placement;
3. Ensure that the family has addressed the educational needs of a school-age child; and
4. Ensure that an adoptive parent who works has made appropriate child care arrangements.

**B.** Following the initial placement visit in subsection (A), a case manager from the adoption entity shall:
1. Visit the adoptive family at least once every three months until the adoption is finalized:
   a. Except, when the adoptive child is a child with special needs, the visits shall occur at least once a month; and
   b. During the first six months following the initial placement visit, at least alternating visits shall occur at the adoptive family's home;
2. Interview all members of the adoptive family's household during the placement supervision period;
3. Discuss how the child and the adoptive parent's family are adapting, the current relationship among members of the adoptive parent's family, and the following issues with the adoptive parent if appropriate in light of the child's age and development:
   a. How the presence of the child has changed familial relationships;
   b. How the child and the extended family view each other;
   c. The role each family member has assumed regarding child care and discipline;
   d. How the adoptive parent is coping with the needs and demands of the placed child;
   e. How the child challenges or tests the placement and how the family reacts to these episodes, including any feelings of insecurity about the propriety of the family members' response;
   f. How the family perceives the child's sense of identity and the need to fill in gaps in the child's history; and
   g. How the child has adjusted to the school environment;
4. If developmentally appropriate, privately interview the child about:
   a. The child's feelings about the adoption;
   b. How the child and family are adapting; and
   c. The child's relationships with the members of the family.

**C.** The case manager shall document all contacts and communications made under this Section.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-419. Post-placement Supervision: Foster Parent Placement**

**A.** When a foster parent plans to adopt a foster child who is age 5 years or older, a case manager from the adoption entity shall privately interview the child and all members of the adoptive family household who are age 5 years or older about their feelings towards the adoption, before the adoption consent is signed.

**B.** When a child is placed for adoption with a person who has been a foster parent to the child, a case manager from the adoption entity shall conduct a home visit at least every two months from the time legal consent for adoption has been signed until the finalization of adoption unless the adoptive child is a child with special needs. If the adoptive child is a child with special needs, the case manager shall visit at least once a month.

**C.** During the visits described in subsection (B), the case manager shall:
1. If developmentally appropriate, privately interview the child to discuss a child's feelings about the adoption; and
2. Interview all members of the adoptive family household, including children, if developmentally appropriate, to discuss, as described in R21-5-418, how the child and family are adapting, and the current relationship among members of the family.

**D.** The case manager shall document all contacts and communications under this Section.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-420. Protracted Placement**

If an adoption is not finalized within two years from the date of consent, and the child is still placed in the adoptive home, the adoption entity handling the adoption shall provide the Department with written documentation explaining the reason why the adoption has

not been finalized, no later than 30 calendar days after the two-year period has ended.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-421. Finalizing the Placement**

An adoption entity shall cooperate with the adoptive parent and the attorney, if any, retained by the adoptive parent, to finalize the adoption.

1. The entity shall provide all information and documents needed to finalize the adoption and shall file a final written report to the court at least 10 days before the final adoption hearing, or at such other time as the Court may require. The report shall include the information listed in this subsection, unless the entity has already provided this information in an earlier report, and the information has not changed since the earlier report.
   a. The name and age of each adoptive parent and the relationship, if any, of each adoptive parent to the child to be adopted;
   b. The name, age, and birthplace of the child to be adopted, and whether any or all of this information is unknown to the adoptive parent;
   c. The entity or other source from which the adoptive parent received the child to be adopted;
   d. The circumstances surrounding the surrender of the child to the entity;
   e. The results of the entity's evaluation of the child and of the adoptive parent, including:
      i. A description of the care the child is receiving;
      ii. The adjustment of the child and parent; and
      iii. A summary statement of the entity's recommendation to the court regarding finalization;
   f. A full description of any property belonging to the child to be adopted;
2. For children 12 years of age and older, the adoption entity shall solicit and consider the child's wishes concerning adoption.
3. The adoption entity shall notify the AHCCCS Administration of any potential third party payer, as prescribed in A.R.S. § 36-2946, if the entity has not already done so.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Amended by final expedited rulemaking at 28 A.A.R. 2479 (September 23, 2022), with an immediate effective date of September 9, 2022 (Supp. 22-3).

**R21-5-422. Placement Disruption**

**A.** When a placement fails, the adoption entity shall provide services, including counseling to the adoptive parent and his or her family and child, to help them cope with the loss and separation.

**B.** An adoption entity shall have and follow written procedures for an adoptive placement disruption. The procedures shall include:

1. Provision of counseling services to the adoptive parent, his or her family, and the child as needed; and
2. Provision for placement of the child in another adoptive home or other developmentally appropriate living arrangement.

**C.** The adoptive entity shall document the reasons for the disruption and shall take such information into account when making future placements for the adoptive parent and the child.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-423. Confidentiality**

Any person or entity who participates in an adoption or provides adoption services shall comply with the confidentiality requirements under A.R.S. §§ 8-120, 8-121, and 36-2903.01.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

## ARTICLE 5. ADOPTION SUBSIDY

**R21-5-501. Definitions**

In addition to the definitions in A.R.S. §§ 8-141 and 8-501, the following definitions apply in this Article.

1. "Adoption agency" means an individual or entity, including a corporation, company, partnership, firm, association, or society, other than the Department, licensed by the Department to place a child for adoption.
2. "Adoption Specialist" means the Department of Child Safety Specialist, or adoption agency staff person, who is responsible for managing the child's case prior to the adoption finalization.
3. "Adoption subsidy" means the same as A.R.S. § 8-141, and includes nonrecurring adoption expenses under A.R.S. § 8-161 et seq. If the child qualifies, the adoption subsidy may include one or more of the following:
   a. Medical, dental, and mental health subsidy;
   b. Maintenance subsidy;
   c. Special services subsidy; and
   d. Reimbursement of nonrecurring adoption expenses.
4. "Adoption subsidy agreement" means the agreement in A.R.S. § 8-144 concerning the Adoption Subsidy Program and includes the agreement in A.R.S. § 8-162 concerning the nonrecurring adoption expense program.
5. "Adoption Subsidy Program" means a unit within the Department of Child Safety that administers the adoption subsidy.
6. "Adoption Subsidy Supervisor" means a Department employee who is responsible for the Adoption Subsidy Program within a defined geographic area, and that the Department has authorized to approve an adoption subsidy agreement.
7. "Adoptive parent" means an adult who the court has certified or approved to adopt a child, or an adult who has adopted a child.
8. "AHCCCS" means the Arizona Health Care Cost Containment System, which is the state's program for medical assistance available under Title XIX of the Social Security Act and state public insurance statutes, A.R.S. Title 36, Chapter 29.
9. "AHCCCS hospital reimbursement system" means the payment structure that AHCCCS uses to pay for inpatient and outpatient hospital services.
10. "Complete adoption subsidy application" means a packet containing the following:
    a. An "Adoptive Family Subsidy Application" form provided by the Department that the adoptive parent, the Adoption Specialist, and Adoption Specialist supervisor have completed and signed; and

b. The supporting documentation and information requested in the "Adoptive Family Subsidy Application."

11. "Debilitating" means a lifelong, progressive, or fatal condition characterized by physical, mental, or developmental impairment that impedes an individual's ability to function independently.
12. "Department" or "DCS" means the Arizona Department of Child Safety.
13. "Developmental disability" means the same as A.R.S. § 8-141.
14. "Diagnose" means to identify a physical, psychological, social, learning, or developmental condition or disability according to the accepted standards of the medical, mental health, or educational professions.
15. "Emergency situation" means a circumstance that, if unaddressed, would be detrimental to a child's life, health, or safety.
16. "Emotional disturbance" means the same as A.R.S. § 8-141.
17. "Lawfully present in the United States" means the child is a U.S. citizen, national, or an alien authorized by an appropriate federal entity or court to be present in the United States.
18. "Legally free" means the parental rights of a child's birth or legal parents have been terminated.
19. "Maintenance subsidy" means a monthly payment paid to a custodial adoptive parent to assist with the costs directly related to meeting some of the adopted child's needs, including child care, health insurance co-payments and deductibles, and supplemental educational services for the adopted child.
20. "Mental disability" means the same as A.R.S. § 8-141.
21. "Nonrecurring adoption expenses" means the same as A.R.S. § 8-161, and are reasonable and necessary expenses directly related to the legal process of adopting a child with special needs. Allowable expenses include adoption fees, court costs, attorney's fees, fingerprinting fees, home study fees, costs for physical and psychological examinations, costs for placement supervision, and travel expenses necessary to complete the adoption.
22. "Physical disability" means the same as A.R.S. § 8-141.
23. "Qualified professional" means a practitioner licensed or certified by the state of Arizona or another state to evaluate and diagnose a condition or disability, or provide medical, dental, mental health services, or approved by the Department to provide educational or respite services.
24. "Sibling relationship" means two or more brothers or sisters who are related by blood or by law, and who are being adopted by the same family.
25. "Special allowance" means funds provided for clothing or personal expenses, therapeutic or personal attendant care, and other specialized payments such as emergency clothing, education, and gift allowances.
26. *"Special needs" means one or more of the following conditions which existed before the finalization of adoption:*
    a. Physical, mental or developmental disability.
    b. Emotional disturbance.
    c. High risk of physical or mental disease.
    d. High risk of developmental disability.
    e. Age of six or more years at the time of application for an adoption subsidy.
    f. Sibling relationship.
    g. Racial or ethnic factors.
    h. High risk of severe emotional disturbance if removed from the care of his foster parents.
    *i. Any combination of the special needs described in this paragraph.* A.R.S. § 8-141.
27. "Special services subsidy" means financial assistance for extraordinary, infrequent, or uncommon needs related to a special needs condition specified in the adoption subsidy agreement.
28. "Standard of care" means a medical or psychological procedure or process that is accepted as treatment for a specific illness, injury, medical, dental, learning, or psychological condition through custom, peer review, or consensus by the professional medical, dental, educational, or mental health community.
29. "Title IV-E" means section 473 of Title IV of the Social Security Act, 42 U.S.C. 673, which establishes the federal adoption assistance program.
30. "Title XIX" means Medicaid, as defined by Section 1900, Title XIX, of the Social Security Act, 42 U.S.C. 1396.
31. "Title XX" means the Social Services Block Grant, as defined by Section 2001, Title XX, of the Social Security Act, 42 U.S.C. 1397.
32. "Undiagnosed pre-existing special need condition" means a physical, mental or developmental disability or emotional disturbance that existed before a court finalized the child's adoption, and that a qualified professional did not confirm before the child's adoption.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-502. Eligibility Criteria**

**A.** The Department shall determine if a child qualifies for the Title IV-E adoption assistance program prior to determining whether the child qualifies for the Adoption Subsidy Program.

**B.** A child shall qualify for Title IV-E adoption assistance if the child meets the additional eligibility criteria required in 42 U.S.C. 673(a)(2). If the child does not meet the additional criteria in Title IV-E, the child may still be eligible to receive adoption subsidy under subsection (C).

**C.** An Arizona child shall be eligible for adoption subsidy when the child is:
1. In the care, custody, and control of the Department, or an adoption agency licensed in Arizona, or was previously adopted and received Title IV-E or Arizona adoption subsidy;
2. Legally free for adoption;
3. Lawfully present in the United States; and
4. Determined to be a child with special needs as defined by Title IV-E of the Social Security Act, and A.R.S. Title 8, Chapter 1, Articles 2 and 3 as follows:
    a. The child cannot or should not be returned to the parent's home;
    b. The child cannot be placed with adoptive parents without an adoption subsidy due to a special need of the child; and
    c. A reasonable but unsuccessful effort was made to place the child without an adoption subsidy, unless the Department determined that it was not in the child's best interest to place the child with another family because of the child's significant emotional ties with the prospective adoptive parent while in their care as a foster child.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-503. Application for Adoption Subsidy**

**A.** The adoptive parent shall submit a complete adoption subsidy application to the Department Adoption Subsidy Program prior to the finalization of the adoption. A complete adoption subsidy application shall include the following:
1. The child's:
   a. Name;
   b. Date of birth;
   c. Social Security Number; and
   d. Ethnicity;
2. The adoptive parents':
   a. Name;
   b. Date of birth;
   c. Social Security Number;
   d. Ethnicity;
   e. Marital status;
   f. Occupation;
   g. Relationship to the child;
   h. Adoption certification status;
3. Information about:
   a. The child's special needs;
   b. Whether the child is lawfully present in the U.S.;
   c. The Department or the adoption agency that has custody of the child;
   d. Whether the child is free for adoption;
   e. Efforts to place the child for adoption without adoption subsidy;
   f. Resources for which the child is eligible; and
   g. Financial benefits for which the child is eligible; and
4. Description of:
   a. The child's pre-existing special need conditions;
   b. The need for maintenance payments; and
   c. Nonrecurring expenses.
5. The adoptive parent shall include the following documentation:
   a. The child's specific special need identified by a qualified professional;
   b. The child's need for a maintenance subsidy from:
      i. The adoptive parent,
      ii. Adoption Specialist, and
      iii. A qualified professional;
   c. The child's lawful presence in the United States if the child is not a U.S. citizen;
   d. The child's pre-existing medical, dental, and mental health conditions as documented by a qualified professional:
      i. Current within one year, or
      ii. Provided in birth records; and
6. Assurances that the following information is available in the adoption case record:
   a. The Department or adoption agency that has custody of the child,
   b. That the child is free for adoption, and
   c. Efforts to place the child for adoption without adoption subsidy.

**B.** An adoption subsidy application is complete when the Adoption Subsidy Program receives the application and all supporting documentation. Documentation may vary according to the conditions of the child, and may include the recommendations of qualified professionals.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-504. Eligibility Determination**

The Department shall review the adoption subsidy application and determine eligibility according to the following:
1. The Department shall approve eligibility for adoption subsidy if a child meets the eligibility criteria listed in R21-5-502 and the adoptive parent submits a complete application. If the Department approves eligibility, the Department shall create an adoption subsidy agreement that the adoptive parent and the Adoption Subsidy Supervisor or designee shall sign before the court enters the final order of adoption.
2. The Department shall deny eligibility for an adoption subsidy if a child does not meet the eligibility criteria listed in R21-5-502. If the Department denies an adoption subsidy, the Department shall send a notice to the adoptive parent that explains the reason for denial, the applicant's right to appeal, and the time-frame to file an appeal.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-505. Adoption Subsidy Agreement**

**A.** The Department shall create an adoption subsidy agreement that lists the scope and nature of the subsidies provided, including:
1. The child's documented pre-existing special needs condition,
2. The types of subsidy approved,
3. The amount or rates as applicable to the types of subsidy approved, and
4. The specific terms and conditions of the agreement.

**B.** The adoption subsidy agreement shall become effective if the following occurs prior to the finalization of the adoption:
1. The adoptive parent signs the agreement and returns it to the Department Adoption Subsidy Program, and
2. The Adoption Subsidy Supervisor or designee signs the agreement.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-506. Medical, Dental, and Mental Health Subsidy**

Adoption subsidy provides medical, dental, and mental health subsidies in the form of federal Medicaid coverage to a child in the Adoption Subsidy Program.
1. If the child resides in Arizona, AHCCCS determines eligibility; or
2. If the child resides in another state, the relevant state agency in that state determines Medicaid eligibility.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-507. Maintenance Subsidy**

**A.** The maintenance subsidy may not cover all the daily living expenses of the adopted child. The Department and the adoptive parent shall negotiate the amount of maintenance subsidy based on a child's current special needs and the family's circumstances.

1. Under A.R.S. § 8-144(B), the amount of the maintenance subsidy shall not exceed the payments allowable for foster care, not including foster care special allowances.
2. The Department shall deduct private or public monetary benefits, such as benefits received through Title II of the Social Security Act, paid to the child from the monthly maintenance subsidy, as allowed under state or federal law. The adoptive parent shall report the receipt of any private or public monetary benefits for the child to the Adoption Subsidy Program as soon as the benefits are received.

**B.** Payment of Maintenance Subsidy
1. The Department shall not begin maintenance subsidy payments prior to the effective date of the adoption subsidy agreement.
2. The Department shall issue maintenance subsidy payments monthly to the adoptive parent as specified in the adoption subsidy agreement.

**C.** Renegotiation of the Maintenance Rate
1. The Department or the adoptive parent may initiate a change in the maintenance subsidy rate if there are changes in the child's needs.
2. The Department may renegotiate the amount of the adoption subsidy; however, the rate shall not exceed the payments allowable for foster care, not including foster care special allowances.
3. The adoptive parent shall provide the Department with documentation supporting the requested change in the maintenance subsidy rate.
4. If the child is in the care or custody of a state agency in Arizona or any other state, an adoption agency, or an individual other than the adoptive parent, the Department shall request, and the adoptive parent shall provide, documentation that the adoptive parent continues to be legally and financially responsible for the child.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-508. Special Services Subsidy**

**A.** Special services subsidy shall be:
1. Related to a special needs condition listed in the adoption subsidy agreement; and
2. Necessary to improve or maintain the adopted child's functioning as documented by an appropriate qualified professional. The Adoption Subsidy Program shall review the documentation at least annually.

**B.** Services approved for the payment of special services subsidy shall be:
1. Provided by a qualified professional;
2. Provided in the least restrictive environment and as close as possible to the adoptive parent's residence;
3. In accordance with the "Standard of Care"; and
4. Not otherwise covered by or provided through maintenance subsidy, medical subsidy, dental subsidy, mental health subsidy, or other resources for which the adopted child is eligible.

**C.** The adoptive parent shall submit the special services request to the Adoption Subsidy Program and receive approval from the Adoption Subsidy Program prior to the adoptive parent's incurring the specified expense. The request shall include:
1. Documentation from a qualified professional that the service is necessary; and
2. Documentation that the adoptive parent had requested the service and the service provider had denied the request or documentation that the service is not available from other potential funding sources, such as AHCCCS/Medicaid, private insurance, school district, or other community resources.

**D.** Special services subsidy shall not include:
1. Payment for services to meet needs other than the pre-existing special needs conditions specifically listed in the adoption subsidy agreement;
2. Payment for medical or dental services usually considered to be routine, such as well-child checkups, immunizations, and other services not related to the child's special needs conditions in the adoption subsidy agreement;
3. Payment for health-related services that are not medically necessary, as determined by a qualified professional;
4. Payment for social or recreational services such as routine child care, dance lessons, sports fees, camps, and similar services; and
5. Payment for educational services that are not necessary to meet the special needs conditions specifically listed in the adoption subsidy agreement, or the services for which the school district is responsible.

**E.** The Department may request an independent review by a qualified professional of a special services request to determine the necessity for medical, dental, psychological, or psychiatric testing or services, or to evaluate the appropriateness of the treatment plan or placement.

**F.** The Department may issue reimbursements to the adoptive parent for approved special services, or the Department may pay the service provider directly.

**G.** Special services subsidy reimbursement is limited as follows:
1. The Department shall reimburse in-state and out-of-state inpatient and outpatient hospital services according to the AHCCCS hospital reimbursement system, as required by A.R.S. § 8-142.01(A), if the adoptive parent has obtained prior approval for the service from the Department. Prior approval is not required in an emergency situation.
2. The Department shall not reimburse special services subsidy amounts in excess of the rates allowed by the Department or AHCCCS. The Department shall use the lowest applicable rates as established by AHCCCS, the Department's Comprehensive Medical and Dental Program (CMDP), or rates established by the Adoption Subsidy Program to be customary and reasonable.
3. The Department shall not pay for requests that the adoptive parent or provider submits more than nine months after the date of service for which the adoptive parent or provider requests payment.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-509. Nonrecurring Adoption Expenses**

**A.** Nonrecurring adoption expenses shall not cover expenses related to visiting and placing the child.

**B.** Reimbursement of nonrecurring adoption expenses is subject to the limitations in A.R.S. § 8-164.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-510. Annual Review; Reporting Change**

**A.** Each year, the Department shall send a review form to the adoptive parent requesting that the adoptive parent provide:
1. Information indicating that the parent remains legally and financially responsible for the child;
2. Information on any change in benefits for the child, such as benefits received through Title II of the Social Security Act;
3. Information on any change in circumstances, including changes in residence, marital status, educational status, or other similar changes; and
4. A description of any changes in the child's special needs conditions that are listed in the adoption subsidy agreement.

**B.** The adoptive parent shall provide the Department with the requested information within 30 days of the adoptive parent's receipt of the review form.

**C.** The adoptive parent shall notify the Department in writing within five calendar days when any of the following occurs:
1. The adoptive parent is no longer legally responsible for the child;
2. The adoptive parent is no longer providing support to the child;
3. The child is no longer residing in the adoptive parent's home;
4. The child has graduated from high school or obtained a general equivalency degree (GED);
5. The child has married;
6. The child has joined the military; or
7. The child dies.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-511. Termination of Adoption Subsidy**

The Department shall terminate an adoption subsidy when any of the following occurs:
1. The child turns 18 years old and is not enrolled in and attending high school or a program leading to a high school diploma or general equivalency degree (GED);
2. The child is aged 18 through 21 years, has been continuously enrolled in school, and either drops out of school, graduates from high school, or obtains a general equivalency degree (GED);
3. The child turns 22 years old;
4. The adoptive parent is no longer legally responsible for the child;
5. The adoptive parent is no longer providing support to the child;
6. The child marries;
7. The child joins the military;
8. The special needs conditions of the child no longer exist;
9. The child dies;
10. The adoptive single parent or both adoptive parents die; or
11. The adoptive parent requests termination.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-512. New or Amended Adoption Subsidy Agreement**

An adoptive parent may apply for a new or amended adoption subsidy agreement after the adoption is final, only upon documentation of an undiagnosed pre-existing special needs condition that existed before the finalization of the adoption.
1. The adoptive parent shall send the Department a written request for adoption subsidy with documentation from a qualified professional diagnosing the special needs condition and confirming that it existed before the final order of adoption.
2. The adoptive parent and the Department shall follow the procedures in this Article for processing applications and determining eligibility.
3. If the Department finds that the child has an undiagnosed pre-existing special needs condition that, if diagnosed prior to the adoption, would have met the eligibility criteria listed in R21-5-502, the Department shall grant a new subsidy or amend the adoption subsidy agreement to cover this special needs condition.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-513. Appeals**

Appeals for the Adoption Subsidy Program shall follow the process in 21 A.A.C. 1, Article 3.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-514. Confidentiality**

The Department shall maintain the confidentiality of all information used in the Adoption Subsidy Program according to all applicable federal and state laws.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

# 8-453. Powers and duties

A. The director shall:

1. Carry out the purposes of the department prescribed in section 8-451.

2. Provide transparency by being open and accountable to the public for the actions of the department.

3. Develop a data system that enables persons and entities that are charged with a responsibility relating to child safety to access all relevant information relating to an abused, neglected or abandoned child as provided by law.

4. Subject to title 41, chapter 4, article 4 and, as applicable, articles 5 and 6, employ deputy directors and other key personnel based on qualifications that are prescribed by the director.

5. Adopt rules to implement the purposes of the department and the duties and powers of the director.

6. Petition, as necessary to implement the case plan established under section 8-824 or 8-845, for the appointment of a guardian or a temporary guardian under title 14, chapter 5 for children who are in the custody of the department pursuant to court order. Persons applying to be guardians or temporary guardians under this section shall be fingerprinted. A foster parent or certified adoptive parent already fingerprinted is not required to be fingerprinted again, if the foster parent or certified adoptive parent is the person applying to be the guardian or temporary guardian.

7. Cooperate with other agencies of this state, county and municipal agencies, faith-based organizations and community social services agencies, if available, to achieve the purposes of this chapter.

8. Exchange information, including case specific information, and cooperate with the department of economic security for the administration of the department of economic security's programs.

9. Administer child welfare activities, including:

(a) Cross-jurisdictional placements pursuant to section 8-548.

(b) Providing the cost of care of:

(i) Children who are in temporary custody, are the subject of a dependency petition or are adjudicated by the court as dependent and who are in out-of-home placement, except state institutions.

(ii) Children who are voluntarily placed in out-of-home placement pursuant to section 8-806.

(iii) Children who are the subject of a dependency petition or are adjudicated dependent and who are in the custody of the department and ordered by the court pursuant to section 8-845 to reside in an independent living program pursuant to section 8-521.

(c) Providing services for children placed in adoption.

10. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

11. Make contracts and incur obligations within the general scope of the department's activities and operations subject to the availability of funds.

12. Coordinate with, contract with or assist other departments, agencies and institutions of this state and local and federal governments in the furtherance of the department's purposes, objectives and programs.

13. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.

14. Collect monies owed to the department.

15. Act as an agent of the federal government in furtherance of any functions of the department.

16. Carry on research and compile statistics relating to the child welfare program throughout this state, including all phases of dependency.

17. Cooperate with the superior court in all matters related to this title and title 13.

18. Provide the cost of care and transitional independent living services for a person under twenty-one years of age pursuant to section 8-521.01.

19. Ensure that all criminal conduct allegations and reports of imminent risk of harm are investigated.

20. Ensure the department's compliance with the Indian child welfare act of 1978 (P.L. 95-608; 92 Stat. 3069; 25 United States Code sections 1901 through 1963).

21. Strengthen relationships with tribal child protection agencies or programs.

B. The director may:

1. Take administrative action to improve the efficiency of the department.

2. Contract with a private entity to provide any functions or services pursuant to this title.

3. Apply for, accept, receive and expend public and private gifts or grants of money or property on the terms and conditions as may be imposed by the donor and for any purpose provided for by this title.

4. Reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business. Volunteers reimbursed for expenses are not eligible for workers' compensation under title 23, chapter 6.

C. The department shall administer individual and family services, including sections on services to children and youth and other related functions in furtherance of social service programs under the social security act, as amended, title IV, parts B and E, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services and other related federal acts and titles.

D. Notwithstanding any other law, a state or local governmental agency or a private entity is not subject to civil liability for the disclosure of information that is made in good faith to the department pursuant to this section.

E. Notwithstanding section 41-192, the department may employ legal counsel to provide legal advice to the director. The attorney general shall represent the department in any administrative or judicial proceeding pursuant to title 41, chapter 1, article 5.

F. The total amount of state monies that may be spent in any fiscal year by the department for foster care as provided in subsection A, paragraph 9, subdivision (b) of this section may not exceed the amount appropriated or authorized by section 35-173 for that purpose. This section does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

# 8-548. Enactment of compact; terms

The interstate compact on the placement of children is hereby enacted into law and entered into with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I. PURPOSE AND POLICY

It is the purpose and policy of the party states to cooperate with each other in the interstate placement of children to the end that:

(a) Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons or institutions having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care.

(b) The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child.

(c) The proper authorities of the state from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made.

(d) Appropriate jurisdictional arrangements for the care of children will be promoted.

ARTICLE II. DEFINITIONS

As used in this compact:

(a) "Child" means a person who, by reason of minority, is legally subject to parental, guardianship or similar control.

(b) "Sending agency" means a party state, officer or employee thereof; a subdivision of a party state, or officer or employee thereof; a court of a party state; a person, corporation, association, charitable agency or other entity which sends, brings or causes to be sent or brought any child to another party state.

(c) "Receiving state" means the state to which a child is sent, brought or caused to be sent or brought, whether by public authorities or private persons or agencies, and whether for placement with state or local public authorities or for placement with private agencies or persons.

(d) "Placement" means the arrangement for the care of a child in a family free or boarding home or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic or any institution primarily educational in character, and any hospital or other medical facility.

ARTICLE III. CONDITIONS FOR PLACEMENT

(a) No sending agency shall send, bring, or cause to be sent or brought into any other party state any child for placement in foster care or as a preliminary to a possible adoption unless the sending agency shall comply with each and every requirement set forth in this article and with the applicable laws of the receiving state governing the placement of children therein.

(b) Prior to sending, bringing or causing any child to be sent or brought into a receiving state for placement in foster care or as a preliminary to a possible adoption, the sending agency shall furnish the appropriate public authorities in the receiving state written notice of the intention to send, bring, or place the child in the receiving state. The notice shall contain:

(1) The name, date and place of birth of the child.

(2) The identity and address or addresses of the parents or legal guardian.

(3) The name and address of the person, agency or institution to or with which the sending agency proposes to send, bring, or place the child.

(4) A full statement of the reasons for such proposed action and evidence of the authority pursuant to which the placement is proposed to be made.

(c) Any public officer or agency in a receiving state which is in receipt of a notice pursuant to paragraph (b) of this article may request of the sending agency, or any other appropriate officer or agency of or in the sending agency's state, and shall be entitled to receive therefrom, such supporting or additional information as it may deem necessary under the circumstances to carry out the purpose and policy of this compact.

(d) The child shall not be sent, brought, or caused to be sent or brought into the receiving state until the appropriate public authorities in the receiving state shall notify the sending agency, in writing, to the effect that the proposed placement does not appear to be contrary to the interests of the child.

ARTICLE IV. PENALTY FOR ILLEGAL PLACEMENT

The sending, bringing, or causing to be sent or brought into any receiving state of a child in violation of the terms of this compact shall constitute a violation of the laws respecting the placement of children of both the state in which the sending agency is located or from which it sends or brings the child and of the receiving state. Such violation may be punished or subjected to penalty in either jurisdiction in accordance with its laws. In addition to liability for any such punishment or penalty, any such violation shall constitute full and sufficient grounds for the suspension or revocation of any license, permit, or other legal authorization held by the sending agency which empowers or allows it to place, or care for children.

ARTICLE V. RETENTION OF JURISDICTION

(a) The sending agency shall retain jurisdiction over the child sufficient to determine all matters in relation to the custody, supervision, care, treatment and disposition of the child which it would have had if the child had remained in the sending agency's state, until the child is adopted, reaches majority, becomes self-supporting or is discharged with the concurrence of the appropriate authority in the receiving state. Such jurisdiction shall also include the power to effect or cause the return of the child or its transfer to another location and custody pursuant to law. The sending agency shall continue to have financial responsibility for support and maintenance of the child during the period of the placement. Nothing contained herein shall defeat a claim of jurisdiction by a receiving state sufficient to deal with an act of delinquency or crime committed therein.

(b) When the sending agency is a public agency, it may enter into an agreement with an authorized public or private agency in the receiving state providing for the performance of one or more services in respect of such case by the latter as agent for the sending agency.

(c) Nothing in this compact shall be construed to prevent a private charitable agency authorized to place children in the receiving state from performing services or acting as agent in that state for a private charitable agency of the sending state; nor to prevent the agency in the receiving state from discharging financial responsibility for the support and maintenance of a child who has been placed on behalf of the sending agency without relieving the responsibility set forth in paragraph (a) hereof.

ARTICLE VI. INSTITUTIONAL CARE OF DELINQUENT CHILDREN

A child adjudicated delinquent may be placed in an institution in another party jurisdiction pursuant to this compact, but no such placement shall be made unless the child is given a court hearing on notice to the parent or guardian with opportunity to be heard, prior to his being sent to such other party jurisdiction for institutional care and the court finds that:

1. Equivalent facilities for the child are not available in the sending agency's jurisdiction; and

2. Institutional care in the other jurisdiction is in the best interest of the child and will not produce undue hardship.

ARTICLE VII. COMPACT ADMINISTRATOR

The executive head of each jurisdiction party to this compact shall designate an officer who shall be general coordinator of activities under this compact in his jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact.

ARTICLE VIII. LIMITATIONS

This compact shall not apply to:

(a) The sending or bringing of a child into a receiving state by his parent, step-parent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and leaving the child with any such relative or non-agency guardian in the receiving state.

(b) Any placement, sending or bringing of a child into a receiving state pursuant to any other interstate compact to which both the state from which the child is sent or brought and the receiving state are party, or to any other agreement between said states which has the force of law.

ARTICLE IX. ENACTMENT AND WITHDRAWAL

This compact shall be open to joinder by any state, territory or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and, with the consent of Congress, the government of Canada or any province thereof. It shall become effective with respect to any such jurisdiction when such jurisdiction has enacted the same into law. Withdrawal from this compact shall be by the enactment of a statute repealing the same, but shall not take effect until two years after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other party jurisdiction. Withdrawal of a party state shall not affect the rights, duties and obligations under this compact of any sending agency therein with respect to a placement made prior to the effective date of withdrawal.

ARTICLE X. CONSTRUCTION AND SEVERABILITY

The provisions of this compact shall be liberally construed to effectuate the purposes thereof. The provisions of this compact shall be severable and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held contrary to the constitution of any state party thereto, the compact shall remain in full force and effect as to the remaining states and in full force and effect as to the state affected as to all severable matters.

## 8-548.01. Financial responsibility

Financial responsibility for any child placed pursuant to the provisions of the interstate compact on the placement of children shall be determined in accordance with the provisions of article V.

## 8-548.02. Interstate compact administrator

Pursuant to the compact the governor shall designate the director of the department as the compact administrator. The compact administrator, acting jointly with like officers of other party states, shall promulgate rules and regulations to carry out more effectively the terms of the compact. The compact administrator shall cooperate with all departments, agencies and officers of and in the government of this state and its subdivisions in facilitating the proper administration of the compact or of any supplementary agreement or agreements entered into by this state thereunder.

## 8-548.03. Supplementary agreements

The compact administrator shall have authority to enter into supplementary agreements with appropriate officials of other states pursuant to the compact. In the event that such supplementary agreement requires or contemplates the use of any institution or facility of this state or requires or contemplates the provision of any service by this state, the supplementary agreement shall have no force or effect until approved by the head of the department or agency under whose jurisdiction the institution or facility is operated or whose department or agency will be charged with the rendering of the service.

## 8-548.04. Financial arrangements

The compact administrator, subject to the approval of the director of the department of administration, may make or arrange for any payments necessary to discharge any financial obligations imposed upon this state by the compact or by any supplementary agreement entered into thereunder.

## 8-548.05. Visitation, inspection and supervision

Any requirements for visitation, inspection or supervision of children, homes, institutions or other agencies in another party state which may apply under sections 8-501, 8-503 through 8-520 and 8-813 shall be deemed to be met if performed pursuant to an agreement entered into by appropriate officers or agencies of this state as contemplated by paragraph (b) of article V of the interstate compact on the placement of children.

## 8-548.06. Responsibilities of state departments, agencies and officers

The courts, departments, agencies and officers of this state and its subdivisions shall enforce this compact and shall do all things appropriate to the effectuation of its purposes and intent which may be within their respective jurisdictions.

**DEPARTMENT OF CHILD SAFETY**
Title 21, Chapter 5, Articles 3 & 4

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 10, 2025

**SUBJECT:** **DEPARTMENT OF CHILD SAFETY**
Title 21, Chapter 5, Article 3 & 4

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**Summary**

This Five-Year Review Report (5YRR) from the Department of Child Safety (Department) relates to seven (7) rules in Title 21, Chapter 5, Article 3 regarding Department Adoption Services and twenty-three (23) rules in Title 21, Chapter 5, Article 4 regarding Adoption Entity Services. Specifically, the Department is the state agency that provides child welfare services, which includes adoption services, and is authorized by Arizona Revised Statutes to promote the placement of children in permanent adoptive homes. The Department provides adoption services, contracts with private agencies to recruit adoptive homes, and licenses adoption agencies (Title 21, Chapter 9) in Arizona. The goal of adoption services is to place children with qualified adoptive parents in a permanent adoptive home.

The Department completed its proposed course of action from its prior 5YRR, which was approved by the Council in June 2020. Specifically, the Department indicates rule R21-5-421(1) was amended by final expedited rulemaking at 28 A.A.R. 2479, with an immediate effective date of September 9, 2022 to create consistency between rule and statute pertaining to when a court report must be submitted prior to a final adoption hearing.

**Proposed Action**

In the current report, the Department is not proposing to take any action regarding the rules.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

The rules being reviewed provide information pertaining to the services provided by the Department and the responsibility of adoption entities. Funding for adoption services in fiscal year 2024 included over two million dollars from a combination of federal and state funds. As of January 31, 2025, 1,374 of the 7,775 children ages 0-17 in out-of-home care had a case plan goal of adoption. In comparison, on January 31, 2020, 2,649 of the 13,298 children ages 0-17 in out-of-home care had a case plan goal of adoption. The Department believes that any cost associated with the rules are offset by the greater benefit of ensuring the safety and protection of Arizona children while seeking a permanent adoptive home for them, and the Department does not plan any rulemaking activity for these rules resulting from this five-year review.

Stakeholders are identified as children in the care of the Department of Child Safety, prospective adoptive parents, birth parents, attorneys and families involved in the adoption process, and the Department.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes that the current rules pose the minimum cost and burden to the persons regulated by these rules.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Department indicates it has not received any written criticisms of the rule in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rule is clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rule is consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rule is effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rule is currently enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates the following federal laws that apply to the rules of these Articles: Adoption and Safe Families Act (ASFA) (P.L. 105-89); Adam Walsh Child Protection and Safety Act (P.L. 109-248); Adoption Promotion Act 2003 (P.L. 108-145); and Keeping Children and Families Safe Act 2003 (P.L. 108-36). However, the Department states the rules in these Articles are not more stringent than federal law.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates that A.R.S. 41-1037 does not apply to these rules because these rules do not require the issuance of a regulatory permit, license, or agency authorization.

**11. Conclusion**

This 5YRR from the Department relates to seven (7) rules in Title 21, Chapter 5, Article 3 regarding Department Adoption Services and twenty-three (23) rules in Title 21, Chapter 5, Article 4 regarding Adoption Entity Services. Specifically, the Department is the state agency that provides child welfare services, which includes adoption services, and is authorized by Arizona Revised Statutes to promote the placement of children in permanent adoptive homes. The Department provides adoption services, contracts with private agencies to recruit adoptive homes, and licenses adoption agencies (Title 21, Chapter 9) in Arizona. The Department has not identified any issues with the rules and, therefore, does not propose to take any course of action regarding the rules.

Council staff recommends approval of this report.

ARIZONA
DEPARTMENT OF
CHILD SAFETY

Kathryn Ptak, Director
Katie Hobbs, Governor

March 13, 2025

VIA EMAIL: grrc@azdoa.gov
Jessica Klein, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Arizona Department of Child Safety, A.A.C. Title 21, Chapter 5, Articles 3 and 4 Five-Year-Review Report

Dear Chairperson Klein:

Please find enclosed the updated Five-Year-Review Report of the Arizona Department of Child Safety (DCS) for A.A.C. Title 21, Chapter 5, Articles 3 and 4 due on March 31, 2025.

DCS hereby certifies compliance with A.R.S. § 41-1091.

For questions about this report, please contact Karen Wouters at Karen.Wouters@azdcs.gov.

Sincerely,

Kathryn Ptak
Director

Enclosure


P.O. Box 6030 ♦ Site Code C010-23 ♦ Phoenix, AZ 85005-6030
Telephone (602) 255-2500

**ARIZONA DEPARTMENT OF CHILD SAFETY**

**Five-Year-Review Report**

**Title 21. Child Safety**

**Chapter 5. Department of Child Safety - Permanency and Support Services**

**Article 3. Department Adoption Services**

**Article 4. Adoption Entity Services**

**March 2025**

**1. Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 8-453(A)(5)

Specific Statutory Authority: A.R.S. §§ 8-105, 8-112, 8-120, 8-121, 8-130, 8-171, 8-172, 8-173

**2. The objective of each rule:**

Article 3: Department Adoption Services

| Rule | Objective |
|---|---|
| R21-5-301. Definitions | The objective of this rule is to provide a uniform set of definitions used throughout this Article, Article 4 of this Chapter, and Chapter 9 all under Title 21. |
| R21-5-302. Adoption Registry: Information Maintained; Confidentiality | The objective of this rule is to identify and define the Department's responsibility for maintenance of the Adoption Registry, content to be maintained, and information required for the release of information. |
| R21-5-303. Department Adoption Services | The objective of this rule is to identify the adoption services provided by the Department. |
| R21-5-304. Department Procedures for Processing Certification Applications | The objective of this rule is to provide a process for receipt of an adoption certification application and a process when the application is complete or incomplete. |
| R21-5-305. Department Priorities for | The objective of this rule is to inform certification applicants about how the Department prioritizes applications. |

| | |
|---|---|
| Receipt of Services | |
| R21-5-306. Department Recruitment Efforts | The objective of this rule is to provide a process the Department will follow for the recruitment of adoptive parents. |
| R21-5-308. Termination of Adoption Services | The objective of this rule is to identify when the Department considers it appropriate to terminate services to an applicant, adoptive parent and/or an adoptive child. |

Article 4: Adoption Entity Services

| Rule | Objective |
|---|---|
| R21-5-401. Definitions | The objective of this rule is to indicate that the definitions in Article 3 of this same Chapter also apply to this Article. |
| R21-5-402. Recruitment | The objective of this rule is to identify the elements required and prohibited when conducting adoption recruitment. |
| R21-5-403. Orientation: Persons Interested in Adoption | The objective of this rule is to establish that the adoption entity must provide an orientation process to persons seeking to adopt unless otherwise permitted by this rule. |
| R21-5-404. Application for Certification | The objective of this rule is to identify the requirements that an adoption entity must gather from a person seeking to adopt. |
| R21-5-405. Certification Investigation | The objective of this rule is to identify the requirements an adoption entity must complete when conducting a certification investigation on the person seeking to adopt. |
| R21-5-406. Certification Report and Recommendation | The objective of this rule is to identify the information gathered and used to recommend or deny an applicant for certification and responsibility to notify the applicant of such recommendation. |
| R21-5-407. Renewal of Certification | The objective of this rule is to identify what is required to extend adoption certification beyond the expiration date. |
| R21-5-408. Communication with Adoptive | The objective of this rule is to outline the information the adoption entity is required to provide, upon request, to the certified adoptive parent awaiting placement. |

| | |
|---|---|
| Parents Awaiting Placement | |
| R21-5-409. Prohibitions Regarding Birth Parents | The objective of this rule is to identify information that cannot be provided to a birth parent who is signing a consent to an adoption. |
| R21-5-410. Information about Birth Parents | The objective of this rule is to identify information that should be obtained from the birth parent(s) consenting to an adoption. |
| R21-5-411. Pre-consent Conference with Birth Parents | The objective of this rule is to establish the requirements of a pre-consent conference with the birth parent(s) and the information that must be covered at the conference. |
| R21-5-412. Consent to Adopt; Unknown Birth Parents | The objective of this rule is to specify how the adoption entity will handle obtaining the consent of a birth parent and how the adoption agency will address the issue of the unknown birth parent. |
| R21-5-413. Adoptable Child: Assessment and Service Plan | The objective of this rule is to identify the steps the adoption entity is responsible for before placing a child in an adoptive placement. |
| R21-5-414. Placement Determination | The objective of this rule is to ensure that all parties to adoption are made aware of how an adoption entity or the Department makes a placement decision. |
| R21-5-415. Provision of Information on Placed Child | The objective of this rule is to ensure that prospective adoptive families receive essential non-identifying information about an adoptive child before making the adoptive placement. |
| R21-5-416. Transportation | The objective of this rule is to specify the safeguards required of an adoption entity when transporting an adoptive child, to assure the safety and protection of the child. |
| R21-5-417. Placement Services | The objective of this rule is to provide information on post-placement services available to adoptive parents. |
| R21-5-418. Post-placement Supervision: Non- | The objective of this rule is to identify what is required of the adoption entity when providing post-placement supervision of children being adopted by non-foster parents. |

| | |
|---|---|
| foster Parent Placement | |
| R21-5-419. Post-placement Supervision: Foster Parent Placement | The objective of this rule is to identify what is required of the adoption entity when providing post-placement supervision of children being adopted by foster parents. |
| R21-5-420. Protracted Placement | The objective of this rule is to prevent unnecessary protracted placements by providing a disincentive to an adoption entity. It requires the adoption entity to report to the Department the reason why an adoption has not finalized after two years. |
| R21-5-421. Finalizing the Placement | The objective of this rule is to identify what information the adoption entity must provide to the court before the hearing on the petition to adopt. |
| R21-5-422. Placement Disruption | The objective of this rule is to identify what is required of the adoption entity when an adoptive placement disrupts. |
| R21-5-423. Confidentiality | The objective of this rule is to require persons who participate in adoption to abide by statutory confidentiality requirements. |

**3.** **Are the rules effective in achieving their objectives?** **Yes _X__** **No ___**

**4.** **Are the rules consistent with other rules and statutes?** **Yes _X__** **No __**

**5.** **Are the rules enforced as written?** **Yes _X__** **No __**

**6.** **Are the rules clear, concise, and understandable?** **Yes _X__** **No ___**

**7.** **Has the agency received written criticisms of the rules within the last five years?** **Yes ___** **No _X_**

**8.** **Economic, small business, and consumer impact comparison:**

The Department of Child Safety is the state agency that provides child welfare services, which includes adoption services, and is authorized by Arizona Revised Statutes to promote the placement of children in permanent adoptive homes. The Department provides adoption services, contracts with private agencies to recruit adoptive

homes, and licenses adoption agencies (Title 21, Chapter 9) in Arizona. The goal of adoption services is to place children with qualified adoptive parents in a permanent adoptive home.

Article 3 provides information pertaining to the services provided by the Department. Article 4 speaks to the responsibility of adoption entities.

As of January 31, 2025, there were 7,775 children ages zero to 17 in out-of-home care. Of these children, 1,374 had a case plan goal of adoption. In comparison, on January 31, 2020, there were 13,298 children ages zero to seventeen in out-of-home care and 2,649 of those children had a case plan goal of adoption.

The Department provides an array of accessible and individualized services designed to support permanency and adoption of children in the care of DCS. The Department directly or through contracts with private agencies provides the following adoption services:

- Recruits prospective adoptive parents.
- Informs persons interested in adopting a child about the adoption process.
- Conducts certification investigations of prospective adoptive parents.
- Takes adoption consents from birth parents.
- Prepares non-identifying, preplacement information on adoptive children for adoptive parents.
- Submits the names and profiles of adoptable children and certified adoptive parents for listing in the Central Adoption Registry.
- Prepares children for adoptive placement.
- Matches adoptable children with certified adoptive parents.
- Places adoptable children in the homes of certified adoptive parents.
- Investigates and reports to the court on the suitability of particular placements.
- Conducts social studies and preparing final reports to the court.
- Assists attorneys and families to complete the adoption process.

Adoption services provided by the Department are not assigned to specialized units; therefore, the number of employees dedicated to provide services under Article 3 is not available. The Department licenses approximately 18 private adoption agencies. Additionally, the Department contracts with 21 agencies to provide foster and adoption support services through DCS. The Department also now has 14 agencies contracted to provide Kinship Support Services, which assists kinship caregivers in foster and adoption services as well.

Funding for adoption services in FY 2024

- For adoption certification, the Department has expended $772,370. This is funded by Title IV-E federal funds and State General Funds.
- For adoption promotion, the Department has expended $1,183,300. This is funded by Title IV-B part II federal funds and State General Funds.
- For child specific recruitment, the Department as expended $299,542. This is funded by Title IV-B part II federal funds and State General Funds.

**9. Has the agency received any business competitiveness analyses of the rules? Yes ___ No _X_**

**10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

The Department has completed the course of action indicated in the previous five-year-review report. R21-5-421 (1) was amended by final expedited rulemaking at 28 A.A.R. 2479, with an immediate effective date of September 9, 2022 to create consistency between rule and statute pertaining to when a court report must be submitted prior to a final adoption hearing.

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department believes that the current rules pose the minimum cost and burden to the persons regulated by these rules. Article 3 pertains to services provided by the Department. Article 4 pertains to the services provided by adoption entities. It is the belief that any cost associated with the rules are offset by the greater benefit of ensuring the safety and protection of Arizona children while seeking a permanent adoptive home for them.

**12. Are the rules more stringent than corresponding federal laws? Yes ___ No _X_**

Federal laws that apply to the rules of this Article includes the following: Adoption and Safe Families Act (ASFA) (P.L. 105-89); Adam Walsh Child Protection and Safety Act (P.L. 109-248); Adoption Promotion Act 2003 (P.L. 108-145); and Keeping Children and Families Safe Act 2003 (P.L. 108-36). The rules in these Articles are not more stringent than federal law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

The Department has determined that A.R.S. 41-1037 does not apply to these rules because these rules do not require the issuance of a regulatory permit, license, or agency authorization.

**14. Proposed course of action**

The Department has reviewed the current rules and does not plan any rulemaking activity for these rules at this time.

Arizona Administrative CODE
www.azsos.gov
Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION



# TITLE 21. CHILD SAFETY

## CHAPTER 5. DEPARTMENT OF CHILD SAFETY - PERMANENCY AND SUPPORT SERVICES

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
July 1, 2022 through September 30, 2022



**Questions about these rules? Contact:**

| | |
|---|---|
| Department: | Department of Child Safety |
| Address: | 3003 N. Central Ave.<br>Phoenix, AZ 85012 |
| Website: | https://dcs.az.gov/about/dcs-rules-rulemaking |
| Name: | Angie Trevino, Rule Development Specialist |
| Telephone: | (602) 619-3163 |
| Fax: | (602) 255-3262 |
| Email: | Angelica.Trevino@azdcs.gov |


**The release of this Chapter in Supp. 22-3 replaces Supp. 20-2, 1-20 pages.**
Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State's website, www.azsos.gov under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*


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# TITLE 21. CHILD SAFETY

## CHAPTER 5. DEPARTMENT OF CHILD SAFETY - PERMANENCY AND SUPPORT SERVICES

Authority: A.R.S. § 8-453(A)(5)

**Supp. 22-3**

***Editor's Note: Chapter 5 contains rules which were exempt from the regular rulemaking process under Laws 2014, 2nd Special Session, Ch. 1, Sec. 158. The law required the Department to post on its website proposed exempt rulemakings for a minimum of 30 days, at which time the public could provide written comments. In addition, at least two public hearings were held prior to the filing of the final exempt rules. Because the Department solicited comments on its proposed exempt rules, the rules filed with the Office of the Secretary of State are considered final exempt rules (Supp. 15-4).***

### CHAPTER TABLE OF CONTENTS

## ARTICLE 1. INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

**R21-5-101. Definitions**

The definitions contained in A.R.S. § 8-548 and the following definitions apply in this Article:

1. "Child" means any person less than the age of 18 years.
2. "Compact" or 'ICPC" means the Interstate Compact on the Placement of Children.
3. "Compact Administrator" means the same as A.R.S. § 8-548.
4. "Compact State" means a state that is a member of the Interstate Compact on the Placement of Children.
5. "Department" or "DCS" means the Arizona Department of Child Safety.
6. "Interstate placement" means any movement of a child from one state to another state for the purpose of establishing a suitable living environment and providing necessary care.
7. "Intra-state placement" means the placement of a child within a state by an agency of that state.
8. "Placement" means the same as in A.R.S. § 8-548.
9. "Receiving state" means the same as in A.R.S. § 8-548.
10. "Sending agency" means the same as in A.R.S. § 8-548.
11. "Sending state" means the state where the sending agency is located, or the state in which the court holds exclusive jurisdiction over a child, which causes, permits, or enables the child to be sent to another state.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-102. Authority**

The ICPC is governed by A.R.S. §§ 8-548 through 8-548.06 and the ICPC regulations. ICPC regulations are posted on the Association of Administrators of the Interstate Compact on the Placement of Children website. These regulations supplement those authorities and must be read in conjunction with them.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-103. Conditions of Placement**

No person, court, or public or private agency in a Compact State shall place a child in another Compact State until the Compact Administrator in the receiving state has notified the Compact Administrator in the sending state, on a prescribed form, that such placement does not appear to be contrary to the interests of the child and does not violate any applicable laws of the receiving state.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-104. Financial Responsibility**

The sending person, court, or public or private agency shall be held financially responsible for:

1. Sending the child to the receiving state;
2. Returning the child to the sending state; and
3. Treatment of the child during the period of placement.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-105. Applicability**

**A.** Except as listed in subsection (B), the ICPC applies to the placement of:

1. Children in another Compact State by an agency, court or person, which has care or custody of the children.
2. Foreign-born children who are brought under the jurisdiction of a Compact State by an international child placing agency.

**B.** In addition to the children listed in statute that are not subject to ICPC, the ICPC does not apply:

1. When a child is placed in an institution caring for the mentally ill, mentally impaired, epileptic, or in any institution primarily educational in character or in any hospital or other medical facility.
2. To the placement of children into and out of the United States when the other jurisdiction involved is a foreign country.
3. When a sending court or agency seeks an independent (not ICPC related) courtesy check for placement with a parent from whom the child was not removed, the responsibility for credentials and quality of the courtesy check rests directly with the sending court or agency and the person or party in the receiving state who agrees to conduct the courtesy check without invoking the protection of the ICPC home study process. This does not prohibit a sending state from requesting an ICPC.
4. The Compact does not apply in court cases of paternity, divorce, custody, and probate pursuant to which or in situations where children are being placed with parents or relatives or non-relatives.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-106. Placement Approval**

Sending and receiving states must obtain approval from the Compact Administrator in both the sending and receiving states prior to the placement of a child in another Compact State.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

**R21-5-107. Operations**

In providing services provided under this Article, the sending and the receiving state shall:

1. Maintain all information required by state and federal law.
2. Comply with all federal and their respective state laws and regulations regarding the disclosure and use of confidential health and personal information.
3. Comply with all federal and their respective state nondiscrimination laws and regulations.
4. Ensure that interpreters, including assistance for the visually or hearing impaired, are available to those receiving services at no cost.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 2979, effective January 2, 2016 (Supp. 15-4).

## ARTICLE 2. INDEPENDENT LIVING AND TRANSITIONAL INDEPENDENT LIVING PROGRAMS

**R21-5-201. Definitions**

The following definitions apply to this Article:

1. "Active participation" means the foster youth is demonstrating efforts toward completion of case plan goals such as regular attendance at school or employment that results in school credits or earned wages.
2. "Aftercare services" means assistance and support available to eligible, former foster youth living in Arizona after the Department, tribal foster care, or other state foster care case is dismissed, and includes services available through the Transitional Independent Living Program.
3. "Age of majority" means that a person is at least 18 years old.
4. "Approved living arrangement" means a residence that has been reviewed by the assigned Child Safety Worker or other responsible agency staff and approved within the individual case plan.
5. "Arizona Young Adult Program" means a group of programs and services designed to assist eligible youth to make a successful transition to adulthood. The programs and services include Independent Living Services, the Independent Living Subsidy Program, Voluntary Out-of-home Care for Foster Youth 18 through 20 Years of Age, and the Transitional Independent Living Program.
6. "Child placing agency" means the same as in A.R.S. § 8-501(A)(1)(a)(iii), and includes a Child Welfare Agency that OLR licenses as a Placing Agency to place a child in a licensed foster home, or facility.
7. "Child Welfare Agency" means the same as in A.R.S. § 8-501.
8. "Child Safety Worker" means the same as in A.R.S. § 8-801.
9. "Custody of the Department" means that the foster youth:
   a. Is in out-of-home care under the supervision of the Department while the subject of a dependency petition, as an adjudicated dependent, or placed voluntarily under A.R.S. § 8-806; or
   b. Is 18, 19, or 20 years of age, a resident of Arizona, and has signed an individual case plan agreement for voluntary out-of-home care. This includes foster youth who were dually adjudicated (dependent and delinquent) and released from a secure setting prior to, or on the foster youth's 19th birthday.
10. "Department" or "DCS" means the Arizona Department of Child Safety.
11. "Eligible youth" means a person who meets the qualifications in A.R.S. § 8-521 for the Independent Living Program, the qualifications in A.R.S. § 8-521.01 for the Transitional Independent Living Program, or is a person who was formerly in another state's child welfare program who would otherwise be eligible.
12. "Employment" means:
    a. Paid employment;
    b. Participation in employment-readiness activities, which include career assessment and exploration, and part time enrollment in an employment or career readiness education program;
    c. Volunteer positions;
    d. Job-shadowing;
    e. Internship; or
    f. Other paid or unpaid employment-related activities.
13. "Extraordinary purchase" means an expenditure by an eligible youth that impedes an eligible youth's ability to meet the financial obligations outlined in the eligible youth's budget.
14. "Foster youth" means a person in the custody of the Department.
15. "Full-time student" means an eligible youth enrolled in an education program identified by the program as being full-time due to the number of credits, credit hours, or other measure of enrollment.
16. "Independent Living Program" means the program authorized by A.R.S § 8-521 to provide an Independent Living Subsidy and educational case management to a foster youth.
17. "Independent Living Services" or "IL Services" means an array of assistance and support services, including those provided under the Independent Living Program, that the Departments provides, contracts, refers, or otherwise arranges that are designed to help a foster youth transition to adulthood by building skills and resources necessary to ensure personal safety, well-being, and permanency into adulthood.
18. "Independent Living Subsidy" or "IL Subsidy" means a monthly stipend provided under the Independent Living Program to a foster youth, to assist in meeting monthly living expenses. This stipend replaces any foster care maintenance payment from the Department for support of the foster youth's daily living expenses.
19. "Individual case plan" means an agreement between an eligible foster youth and the Department, directed by the foster youth that documents specific services and assistance that support the foster youth's goals in relation to:
    a. Natural supports including permanent connections to and relationships with family and community, including peer and community mentors;
    b. A safe, stable, desired living arrangement, which may include a permanent arrangement such as guardianship or adoption;
    c. Daily living skills;
    d. Secondary and postsecondary education and training;
    e. Employment and career planning;
    f. Physical health, including reproductive health;
    g. Life care planning;
    h. Emotional health;
    i. Mental health;
    j. Spiritual or faith needs;
    k. Interpersonal relationships; and
    l. Age-appropriate extra-curricular, enrichment, and social activities.
20. "Individual service plan" means an agreement that is directed by an eligible youth in the TIL Program that documents specific services and assistance to support the eligible youth's goals including, as applicable:
    a. Financial,
    b. Housing,
    c. Counseling,
    d. Employment,
    e. Education, and
    f. Other appropriate support and services.
21. "Life skills assessment" means a measure of an eligible youth's ability to function in a variety of areas such as daily living skills, knowledge of community resources, and budgeting, as determined by a validated assessment tool.
22. "Medical professional" means a doctor of medicine or osteopathy, physician's assistant, or registered nurse practitioner licensed in A.R.S. Title 32, or a doctor of medi-

cine licensed and authorized to practice in another state or foreign country. A medical professional from another state or foreign country must provide verification of valid and current licensure in that state or country.

23. "Misuse of funds" means that an eligible youth has expended money provided by the Department for specific purposes (such as education or living expenses) on an item that is not permitted by law (such as illegal drugs and alcohol), or on an extraordinary purchase that is not included in an approved budget or individual case or service plan, to the degree that the funds are not available for necessary items and purchases approved within the case plan, service plan, or budget.
24. "Natural supports" means relationships and connections that occur in everyday life, independent of formal services, with people or groups who provide personal or other support during a person's lifetime.
25. "Out-of-home care" means a placement approved by the Department such as a licensed foster home, residential group care facility operated by a Child Welfare Agency, therapeutic residential facility, independent living setting, approved unlicensed independent living setting, or in a relative or non-relative placement. Out-of-home care excludes a detention facility, forestry camp, training school, or any other facility operated primarily for the detention of a child who is determined delinquent.
26. "Personal Crisis" means an unexpected event or series of events in an eligible youth's life that prevents or impedes participation in scheduled services or activities.
27. "Residential group care facility" means a Child Welfare Agency that is licensed to receive more than five children for 24-hour social, emotional, or educational supervised care and maintenance at the request of a child, child placing agency, law enforcement agency, parent, guardian, or court. A residential group care facility provides care in a residential setting for children for an extended period of time.
28. "Responsible agency staff" means the assigned Child Safety Worker, another identified Department employee, or contracted staff.
29. "Service team members" means the eligible youth, the youth's attorney(s), the Guardian ad Litem (GAL), the Court Appointed Special Advocate (CASA), tribal child welfare staff, other parties to the dependency case, contract, or other service providers, responsible agency staff, and other adults involved with the youth or supporting the youth's activities or employment.
30. "Substantial non-compliance" means an eligible youth's:
    a. Termination from an educational, vocational, or employment program due to lack of attendance or failure to make satisfactory progress as defined by the program for reasons unrelated to physical health including pregnancy, emotional, or mental health;
    b. Persistent lack of communication during a 60-day period with the assigned Child Safety Worker or other responsible agency staff known to the youth that results in a loss of contact with the eligible youth, or interferes with the Department's ability to provide services and supervision or to document individual case plan or service plan progress;
    c. Persistent misuse of funds provided to support individual case plan or service plan goals; or
    d. For an eligible foster youth, failure to communicate unexpected changes in the living arrangement as agreed to in the individual case plan or the Independent Living Subsidy agreement.
31. "Transitional Independent Living Program" or "TIL Program" means a program of services for residents of Arizona who are eligible youth under A.R.S. § 8-521.01, that provides assistance and support in counseling, education, vocation, employment, and the attainment or maintenance of housing.
32. "Transitional Independent Living Services" or "TIL Services" means those services the Department provides through the Transitional Independent Living Program under A.R.S. § 8-521.01, and may include assistance and support with health care, money management, housing, counseling, education, vocational training, and employment. The Department or its contractors provide services through a written agreement with the eligible youth.
33. "Validated assessment tool" means a written or verbal survey tool that can demonstrate empirical evidence for reliability and validity.
34. "Work day" means Monday through Friday, excluding Arizona state holidays.
35. "Young Adult Transitional Insurance" means a category of health care coverage under the state Medicaid program (Arizona Health Care Cost Containment System or AHCCCS) for Medicaid eligible youth who have reached the age of majority in foster care.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Amended by emergency rulemaking at 25 A.A.R. 771, effective March 21, 2019, for 180 days (Supp. 19-1). Emergency amendments renewed at 25 A.A.R. 2485, for an additional 180 days effective September 18, 2019 (Supp. 19-3). Emergency expired; amended by final rulemaking at 26 A.A.R. 241, effective March 15, 2020 (Supp. 20-1).

**R21-5-202. Provision of Services**

**A.** The Department shall provide services and stipends for the IL Services, IL Subsidy, and TIL services to eligible youth in a manner that is fair and equitable.

**B.** The Department shall provide Independent Living Services to eligible foster youth based on needs identified by the eligible foster youth, by service team recommendations, or the findings of a life skills assessment. The services shall address needs identified in the eligible foster youth's individual case plan and may include one or more of the following, depending on the individual case plan goals:
1. Information and assistance to create and maintain a network of natural supports;
2. Independent living skills training;
3. Program incentives;
4. Information and assistance in life care and health care planning, including enrollment in a health plan;
5. Educational, career, and vocational planning;
6. Financial assistance for post-secondary education and training;
7. Out-of-home care for foster youth 18 through 20 years of age; or
8. Aftercare services through the Transitional Independent Living Program.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-203. Denial of Services**

The Department shall deny services if a person does not meet the eligibility requirements of A.R.S. §§ 8-806, 8-521, 8-521.01, and R21-5-204.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-204. Eligibility**

**A.** Independent Living Services. In order to be eligible for IL Services a person shall:
1. Be at least 16 years of age and less than 21 years of age;
2. Be in the custody of the Department or tribal child welfare agency;
3. Reside in out-of-home care;
4. Be referred by the eligible youth's assigned Child Safety Worker, other Department staff, or a tribal social services representative; and
5. Be a resident of Arizona if 18, 19, or 20 years of age.

**B.** Independent Living Subsidy.
1. In order to be eligible for the IL Subsidy, a person shall:
   a. Be at least 17 years of age, in the custody of the Department, and employed or a full-time student.
   b. With the assistance of the responsible agency staff, complete the Independent Living Subsidy Agreement or other approved forms designated by the Department.
2. Conditions for approval and continuation in the Independent Living Subsidy Program include:
   a. Active participation in activities outlined in the individual case plan;
   b. Adherence to the terms of the IL Subsidy Agreement, including:
      i. Communication with the Child Safety Worker;
      ii. Maintenance of a Department-approved living arrangement, including approval of a roommate, except those assigned by school or work; and
      iii. Participation in scheduled meetings to review progress and update the individual case plan and IL Subsidy Agreement.
3. Eligible youth 18, 19, and 20 years of age who are temporarily residing out of state for the purpose of education or vocational training, and who maintain Arizona residency, may receive the Independent Living Subsidy under the same conditions as above.

**C.** Transitional Independent Living Program. Under A.R.S. § 8-521.01, in order to be eligible for the Transitional Independent Living Program, a person must be less than 21 years of age and have been in out-of-home care and in the custody of the Department, a licensed residential group care facility, or a tribal child welfare agency while 16, 17, or 18 years of age. Persons who were in another state's child welfare agency under the same conditions are also eligible.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-205. Out-of-home Care Services for Foster Youth 18 through 20 Years of Age**

**A.** The Department may provide out-of-home care services and supervision to a foster youth less than 21 years of age, who reached the age of 18 years while in the custody of the Department, and was either in out-of-home care or in secure care, as defined by A.R.S. § 8-201, through a delinquency action, when the foster youth:
1. Requests out-of-home care;
2. Has residency in the state of Arizona;
3. Participates in developing an individual case plan agreement for out-of-home care; and
4. Demonstrates acceptance of personal responsibility for his or her part of the agreement through active participation in the individual case plan.

**B.** The foster youth, Child Safety Worker, and involved service team members shall develop the individual case plan for out-of-home care:
1. Within the 90-day period prior to the foster youth's 18th birthday for foster youth continuing in out-of-home care past 18 years of age;
2. Within ten work days for foster youth who enter out-of-home care during the 90-day period prior to the foster youth's 18th birthday; and
3. For eligible youth re-entering foster care at 18 years of age or older, within seven work days of the eligible youth's return to Department care and supervision.

**C.** The individual case plan shall outline the services and supports to be provided under R21-5-202(B) and include at least one of the following activities:
1. Completion of secondary education or a program leading to an equivalent credential;
2. Enrollment in an institution that provides post-secondary education or vocational education;
3. Participation in a program or activity designed to promote or remove barriers to employment; or
4. Employment of at least 80 hours per month.

**D.** Foster youth participating in out-of-home care shall demonstrate acceptance of personal responsibility by actively participating in an individual case plan, unless prevented by a documented behavioral health or medical condition, or other personal crisis or life event, such as pregnancy, birth, necessary maternity leave as determined by a medical professional, adoption, or guardianship of a child.

**E.** The Child Safety Worker shall support the foster youth to address any documented condition, crisis, or life event listed in subsection (D), by:
1. Facilitating a youth led discussion that includes a review of the supports and services available as intervention strategies, to assist in resolving the condition, crisis, or concern;
2. Documenting the foster youth's preferred intervention strategy for addressing the condition, crisis, or concern; and
3. Expeditiously providing or otherwise arranging the preferred intervention strategy.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Amended by emergency rulemaking at 25 A.A.R. 771, effective March 21, 2019, for 180 days (Supp. 19-1). Emergency amendments renewed at 25 A.A.R. 2485, for an additional 180 days effective September 18, 2019 (Supp. 19-3). Emergency expired; amended by final rulemaking at 26 A.A.R. 241, effective March 15, 2020 (Supp. 20-1).

**R21-5-206. Transitional Independent Living Program**

**A.** The Transitional Independent Living Program provides services to eligible youth, under A.R.S. § 8-521.01 that comple-

ments their own efforts toward becoming self-sufficient. The Department may provide the following assistance, depending on individual service plan goals:

1. Financial,
2. Housing,
3. Counseling,
4. Employment,
5. Education, and
6. Other appropriate support and services.

**B.** The eligible youth requesting services through the Transitional Independent Living Program shall provide the following information to the responsible agency staff:

1. Identifying information including:
   a. Name (and any aliases); and
   b. Date of birth;
2. Information regarding the eligible youth's former foster care status such as the state or tribal child welfare system where the youth was in care, and approximate dates of care, if known; and
3. Any available contact information for the youth, including:
   i. Phone number,
   ii. Friend or family phone number,
   iii. Email address, and
   iv. Any other communication method identified by the youth.

**C.** An eligible youth and responsible agency staff shall develop an individual service plan for the eligible youth to receive these services.

**D.** The individual service plan shall address the level of need based on the items noted in subsection (A).

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-207. Re-entry Into Out-of-home Care**

**A.** The Department shall facilitate re-entry into out-of-home care for eligible youth participating in the Transitional Independent Living Program.

**B.** On request for re-entry by the eligible youth, the Department shall confirm the eligible youth's request to receive out-of-home care, supervision, and other services with the youth and within ten work days:

1. Facilitate a meeting with the eligible youth to review the requirements under R21-5-205;
2. Assist the eligible youth to develop an individual case plan that includes an effective date for reopening the Department case;
3. Identify the name and contact information of the Child Safety Worker or responsible agency staff assigned to the case;
4. Identify the out-of-home care type selected such as, foster home, residential group care facility, Independent Living Program, or other arrangement;
5. Notify the identified Child Safety Worker or responsible agency staff assigned to the case; and
6. Complete all necessary authorizations for out-of-home care and other services to reasonably ensure a smooth transition from the TIL Services to the IL Services.

**C.** If the eligible youth reports he or she is in crisis and unsafe, the Department shall immediately assess the youth's safety and assist the youth to secure a safe living arrangement and to manage the crisis.

**D.** An eligible youth may request to postpone re-entry, decline re-entry at any time, or re-initiate the request any time prior to the eligible youth's 21st birthday. The responsibilities of the Department to process the request for re-entry shall begin upon the Department's receipt of the eligible youth's request for re-entry under subsection (B).

**E.** Supports and services shall continue for youth who re-enter out-of-home care, as outlined in R21-5-205.

**F.** If the Department denies re-entry, the Department shall provide the youth with written notification of the reason for this decision and the youth's grievance and appeal rights within 15 work days of the request for re-entry.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-208. Termination of Services**

**A.** The Department may terminate IL Services, including out-of-home care for foster youth 18 through 20 years of age, and TIL services if the eligible youth:

1. Reaches the age of 21 years;
2. Reaches the age of 18 years and does not desire continued services;
3. Makes a voluntary decision to terminate services; or
4. Demonstrates substantial non-compliance or otherwise refuses to meet the requirements of the individual case plan or individual service plan after the responsible agency staff or designee has made active efforts to engage the eligible youth in identifying and resolving issues, including assessing the effectiveness of current services, and identifying and providing additional or different support services.

**B.** The Department shall deny IL Services, including out-of-home care for foster youth age 18 through 20 years, and TIL services if the Department determines the person is:

1. Not eligible;
2. Unwilling to create an individual case or service plan; or
3. Not participating in the individual case or service plan.

**C.** The Child Safety Worker or responsible agency staff shall notify the person in writing of the Department's decision to terminate or deny services within ten work days of the person's application for services.

**D.** The notice shall include information on the person's right to grieve any decision to terminate or deny services.

**E.** Within ten work days of the notice to terminate or deny services, the Child Safety Worker or responsible agency staff shall contact the person to:

1. Assist the person through the grievance process including the completion and submittal of any required Department forms; or
2. Identify and engage a personal advocate to assist the person through the grievance process, including the completion and submittal of any required Department forms.

**F.** When termination of services to a foster youth is planned due to one of the reasons outlined in (A)(1) through (3) of this Section, the Child Safety Worker or responsible agency staff shall schedule a discharge staffing with the foster youth within ten work days of the foster youth's 21st birthday or the Department's receipt of the foster youth's notice to discontinue services to provide any necessary documents not previously provided, such as a birth certificate, social security card, state identification card, credit report, and a copy of the foster youth's health and education records.

**G.** The Department shall not terminate services for substantial non-compliance under subsection (A)(4) until the Child Safety Worker or responsible agency staff satisfies all responsibilities including:
1. Staffing of the individual case or service plan;
2. Adhering to the grievance process described in R21-5-209; and
3. Developing and implementing a discharge plan that provides information on available community resources, and connects the person to those resources.

**H.** Services shall remain in effect until the reasons for termination are resolved or the grievance or appeal process is completed.

**I.** For Independent Living Subsidy only, if the Department determines that continuation of the Independent Living Subsidy would place the foster youth at risk of immediate harm, the Child Safety Worker or responsible agency staff shall:
1. Document this fact in the case file progress notes, and
2. Arrange for a safe living arrangement and sufficient support services to reasonably ensure the foster youth's safety in the interim.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-209. Grievance Process**

**A.** A person eligible for services under R21-5-204 who disagrees with a Department adverse action decision to reduce, terminate, or deny services for that person may:
1. File a grievance under this Section;
2. Choose not to file a grievance and appeal the adverse action under A.A.C. Title 21, Chapter 1, Article 3 by filing a notice of appeal within 20 days after receipt of the adverse action decision reducing, terminating, or denying services; or
3. File a grievance, and if the person is dissatisfied with the results of the grievance process, appeal under A.A.C. Title 21, Chapter 1, Article 3 by filing a notice of appeal within 20 days after receipt of the grievance response letter.

**B.** In the event that a person disagrees with a Department decision to reduce, terminate, or deny services, the Child Safety Worker or responsible agency staff shall:
1. Inform the person of the formal grievance process;
2. Provide the person with the Department's grievance form and directions for submittal to the designated Department staff, such as the Department's Ombudsman's Office; and
3. Offer to assist the person in completing and submitting the form, or referring the person to the appropriate Department staff, such as the Department's Ombudsman, for assistance in completing and submitting the form.

**C.** Upon receipt of the grievance form, the Department shall:
1. Schedule a face-to-face meeting with the person who filed the grievance within seven work days from the date the grievance was received by the Department, or schedule a teleconference if a face-to-face meeting is not possible;
2. Evaluate the grievance to determine if the grievance can be resolved by the Department to the satisfaction of the person;
3. Mail a grievance response letter to the person within three work days of the meeting; and
4. Include an appeal form with the grievance response letter so the person may appeal the adverse action.

**D.** If the person agrees with the Department's decision to terminate services, the Child Safety Worker or responsible agency staff shall proceed with case closure including completing a discharge plan with the person that includes information on aftercare services and other community based support.

**E.** The Department shall retain documentation of all grievances in the case file according to the Department's retention schedule.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

## ARTICLE 3. DEPARTMENT ADOPTION SERVICES

**R21-5-301. Definitions**

In addition to the definitions in A.R.S. § 8-101, the following definitions apply in this Article, Article 4 of this Chapter, and 21 A.A.C. 9:
1. "Adoptable child" means a child who is legally available for adoption but who has not been placed for adoption.
2. "Adoptee" means a child who is the subject of a legal petition for adoption.
3. "Adoption agency" means an individual or entity, including a corporation, company, partnership, firm, association, or society, other than the Department, licensed by the Department to place a child for adoption.
4. "Adoption entity" or "entity" means the Department and includes an adoption agency, but does not include a private attorney who is licensed to practice law in the state of Arizona and who is only assisting in a direct placement adoption to the extent allowed by A.R.S. § 8-130(C).
5. "Adoption placement" or "placement" means the act of placing an adoptable child in the home of an adoptive parent who has filed, or is contemplating filing, a petition to adopt the child.
6. "Adoption Registry" means the electronic database described in A.R.S. § 8-105.
7. "Adoption services" means activities conducted in furtherance of an adoption and includes the activities listed in A.A.C. R21-5-303 and R21-9-201(B).
8. "Adoptive parent" means an individual who has successfully completed the application process and has been certified by the court to adopt. An adoptive parent includes an individual who does not have a child placed in their home.
9. "Agency placement" means the child is placed in an adoptive home chosen by the adoption agency.
10. "AHCCCS" means the Arizona Health Care Cost Containment System, which is the State's program for medical assistance available under Title XIX of the Social Security Act and state public insurance statutes under A.R.S. Title 36, Chapter 29.
11. "Applicant" means an individual who has applied to become an adoptive parent.
12. "Birth parent" means the biological mother or father of a child.
13. "Central Registry" means the information maintained by the Department of substantiated reports of child abuse or neglect for the purposes of A.R.S. § 8-804.
14. "Certification application" means the form that an applicant submits to an adoption entity or to the court to request a certification investigation to become certified as an adoptive parent.
15. "Certification investigation" means the process referred to in A.R.S. § 8-105(C) by which an adoption entity

determines if an applicant is a fit and proper person to adopt.

16. "Certification order" means a judicial determination that an applicant is acceptable to adopt children.
17. "Certification report" or "adoptive home study" means the written report described in A.R.S. § 8-105, in which an adoption entity summarizes the results of a certification investigation and makes a recommendation for or against certification of an applicant.
18. "Child with special needs" means a child who has one of the special needs listed in A.R.S. § 8-141.
19. "Department" or "DCS" means the Arizona Department of Child Safety.
20. "Developmentally appropriate" means an action that takes into account:
    a. A child's age and family background;
    b. The predictable changes that occur in a child's physical, emotional, social, cultural, and cognitive development; and
    c. A child's pattern and history of growth, personality, and learning style.
21. "Direct placement" means the child is placed in an adoptive home by the birth parent or legal parent.
22. "Final report to the court" means a written report that includes a social study under A.R.S. § 8-112, in which an adoption entity advises the court of the entity's assessment and recommendations about the finalization of a particular adoption.
23. "Foster parent" means the same as in A.R.S. § 8-501.
24. "ICPC" means the Interstate Compact on the Placement of Children described in A.R.S. § 8-548.
25. "ICWA" means the Indian Child Welfare Act described in 25 U.S.C. 1901 et seq.
26. "Legally available" means a child whose birth or legal parents are deceased, have voluntarily relinquished their parental rights, or whose parental rights have been terminated by the court.
27. "License" means a permission granted by the Department to an adoption agency authorizing the adoption agency to perform adoption services in A.A.C. R21-9-201(B).
28. "Open adoption" means an adoption in which the adoptive parent and the birth or legal parent agree to share varying degrees of each other's personal information for future contact.
29. "Out-of-state agency" means any person or entity that is authorized or licensed by a state other than Arizona, or a foreign country, to perform adoption services.
30. "Placed child" means an adoptable child who has been placed with an adoptive parent, and the adoptive parent has not yet filed a petition to adopt the child.
31. "Placement supervision period" means the time period from the date of adoption placement until the court enters a final order of adoption, during which the adoptive parent has the rights under A.R.S. § 8-113.
32. "Reasonable fee" means
    a. A fee commensurate with:
        i. The actual cost of providing a specific adoption service or item to a specific individual, or
        ii. The average cost of a service or item if the adoption entity routinely uses an averaging method to determine the cost of a particular service or item.
    b. A reasonable fee may include reasonable compensation for officers and employees and a reasonable profit margin above actual or averaged costs.
33. "Service plan" means a written document of developmentally appropriate pre-placement and post-placement services necessary to facilitate a child's transition to an adoptive home.
34. "Social study" means the written report described in A.R.S. § 8-112, after a petition for adoption has been filed, where the adoption entity summarizes the results of its investigation, and makes a definite recommendation for or against the proposed adoption and the reasons for that recommendation.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-302. Adoption Registry: Information Maintained; Confidentiality**

**A.** The Department shall maintain and keep current the Adoption Registry with the information required under A.R.S. § 8-105. The Adoption Registry shall include the following current information for each child or adoptive parent listed on the Adoption Registry:
1. The child's availability for adoptive placement,
2. The adoptive parent's certification status,
3. The adoptive parent's availability for adoptive placement, and
4. The type of child the adoptive parent is open to considering for adoption including:
    a. Age;
    b. Sex; or
    c. Special needs.

**B.** Upon request, the Department shall provide personally identifiable Adoption Registry information to:
1. The court;
2. An adoption agency, including a private attorney;
3. Under a court order, a National or Regional Adoption registry and exchange; and
4. An out-of-state agency.

**C.** Before providing information, the Department shall obtain, from the person requesting the information, the following:
1. The name and affiliation of the person requesting the information;
2. The reason for the request; and
3. If the requesting party is other than a court representative, a signed statement acknowledging that the information is confidential and promising not to release the information to anyone except as allowed by A.R.S. §§ 8-120, 8-121, and 8-105.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-303. Department Adoption Services**

**A.** The Department provides the following adoption services for families and children in accordance with the limitations and provisions of A.R.S. Title 8, Chapter 1, Article 1:
1. For families:
    a. Recruiting adoptive parents;
    b. Informing persons interested in adopting a child about the adoption process;
    c. Conducting certification investigations of applicants under A.R.S. § 8-105;

d. Preparing certification reports under A.R.S § 8-105; and
e. Submitting the names and profiles of adoptive parents for listing in the Adoption Registry.

2. For children:
a. Accepting adoption consents from birth parents;
b. Preparing non-identifying, pre-placement information on adoptive children for adoptive parents, as required in A.R.S. § 8-129;
c. Submitting the name and profile of an adoptive child for listing in the Adoption Registry;
d. Preparing a child for adoptive placement;
e. Matching an adoptable child with an adoptive parent;
f. Placing an adoptable child in the home of an adoptive parent;
g. Investigating and reporting to the court on the acceptability of an adoptive parent under A.R.S. § 8-105(H);
h. Monitoring an adoption placement during the placement supervision period;
i. Providing services to a child placed for adoption and the adoptive family to assist with adjustment to the adoption placement;
j. Conducting a social study under A.R.S. § 8-112 and preparing a final report to the court determining suitability of placement; and
k. Assisting an attorney by providing legal documents to enable an adoptive parent to complete the adoption process.

**B.** When performing adoption services, the Department shall adhere to the standards established for an adoption agency in 21 A.A.C. 9.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-304. Department Procedures for Processing Certification Applications**

**A.** Upon review of a certification application, the Department shall notify the applicant in writing that the application is either complete or incomplete. An application is complete when it contains the information and supporting documentation described in R21-5-404. If the application is incomplete, the notice shall specify what information is missing.

**B.** An applicant with an incomplete application has 30 days from the date of the notice to provide the missing information. If the applicant fails to do so, the Department may close the file. An applicant whose file has been closed and who later wishes to apply for certification may reapply.

**C.** Upon review of a complete application, the Department shall decide whether to accept the application, according to the priority schedule listed in R21-5-305, and the availability of the Department's resources. If the Department cannot accept the application, the Department shall return the original application and all supporting documentation to the applicant. The applicant may reapply.

**D.** After the Department accepts the completed application, the Department shall provide the applicant written notice of the acceptance. The Department shall complete the certification investigation as specified in R21-5-405 within 90 days of the date of the notice. The Department shall prepare a certification report under R21-5-406.

**E.** The Department shall process a renewal application under this Section and R21-5-407.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-305. Department Priorities for Receipt of Services**

The Department shall accept and process certification applications and render adoption services according to the following priority schedule:

1. An applicant for whom the court has ordered the Department to do a certification investigation and report;
2. An applicant seeking to adopt a particular adoptable child with special needs;
3. An applicant wishing to adopt a child with special needs;
4. An applicant considering adopting a child with special needs; and
5. All other applicants.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-306. Department Recruitment Efforts**

The Department shall actively recruit persons to adopt children with special needs by:

1. Publicizing the need for such adoptive parents;
2. Registering adoptable children, as appropriate, with the Adoption Registry or other local, state, regional and national adoption resources;
3. Advising prospective adoptive parents of:
a. The availability of children with special needs,
b. The procedures involved in adopting such children, and
c. The support services and subsidies that may be available to persons adopting such children; and
4. Other measures similar to those described in this Section.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-307. Expired**

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 1322, effective June 3, 2020 (Supp. 20-2).

**R21-5-308. Termination of Adoption Services**

**A.** The Department may terminate services to an applicant or adoptive parent when:

1. The adoption is finalized;
2. The applicant or adoptive parent requests closure before receiving a child for placement;
3. The applicant or adoptive parent ceases to be a resident of Arizona before receiving a child for placement;
4. The court declines to certify the applicant or adoptive parent;
5. The applicant or adoptive parent refuses to comply with the requirements in A.R.S. Title 8, Chapter 1, Article 1, or this Chapter, Articles 3 and 4;
6. The applicant fails to submit a completed certification application within 90 days of the date on which the Department sent the person an application form;

7. The adoptive parent is no longer willing to be an adoptive parent; or.
8. The adoptive parent is no longer certified to adopt.

**B.** The Department may terminate adoption services to an adoptive child when:
1. The court issues a final adoption order; or
2. The court determines that adoption is no longer the most appropriate case plan for the child, and the Department provides alternate services consistent with the child's new case plan.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

## ARTICLE 4. ADOPTION ENTITY SERVICES

**R21-5-401. Definitions**

The definitions in R21-5-301 apply in this Article.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-402. Recruitment**

**A.** When recruiting applicants, an adoption entity shall comply with the requirements of this Section.

**B.** The adoption entity shall conduct recruitment efforts pursuant to a written plan, which shall describe:
1. Specific recruitment goals, including:
   a. The number and composition of adoptive parents the entity will serve; and
   b. The children the entity will accept for placement and any limitations such as:
      i. Age;
      ii. Medical special needs;
      iii. Developmental special needs;
      iv Mental health; or behavioral health special needs.
2. Methods of recruitment;
3. The number and professional qualifications of staff designated to handle recruitment; and
4. The means by which the adoption entity shall fund the agency's recruitment efforts.

**C.** The adoption entity's recruitment efforts shall be consistent with the personal characteristics of the children the entity has available for adoption and reasonably expects will become available for adoption through the entity.

**D.** An adoption entity shall not:
1. Promise to place more children than the adoption entity's prior history shows it can reasonably expect to place;
2. Promise to place a child in less time than the average waiting period demonstrated by the adoption entity's past practice;
3. Promise adoption subsidy prior to the formal approval and receipt of an adoption assistance agreement that meets the requirements of A.R.S. Title 8 Chapter 1 Article 2; or
4. Make any other statements or promises the entity knows or reasonably should know are false, misleading, or inaccurate.

**E.** The Department may take an adverse licensing action against an adoption agency that does not comply with this Section.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-403. Orientation: Persons Interested in Adoption**

**A.** Prior to accepting a certification application from a person considering the adoption of a child, or an application for placement from a person who intends to seek a placement through the adoption entity, an adoption entity shall provide the person with an adoption orientation, which shall explain the following:
1. The adoption process, including all legally mandated procedures, and estimated time-frames for completion of such procedures;
2. The adoption entity's policies and procedures that directly affect services to adoptive parents;
3. The adoption entity's fee structure and written fee agreement;
4. The types and number of children the agency typically has had and reasonably expects to have available for adoption placement and the average length of time between certification and placement;
5. The Department's responsibility for licensing and monitoring agencies, and the public's right to register a complaint about an agency as prescribed in 21 A.A.C. 9, Article 2;
6. The function of the Adoption Registry and the adoptive parent's right to decide whether to be included in the Adoption Registry; and
7. Confidentiality requirements, open adoptions, and the confidential intermediary program described in A.R.S. § 8-134.

**B.** A person who is already knowledgeable about all or part of the matters listed in subsection (A) may waive orientation on those matters, with the approval of the adoption entity. A person may be knowledgeable due to a prior adoption through an Arizona adoption entity, employment in adoption services, or for other similar reasons.

**C.** An adoption entity shall maintain written documentation showing that any person who has applied to the entity for certification or for placement of a child has received the orientation described in subsection (A), required by R21-9-227, or has obtained a waiver described in subsection (B). If some or all of the adoption orientation is waived, the adoption entity shall document the matters waived and the reasons for the waiver.

**D.** An adoption entity shall not charge a person for anything other than a certification application fee, or enter into an adoption fee agreement with a person, until the person has received the orientation in subsection (A).

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-404. Application for Certification**

An applicant who wishes to become certified as an adoptive parent shall apply for certification as provided in A.R.S. § 8-105. An adoption entity shall require an applicant to provide at least the following information:
1. Personally identifying information for each prospective adoptive parent, including:
   a. Name and date of birth;
   b. Social Security number;
   c. Race and ethnicity;
   d. Physical description;
   e. Current address and duration of Arizona residency;
   f. Marital history; and

g. The name, address, and phone number of immediate family members, including emancipated adult children;
2. The name, date of birth, and social security number of any person currently residing with the applicant;
3. A listing of the applicant's insurance policies, including:
a. Any insurance that may be available to cover the medical expenses of a birth mother or adoptive child; and
b. The name of the insured, the insurance policy number, and the effective dates of coverage;
4. A current financial statement describing the applicant's assets, income, debts, and financial obligations;
5. A physician's statement as to the applicant's current physical and mental health;
6. A medical and psychological history on the applicant and the applicant's household members. The history may be a declaration by the applicant of past physical and mental illness for the applicant and any household member;
7. The applicant's employment history;
8. The applicant's social history;
9. A statement from the applicant as to the type of child the applicant seeks to adopt and whether the applicant desires to adopt or would consider adopting a child with special needs;
10. Information on the following legal proceedings in which the applicant has been a party:
a. Dependency proceedings,
b. Severance or termination of parental rights proceedings,
c. Child support enforcement proceedings,
d. Proceedings involving allegations of child abuse or neglect,
e. Adoption proceedings, or
f. All criminal proceedings;
11. The applicant's prior history of adoption certification, including prior applications for certification and the dates of any certification denials;
12. Whether the applicant wishes to be listed on the Adoption Registry;
13. A fingerprint card or fingerprints processed through the Court, meeting the requirements of A.R.S. § 41.1758.07 on each applicant and each adult residing in the home more than the age of 18 years; and
14. The names, addresses, and phone numbers of five personal references; two references from family members related to the applicant by blood or marriage, and three other references, who have known the applicant at least two years and who can attest to the applicant's character and fitness to adopt.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-405. Certification Investigation**

**A.** Following acceptance of a completed certification application, the adoption entity shall conduct a certification investigation that includes:
1. Personal interviews with the adoptive family. Such interviews shall:
a. Occur on at least two separate occasions, at least one of which shall be at the adoptive parent's residence;
b. Comprise no less than four hours of in person contact, and at least one hour shall take place at the adoptive parent's residence;
c. Include at least one separate interview with each member of the adoptive parent's household who is more than the age of five; and
d. Include at least one joint interview with both adoptive parents if they are married;
2. Written statements from and personal contact (either a face-to-face meeting or a telephone call) with at least three of the applicant's personal references;
3. An inquiry as to whether the applicant wishes to be listed in the Adoption Registry;
4. Verification of the applicant's financial condition through a review of one or more of the documents listed in subsection (A)(7)(g) below;
5. A request to the Department for a check of the Central Registry to determine if the applicant has a past record of substantiated allegations of child abuse or neglect;
6. An evaluation of the success of the placement of other children adopted by the applicant;
7. A review of any supporting documentation the adoption entity reasonably deems necessary to determine an applicant's fitness to adopt, including:
a. A physician's statement regarding the physical health of other adult household members and the applicant's children living in the home;
b. A statement from a psychiatrist or psychologist regarding the mental health of the applicant and the applicant's other household members;
c. Birth certificates;
d. Marriage certificate;
e. Dissolution of marriage or divorce papers and orders, including child support documentation;
f. Military discharge papers;
g. Financial statements, tax returns, pay stubs, and W-2 statements;
h. Bankruptcy papers;
i. Insurance policy information; and
j. Documentation showing Arizona residency.

**B.** A person who meets the qualifications listed in 21 A.A.C. 9, Article 2, shall perform the certification investigation and shall document all personal contacts made and all information reviewed and considered during the investigation.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-406. Certification Report and Recommendation**

**A.** Upon completion of the certification investigation, the adoption entity shall prepare a certification report under A.R.S. § 8-105.

**B.** In determining whether to recommend certification of an applicant, the adoption entity shall consider all factors bearing on fitness to adopt, including, but not limited to:
1. The factors listed in A.R.S. § 8-105;
2. The length and stability of the applicant's marital relationship, if applicable;
3. The applicant's age and health;
4. Past, significant disturbances, or events in the applicant's immediate family, such as:
a. Involuntary job separation,
b. Divorce, or death of spouse, child, or parent, and
c. History of child abuse or neglect;

5. The applicant's ability to financially provide for an adopted child; and
6. The applicant's history of providing financial support to the applicant's other children, including compliance with court-ordered child support obligations.

**C.** The certification report shall specifically note any instances where an applicant has:
1. Been charged with, been convicted of, pled no contest to, or is awaiting trial, on charges of an offense listed in A.R.S. § 41-1758.07; or
2. Been a party to a dependency, guardianship, or termination of parental rights action.

**D.** If the report recommends denial of certification, the adoption entity shall send the applicant written notice of the unfavorable recommendation, the reason for the denial, and an explanation of the applicant's right under A.R.S. § 8-105, to petition the court for review. The adoption entity shall mail the notice to the applicant at least five work days prior to filing the certification report with the Court.

**E.** The adoption entity may notify the adoptive parent of the Court's certification decision if the Court fails to do so.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-407. Renewal of Certification**

**A.** A certified adoptive parent who has not filed a petition for adoption within one year of the original certification order, may apply for an extension of certification, as provided in A.R.S. § 8-105.

**B.** If the Court directs an adoption entity to investigate a certified adoptive parent who has requested a renewal of certification, the entity shall obtain from the adoptive parent seeking renewal:
1. A copy of the request for renewal of certification;
2. An updated profile of any changes in the certified adoptive parent's social, family, medical, and financial circumstances;
3. New fingerprint clearance per Court requirements, following original certification;
4. A current physical health statement for all members of the adoptive parent's household at least every third year following original certification; and
5. Other information as the Court may request.

**C.** When investigating a request for a renewal of certification, the adoption entity shall, at a minimum, complete the following:
1. Conduct an in person interview at the applicant's home with the applicant and the applicant's other household members more than the age of five years,
2. Investigate any change in circumstances described in the request for renewal as necessary to determine continuing fitness to adopt, and
3. Document all actions.

**D.** Upon completion of the renewal investigation, the adoption entity shall prepare and file with the Court a certification investigation that shall contain a recommendation for or against renewal of certification.

**E.** If the adoption entity recommends that certification not be renewed, the entity shall send the adoptive parent the notice in R21-5-406(D).

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-408. Communication with Adoptive Parents Awaiting Placement**

Upon request, an adoption entity shall inform an adoptive parent awaiting placement of a child of the following:
1. The status of the adoptive parent's case;
2. The number of children the adoption entity currently has available for adoption;
3. The number of times the adoptive parent has been considered for the placement of a child;
4. The number of approved adoptive parents awaiting placement of a child through the adoption entity; and
5. The number of placements the adoption entity made in the prior year, the number of placements the adoption entity has made to date in the current year, and the number of placements the adoption entity anticipates making during the remainder of the current year.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-409. Prohibitions Regarding Birth Parents**

An adoption entity shall not:
1. Promise a birth parent that the birth parent shall have future contact with the child or the adoptive parent but may explain the concept of open adoption;
2. Promise a birth parent that the child will be placed with a specific adoptive parent or type of adoptive parent, except in a direct placement adoption. The adoption entity may advise the parent that it will use the entity's best efforts to honor any placement preferences the birth parent may have, to the extent that such preferences are consistent with the best interests of the child;
3. Promise a birth parent any financial or other consideration prohibited by law; or
4. Do or say anything to coerce or pressure a birth parent to sign a consent to adopt.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-410. Information about Birth Parents**

**A.** Before accepting a child for placement, the adoption entity shall make a good faith effort to obtain the following information described in this Section from the child's birth parent, or person having custody of the child:
1. Information about each birth parent including:
   a. Name and any aliases used;
   b. Address, phone number, and residential history;
   c. Date and place of birth;
   d. Social security number;
   e. Race, citizenship, and any Native American tribal affiliation or membership;
   f. Physical description;
   g. Name of current employer and employment history;
   h. Educational history;
   i. Marital history and status;
   j. Record of other births and children born to the birth parent;
   k. Hobbies;
   l. Future plans;
   m. Record of arrests or convictions;
   n. Medical, psychological, and substance use history;

o. For the birth mother, history of prenatal care, gestational substance or drug abuse, pregnancy, and delivery;
p. Immediate family relationships; and
q. Significant family events.

2. An explanation of the birth parent's decision to place the child for adoption, the factors that influenced the decision, and a record of any counseling the birth parent received concerning the decision.
3. A record of the birth parent's contact with the child.
4. A statement of the birth parent's feelings about future contact with the child.
5. A list of the birth parent's preferences regarding an adoptive home for the child.
6. Medical or psychological history on the birth parent's own parents, siblings, grandparents, aunts, uncles, and first cousins.
7. Information on the child being surrendered for adoption, as appropriate to the age of the child and the child's:
   a. Developmental history,
   b. Medical and psychological history,
   c. Family background,
   d. Educational history, and
   e. Membership in or affiliation with any Native American tribe.
8. A listing of the birth parent's insurance policies, including:
   a. Any insurance that may be available to cover the medical expenses of the birth mother or adoptive child; and
   b. The name of the insured, the insurance policy number, and the effective dates of coverage.

**B.** The adoption entity shall document all statements and information in a permanent record.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-411. Pre-consent Conference with Birth Parents**

**A.** The adoption entity shall have a pre-consent conference with each birth parent who must provide consent to adoption under A.R.S. § 8-106, to explain in a language and form that each birth parent can understand the following:
1. The legal and practical consequences of executing a consent, including:
   a. Applicable ICWA provisions; and
   b. The fact that the consent, and all other affidavits executed in connection with an adoption, are executed under penalty of perjury;
2. The irrevocability and inalterability of a consent;
3. The legal prohibition against paying the birth parent to execute a consent;
4. The fact that the birth parent has no obligation to sign the consent; and
5. The provisions of A.R.S. § 8-106, regarding an affidavit of any potential father.

**B.** The pre-consent conference shall occur:
1. No earlier than 12 hours after the birth of a child if the conference was not held before the birth under subsection (B)(2);
2. No earlier than 60 days before the anticipated due date, if the conference is held before the child's birth;
3. At least 24 hours before presenting a birth parent with the consent form for signature; and
4. At a time that takes into account the known medical and emotional condition of each available birth parent.

**C.** The person conducting the pre-consent conference shall provide the birth parent with a sample consent form and shall convey the information described in subsection (A) in a language and form that the birth parent can understand.

**D.** The person conducting the pre-consent conference shall document that the information was given and understood and shall obtain the birth parent's signature on the documentation. If the conference is by telephone under subsection (E), the person may obtain the signature through the mail at a later date. If the conference is not held, the person shall document the reason under subsection (E).

**E.** The pre-consent conference may be by telephone and is not required if the birth parent cannot be located or refuses to participate in the conference. The adoption entity shall document the reason why the conference did not occur.

**F.** If required to obtain a consent from a birth father under A.R.S. § 8-106, the adoption entity shall, prior to obtaining the birth father's signature, advise the birth father of the matters listed in subsection (A) in a form and language the birth father can understand. The adoption entity shall include the advice listed in subsection (A) on the consent form.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-412. Consent to Adopt; Unknown Birth Parent**

**A.** A person who obtains a birth parent's signature on a consent shall not do so until the person reasonably determines:
1. That the requirements of R21-5-411 have been met;
2. That the birth parent is not acting under duress;
3. That the birth parent is physically and mentally capable of exercising informed consent; and
4. That the birth parent has revealed all information known about the identity and location of the other birth parent.

**B.** No one shall advise a birth parent to falsely state that he or she does not know the identity or location of the other birth parent.

**C.** When a birth parent professes not to know the identity or location of the other birth parent, the person taking the consent shall explain the risks and consequences of this response, including the following:
1. Potential invalidation of the adoption;
2. Potential detriment to the child's social and physical well-being, due to lack of information concerning the unidentified birth parent's social and medical history; and
3. Potential penalties for perjury.

**D.** When a birth parent knows, but refuses to disclose, the identity or location of the other birth parent, the adoption entity shall advise the birth parent as provided in subsection (C) and shall also explain that the Court may refuse to finalize the adoption.

**E.** The adoption entity shall document all action taken in compliance with this Section.

**F.** The adoption entity shall give the birth parent a copy of the consent and retain a copy in the permanent adoption file.

**G.** The adoption entity shall request a search of the confidential putative fathers registry of information that the Arizona Department of Health Services maintains under A.R.S. § 8-106.01 when:
1. A birth father's identity is unknown or undisclosed, and
2. The adoption entity believes that a search of the putative fathers registry may prevent disruption of a placement or an adoption.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-413. Adoptable Child: Assessment and Service Plan**

**A.** Prior to selecting an adoptive placement for an adoptable child, the adoption entity shall:
1. Assess the child's medical, psychological, social, and developmental needs;
2. Design an adoptive family profile consistent with the child's needs and best interests;
3. Develop a written service plan; and
4. Assess whether the child is a potential candidate for an adoption subsidy.

**B.** The service plan shall, at a minimum, include:
1. Placing the child on the Adoption Registry if there is no adoptive parent readily available to adopt the child;
2. Giving the child a developmentally appropriate explanation of the adoption process.

**C.** The adoption entity shall provide the child with services in accordance with the child's service plan.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-414. Placement Determination**

**A.** An adoption entity shall have and follow a written policy for making placement recommendations and decisions in both direct placement and adoption placement adoptions.

**B.** Except as otherwise provided in subsection (C), in an agency placement adoption a team shall make the placement decision. The team shall at a minimum, include:
1. The case manager or person who assessed the adoptable child, and
2. The case manager or person who is knowledgeable about the potential adoptive parents for the adoptable child.

**C.** In international adoptions, where the case manager or person who assessed the child is out of the country and unavailable, the adoption team shall include the person who is most familiar with the adoptable child's needs.

**D.** In an agency placement adoption, an adoption entity shall place an adoptable child in the adoptive setting that best meets the child's safety, social, emotional, physical and mental health needs. In determining who can best meet the needs, the adoption entity shall consider ICWA placement preferences if applicable and the following relevant factors in no order of preference:
1. The marital status, length and stability of the marital relationship of the adoptive parent;
2. The family's ability to meet the child's emotional, physical, mental, and social needs;
3. The family's ability to financially provide for the child;
4. The wishes of a child who is 12 years of age or more;
5. Family relationships between the child and the adoptive parent's family members;
6. The placement of the child's siblings;
7. The availability of relatives, the adoptable child's former foster parents, or other significant persons to provide support to the adoptive parent and child;
8. The wishes of the child's birth parent; and
9. All information in the case files of the child and the adoptive parent.

**E.** The adoption entity shall document the placement decision.
1. For adoptions conducted pursuant to the ICPC, the documentation shall comply with the requirements of the ICPC under A.R.S. § 8-548 et seq.
2. For all other adoptions, the documentation shall include the following:
   a. The adoptive child's critical needs and characteristics that weigh most heavily in the placement determination,
   b. The names and general characteristics of those adoptive parents who most closely match the child's needs and who are seriously considered for placement, and
   c. The reasons why a particular adoptive parent chosen for placement best meets the child's needs.

**F.** For adoptions not covered by the ICPC, the adoption entity may document the placement decision in a file or placement log that is separate from the clients' case files.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-415. Provision of Information on a Placed Child**

After selecting an adoptive placement for a child, and before placing the child with the chosen adoptive parent, the adoption entity shall provide the adoptive parent with all non-identifying information available on the child, including, without limitation, the following:
1. All records concerning the child's medical, psychological, social, legal, family, and educational background;
2. All records concerning the birth parents' medical, psychological, social, legal, family, and educational background;
3. The medical and social background on the child's other immediate family members, including siblings and birth grandparents;
4. The child's plan for adoption services, as described in R21-4-413; and
5. Information on adoption subsidy that may be available for the child.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-4-416. Transportation**

An adoption entity that transports an adoptive child shall:
1. Ensure that any person who transports an adoptive child is informed of the child's medical needs and is capable of meeting any medical needs that are reasonably likely to arise during transport;
2. Not leave an adoptive child unattended during transportation if the adoptive child:
   a. Is less than seven years of age;
   b. Has a developmental disability; and
   c. Is more than seven years of age if the adoption entity has determined, and documented in the child's record, that the child is physically and emotionally incapable of traveling alone;
3. Require all persons who provide transport to carry personal identification and a written statement from the adoption entity describing the person's authority and responsibilities while performing transport duties;
4. Require proof of driver's license from any person accepting temporary or permanent responsibility for transporting an adoptive child during the course of placement;

5. Document all transportation plans and actual transportation events in the child's record;
6. All vehicles used in transporting adoptive children shall be insured;
7. Ensure that an adoptive child is properly secured in a child restraint system that meets the requirements listed in R21-9-224(E).

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-417. Placement Services**

**A.** An adoption entity shall make counseling services available to the adoptive parents' family as the entity deems reasonable and necessary to facilitate the child's acceptance into the adoptive parent's family and to preserve stability. The adoption entity may make such services available by advising the adoptive family that such services may be beneficial and referring the adoptive parent and his or her family to community resources and providers.

**B.** The adoption entity shall make information on adoption related educational and supportive resources available to adoptive parents.

**C.** The adoptive parent must sign a document stating if he or she is declining any form of adoption counseling.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-418. Post-placement Supervision: Non-foster Parent Placement**

**A.** When a child is placed for adoption with a person who is not the child's foster parent, a case manager from the adoption entity shall visit the home within 30 calendar days of the date of adoptive placement to:
1. Ensure that the adoptive parent received all available non-identifying information from the adoption entity on the child;
2. Address any questions or concerns the adoptive parent or child may have about the adoption process or placement;
3. Ensure that the family has addressed the educational needs of a school-age child; and
4. Ensure that an adoptive parent who works has made appropriate child care arrangements.

**B.** Following the initial placement visit in subsection (A), a case manager from the adoption entity shall:
1. Visit the adoptive family at least once every three months until the adoption is finalized:
   a. Except, when the adoptive child is a child with special needs, the visits shall occur at least once a month; and
   b. During the first six months following the initial placement visit, at least alternating visits shall occur at the adoptive family's home;
2. Interview all members of the adoptive family's household during the placement supervision period;
3. Discuss how the child and the adoptive parent's family are adapting, the current relationship among members of the adoptive parent's family, and the following issues with the adoptive parent if appropriate in light of the child's age and development:
   a. How the presence of the child has changed familial relationships;
   b. How the child and the extended family view each other;
   c. The role each family member has assumed regarding child care and discipline;
   d. How the adoptive parent is coping with the needs and demands of the placed child;
   e. How the child challenges or tests the placement and how the family reacts to these episodes, including any feelings of insecurity about the propriety of the family members' response;
   f. How the family perceives the child's sense of identity and the need to fill in gaps in the child's history; and
   g. How the child has adjusted to the school environment;
4. If developmentally appropriate, privately interview the child about:
   a. The child's feelings about the adoption;
   b. How the child and family are adapting; and
   c. The child's relationships with the members of the family.

**C.** The case manager shall document all contacts and communications made under this Section.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-419. Post-placement Supervision: Foster Parent Placement**

**A.** When a foster parent plans to adopt a foster child who is age 5 years or older, a case manager from the adoption entity shall privately interview the child and all members of the adoptive family household who are age 5 years or older about their feelings towards the adoption, before the adoption consent is signed.

**B.** When a child is placed for adoption with a person who has been a foster parent to the child, a case manager from the adoption entity shall conduct a home visit at least every two months from the time legal consent for adoption has been signed until the finalization of adoption unless the adoptive child is a child with special needs. If the adoptive child is a child with special needs, the case manager shall visit at least once a month.

**C.** During the visits described in subsection (B), the case manager shall:
1. If developmentally appropriate, privately interview the child to discuss a child's feelings about the adoption; and
2. Interview all members of the adoptive family household, including children, if developmentally appropriate, to discuss, as described in R21-5-418, how the child and family are adapting, and the current relationship among members of the family.

**D.** The case manager shall document all contacts and communications under this Section.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-420. Protracted Placement**

If an adoption is not finalized within two years from the date of consent, and the child is still placed in the adoptive home, the adoption entity handling the adoption shall provide the Department with written documentation explaining the reason why the adoption has

not been finalized, no later than 30 calendar days after the two-year period has ended.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-421. Finalizing the Placement**

An adoption entity shall cooperate with the adoptive parent and the attorney, if any, retained by the adoptive parent, to finalize the adoption.

1. The entity shall provide all information and documents needed to finalize the adoption and shall file a final written report to the court at least 10 days before the final adoption hearing, or at such other time as the Court may require. The report shall include the information listed in this subsection, unless the entity has already provided this information in an earlier report, and the information has not changed since the earlier report.
   a. The name and age of each adoptive parent and the relationship, if any, of each adoptive parent to the child to be adopted;
   b. The name, age, and birthplace of the child to be adopted, and whether any or all of this information is unknown to the adoptive parent;
   c. The entity or other source from which the adoptive parent received the child to be adopted;
   d. The circumstances surrounding the surrender of the child to the entity;
   e. The results of the entity's evaluation of the child and of the adoptive parent, including:
      i. A description of the care the child is receiving;
      ii. The adjustment of the child and parent; and
      iii. A summary statement of the entity's recommendation to the court regarding finalization;
   f. A full description of any property belonging to the child to be adopted;
2. For children 12 years of age and older, the adoption entity shall solicit and consider the child's wishes concerning adoption.
3. The adoption entity shall notify the AHCCCS Administration of any potential third party payer, as prescribed in A.R.S. § 36-2946, if the entity has not already done so.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4). Amended by final expedited rulemaking at 28 A.A.R. 2479 (September 23, 2022), with an immediate effective date of September 9, 2022 (Supp. 22-3).

**R21-5-422. Placement Disruption**

**A.** When a placement fails, the adoption entity shall provide services, including counseling to the adoptive parent and his or her family and child, to help them cope with the loss and separation.

**B.** An adoption entity shall have and follow written procedures for an adoptive placement disruption. The procedures shall include:

1. Provision of counseling services to the adoptive parent, his or her family, and the child as needed; and
2. Provision for placement of the child in another adoptive home or other developmentally appropriate living arrangement.

**C.** The adoptive entity shall document the reasons for the disruption and shall take such information into account when making future placements for the adoptive parent and the child.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-423. Confidentiality**

Any person or entity who participates in an adoption or provides adoption services shall comply with the confidentiality requirements under A.R.S. §§ 8-120, 8-121, and 36-2903.01.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

## ARTICLE 5. ADOPTION SUBSIDY

**R21-5-501. Definitions**

In addition to the definitions in A.R.S. §§ 8-141 and 8-501, the following definitions apply in this Article.

1. "Adoption agency" means an individual or entity, including a corporation, company, partnership, firm, association, or society, other than the Department, licensed by the Department to place a child for adoption.
2. "Adoption Specialist" means the Department of Child Safety Specialist, or adoption agency staff person, who is responsible for managing the child's case prior to the adoption finalization.
3. "Adoption subsidy" means the same as A.R.S. § 8-141, and includes nonrecurring adoption expenses under A.R.S. § 8-161 et seq. If the child qualifies, the adoption subsidy may include one or more of the following:
   a. Medical, dental, and mental health subsidy;
   b. Maintenance subsidy;
   c. Special services subsidy; and
   d. Reimbursement of nonrecurring adoption expenses.
4. "Adoption subsidy agreement" means the agreement in A.R.S. § 8-144 concerning the Adoption Subsidy Program and includes the agreement in A.R.S. § 8-162 concerning the nonrecurring adoption expense program.
5. "Adoption Subsidy Program" means a unit within the Department of Child Safety that administers the adoption subsidy.
6. "Adoption Subsidy Supervisor" means a Department employee who is responsible for the Adoption Subsidy Program within a defined geographic area, and that the Department has authorized to approve an adoption subsidy agreement.
7. "Adoptive parent" means an adult who the court has certified or approved to adopt a child, or an adult who has adopted a child.
8. "AHCCCS" means the Arizona Health Care Cost Containment System, which is the state's program for medical assistance available under Title XIX of the Social Security Act and state public insurance statutes, A.R.S. Title 36, Chapter 29.
9. "AHCCCS hospital reimbursement system" means the payment structure that AHCCCS uses to pay for inpatient and outpatient hospital services.
10. "Complete adoption subsidy application" means a packet containing the following:
    a. An "Adoptive Family Subsidy Application" form provided by the Department that the adoptive parent, the Adoption Specialist, and Adoption Specialist supervisor have completed and signed; and

b. The supporting documentation and information requested in the "Adoptive Family Subsidy Application."

11. "Debilitating" means a lifelong, progressive, or fatal condition characterized by physical, mental, or developmental impairment that impedes an individual's ability to function independently.
12. "Department" or "DCS" means the Arizona Department of Child Safety.
13. "Developmental disability" means the same as A.R.S. § 8-141.
14. "Diagnose" means to identify a physical, psychological, social, learning, or developmental condition or disability according to the accepted standards of the medical, mental health, or educational professions.
15. "Emergency situation" means a circumstance that, if unaddressed, would be detrimental to a child's life, health, or safety.
16. "Emotional disturbance" means the same as A.R.S. § 8-141.
17. "Lawfully present in the United States" means the child is a U.S. citizen, national, or an alien authorized by an appropriate federal entity or court to be present in the United States.
18. "Legally free" means the parental rights of a child's birth or legal parents have been terminated.
19. "Maintenance subsidy" means a monthly payment paid to a custodial adoptive parent to assist with the costs directly related to meeting some of the adopted child's needs, including child care, health insurance co-payments and deductibles, and supplemental educational services for the adopted child.
20. "Mental disability" means the same as A.R.S. § 8-141.
21. "Nonrecurring adoption expenses" means the same as A.R.S. § 8-161, and are reasonable and necessary expenses directly related to the legal process of adopting a child with special needs. Allowable expenses include adoption fees, court costs, attorney's fees, fingerprinting fees, home study fees, costs for physical and psychological examinations, costs for placement supervision, and travel expenses necessary to complete the adoption.
22. "Physical disability" means the same as A.R.S. § 8-141.
23. "Qualified professional" means a practitioner licensed or certified by the state of Arizona or another state to evaluate and diagnose a condition or disability, or provide medical, dental, mental health services, or approved by the Department to provide educational or respite services.
24. "Sibling relationship" means two or more brothers or sisters who are related by blood or by law, and who are being adopted by the same family.
25. "Special allowance" means funds provided for clothing or personal expenses, therapeutic or personal attendant care, and other specialized payments such as emergency clothing, education, and gift allowances.
26. *"Special needs" means one or more of the following conditions which existed before the finalization of adoption:*
    a. Physical, mental or developmental disability.
    b. Emotional disturbance.
    c. High risk of physical or mental disease.
    d. High risk of developmental disability.
    e. Age of six or more years at the time of application for an adoption subsidy.
    f. Sibling relationship.
    g. Racial or ethnic factors.
    h. High risk of severe emotional disturbance if removed from the care of his foster parents.
    *i. Any combination of the special needs described in this paragraph.* A.R.S. § 8-141.
27. "Special services subsidy" means financial assistance for extraordinary, infrequent, or uncommon needs related to a special needs condition specified in the adoption subsidy agreement.
28. "Standard of care" means a medical or psychological procedure or process that is accepted as treatment for a specific illness, injury, medical, dental, learning, or psychological condition through custom, peer review, or consensus by the professional medical, dental, educational, or mental health community.
29. "Title IV-E" means section 473 of Title IV of the Social Security Act, 42 U.S.C. 673, which establishes the federal adoption assistance program.
30. "Title XIX" means Medicaid, as defined by Section 1900, Title XIX, of the Social Security Act, 42 U.S.C. 1396.
31. "Title XX" means the Social Services Block Grant, as defined by Section 2001, Title XX, of the Social Security Act, 42 U.S.C. 1397.
32. "Undiagnosed pre-existing special need condition" means a physical, mental or developmental disability or emotional disturbance that existed before a court finalized the child's adoption, and that a qualified professional did not confirm before the child's adoption.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-502. Eligibility Criteria**

**A.** The Department shall determine if a child qualifies for the Title IV-E adoption assistance program prior to determining whether the child qualifies for the Adoption Subsidy Program.

**B.** A child shall qualify for Title IV-E adoption assistance if the child meets the additional eligibility criteria required in 42 U.S.C. 673(a)(2). If the child does not meet the additional criteria in Title IV-E, the child may still be eligible to receive adoption subsidy under subsection (C).

**C.** An Arizona child shall be eligible for adoption subsidy when the child is:
1. In the care, custody, and control of the Department, or an adoption agency licensed in Arizona, or was previously adopted and received Title IV-E or Arizona adoption subsidy;
2. Legally free for adoption;
3. Lawfully present in the United States; and
4. Determined to be a child with special needs as defined by Title IV-E of the Social Security Act, and A.R.S. Title 8, Chapter 1, Articles 2 and 3 as follows:
    a. The child cannot or should not be returned to the parent's home;
    b. The child cannot be placed with adoptive parents without an adoption subsidy due to a special need of the child; and
    c. A reasonable but unsuccessful effort was made to place the child without an adoption subsidy, unless the Department determined that it was not in the child's best interest to place the child with another family because of the child's significant emotional ties with the prospective adoptive parent while in their care as a foster child.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-503. Application for Adoption Subsidy**

**A.** The adoptive parent shall submit a complete adoption subsidy application to the Department Adoption Subsidy Program prior to the finalization of the adoption. A complete adoption subsidy application shall include the following:
1. The child's:
   a. Name;
   b. Date of birth;
   c. Social Security Number; and
   d. Ethnicity;
2. The adoptive parents':
   a. Name;
   b. Date of birth;
   c. Social Security Number;
   d. Ethnicity;
   e. Marital status;
   f. Occupation;
   g. Relationship to the child;
   h. Adoption certification status;
3. Information about:
   a. The child's special needs;
   b. Whether the child is lawfully present in the U.S.;
   c. The Department or the adoption agency that has custody of the child;
   d. Whether the child is free for adoption;
   e. Efforts to place the child for adoption without adoption subsidy;
   f. Resources for which the child is eligible; and
   g. Financial benefits for which the child is eligible; and
4. Description of:
   a. The child's pre-existing special need conditions;
   b. The need for maintenance payments; and
   c. Nonrecurring expenses.
5. The adoptive parent shall include the following documentation:
   a. The child's specific special need identified by a qualified professional;
   b. The child's need for a maintenance subsidy from:
      i. The adoptive parent,
      ii. Adoption Specialist, and
      iii. A qualified professional;
   c. The child's lawful presence in the United States if the child is not a U.S. citizen;
   d. The child's pre-existing medical, dental, and mental health conditions as documented by a qualified professional:
      i. Current within one year, or
      ii. Provided in birth records; and
6. Assurances that the following information is available in the adoption case record:
   a. The Department or adoption agency that has custody of the child,
   b. That the child is free for adoption, and
   c. Efforts to place the child for adoption without adoption subsidy.

**B.** An adoption subsidy application is complete when the Adoption Subsidy Program receives the application and all supporting documentation. Documentation may vary according to the conditions of the child, and may include the recommendations of qualified professionals.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-504. Eligibility Determination**

The Department shall review the adoption subsidy application and determine eligibility according to the following:
1. The Department shall approve eligibility for adoption subsidy if a child meets the eligibility criteria listed in R21-5-502 and the adoptive parent submits a complete application. If the Department approves eligibility, the Department shall create an adoption subsidy agreement that the adoptive parent and the Adoption Subsidy Supervisor or designee shall sign before the court enters the final order of adoption.
2. The Department shall deny eligibility for an adoption subsidy if a child does not meet the eligibility criteria listed in R21-5-502. If the Department denies an adoption subsidy, the Department shall send a notice to the adoptive parent that explains the reason for denial, the applicant's right to appeal, and the time-frame to file an appeal.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-505. Adoption Subsidy Agreement**

**A.** The Department shall create an adoption subsidy agreement that lists the scope and nature of the subsidies provided, including:
1. The child's documented pre-existing special needs condition,
2. The types of subsidy approved,
3. The amount or rates as applicable to the types of subsidy approved, and
4. The specific terms and conditions of the agreement.

**B.** The adoption subsidy agreement shall become effective if the following occurs prior to the finalization of the adoption:
1. The adoptive parent signs the agreement and returns it to the Department Adoption Subsidy Program, and
2. The Adoption Subsidy Supervisor or designee signs the agreement.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-506. Medical, Dental, and Mental Health Subsidy**

Adoption subsidy provides medical, dental, and mental health subsidies in the form of federal Medicaid coverage to a child in the Adoption Subsidy Program.
1. If the child resides in Arizona, AHCCCS determines eligibility; or
2. If the child resides in another state, the relevant state agency in that state determines Medicaid eligibility.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-507. Maintenance Subsidy**

**A.** The maintenance subsidy may not cover all the daily living expenses of the adopted child. The Department and the adoptive parent shall negotiate the amount of maintenance subsidy based on a child's current special needs and the family's circumstances.

1. Under A.R.S. § 8-144(B), the amount of the maintenance subsidy shall not exceed the payments allowable for foster care, not including foster care special allowances.
2. The Department shall deduct private or public monetary benefits, such as benefits received through Title II of the Social Security Act, paid to the child from the monthly maintenance subsidy, as allowed under state or federal law. The adoptive parent shall report the receipt of any private or public monetary benefits for the child to the Adoption Subsidy Program as soon as the benefits are received.

**B.** Payment of Maintenance Subsidy
1. The Department shall not begin maintenance subsidy payments prior to the effective date of the adoption subsidy agreement.
2. The Department shall issue maintenance subsidy payments monthly to the adoptive parent as specified in the adoption subsidy agreement.

**C.** Renegotiation of the Maintenance Rate
1. The Department or the adoptive parent may initiate a change in the maintenance subsidy rate if there are changes in the child's needs.
2. The Department may renegotiate the amount of the adoption subsidy; however, the rate shall not exceed the payments allowable for foster care, not including foster care special allowances.
3. The adoptive parent shall provide the Department with documentation supporting the requested change in the maintenance subsidy rate.
4. If the child is in the care or custody of a state agency in Arizona or any other state, an adoption agency, or an individual other than the adoptive parent, the Department shall request, and the adoptive parent shall provide, documentation that the adoptive parent continues to be legally and financially responsible for the child.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-508. Special Services Subsidy**

**A.** Special services subsidy shall be:
1. Related to a special needs condition listed in the adoption subsidy agreement; and
2. Necessary to improve or maintain the adopted child's functioning as documented by an appropriate qualified professional. The Adoption Subsidy Program shall review the documentation at least annually.

**B.** Services approved for the payment of special services subsidy shall be:
1. Provided by a qualified professional;
2. Provided in the least restrictive environment and as close as possible to the adoptive parent's residence;
3. In accordance with the "Standard of Care"; and
4. Not otherwise covered by or provided through maintenance subsidy, medical subsidy, dental subsidy, mental health subsidy, or other resources for which the adopted child is eligible.

**C.** The adoptive parent shall submit the special services request to the Adoption Subsidy Program and receive approval from the Adoption Subsidy Program prior to the adoptive parent's incurring the specified expense. The request shall include:
1. Documentation from a qualified professional that the service is necessary; and
2. Documentation that the adoptive parent had requested the service and the service provider had denied the request or documentation that the service is not available from other potential funding sources, such as AHCCCS/Medicaid, private insurance, school district, or other community resources.

**D.** Special services subsidy shall not include:
1. Payment for services to meet needs other than the pre-existing special needs conditions specifically listed in the adoption subsidy agreement;
2. Payment for medical or dental services usually considered to be routine, such as well-child checkups, immunizations, and other services not related to the child's special needs conditions in the adoption subsidy agreement;
3. Payment for health-related services that are not medically necessary, as determined by a qualified professional;
4. Payment for social or recreational services such as routine child care, dance lessons, sports fees, camps, and similar services; and
5. Payment for educational services that are not necessary to meet the special needs conditions specifically listed in the adoption subsidy agreement, or the services for which the school district is responsible.

**E.** The Department may request an independent review by a qualified professional of a special services request to determine the necessity for medical, dental, psychological, or psychiatric testing or services, or to evaluate the appropriateness of the treatment plan or placement.

**F.** The Department may issue reimbursements to the adoptive parent for approved special services, or the Department may pay the service provider directly.

**G.** Special services subsidy reimbursement is limited as follows:
1. The Department shall reimburse in-state and out-of-state inpatient and outpatient hospital services according to the AHCCCS hospital reimbursement system, as required by A.R.S. § 8-142.01(A), if the adoptive parent has obtained prior approval for the service from the Department. Prior approval is not required in an emergency situation.
2. The Department shall not reimburse special services subsidy amounts in excess of the rates allowed by the Department or AHCCCS. The Department shall use the lowest applicable rates as established by AHCCCS, the Department's Comprehensive Medical and Dental Program (CMDP), or rates established by the Adoption Subsidy Program to be customary and reasonable.
3. The Department shall not pay for requests that the adoptive parent or provider submits more than nine months after the date of service for which the adoptive parent or provider requests payment.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-509. Nonrecurring Adoption Expenses**

**A.** Nonrecurring adoption expenses shall not cover expenses related to visiting and placing the child.

**B.** Reimbursement of nonrecurring adoption expenses is subject to the limitations in A.R.S. § 8-164.

**Historical Note**
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-510. Annual Review; Reporting Change**

**A.** Each year, the Department shall send a review form to the adoptive parent requesting that the adoptive parent provide:
1. Information indicating that the parent remains legally and financially responsible for the child;
2. Information on any change in benefits for the child, such as benefits received through Title II of the Social Security Act;
3. Information on any change in circumstances, including changes in residence, marital status, educational status, or other similar changes; and
4. A description of any changes in the child's special needs conditions that are listed in the adoption subsidy agreement.

**B.** The adoptive parent shall provide the Department with the requested information within 30 days of the adoptive parent's receipt of the review form.

**C.** The adoptive parent shall notify the Department in writing within five calendar days when any of the following occurs:
1. The adoptive parent is no longer legally responsible for the child;
2. The adoptive parent is no longer providing support to the child;
3. The child is no longer residing in the adoptive parent's home;
4. The child has graduated from high school or obtained a general equivalency degree (GED);
5. The child has married;
6. The child has joined the military; or
7. The child dies.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-511. Termination of Adoption Subsidy**

The Department shall terminate an adoption subsidy when any of the following occurs:
1. The child turns 18 years old and is not enrolled in and attending high school or a program leading to a high school diploma or general equivalency degree (GED);
2. The child is aged 18 through 21 years, has been continuously enrolled in school, and either drops out of school, graduates from high school, or obtains a general equivalency degree (GED);
3. The child turns 22 years old;
4. The adoptive parent is no longer legally responsible for the child;
5. The adoptive parent is no longer providing support to the child;
6. The child marries;
7. The child joins the military;
8. The special needs conditions of the child no longer exist;
9. The child dies;
10. The adoptive single parent or both adoptive parents die; or
11. The adoptive parent requests termination.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-512. New or Amended Adoption Subsidy Agreement**

An adoptive parent may apply for a new or amended adoption subsidy agreement after the adoption is final, only upon documentation of an undiagnosed pre-existing special needs condition that existed before the finalization of the adoption.
1. The adoptive parent shall send the Department a written request for adoption subsidy with documentation from a qualified professional diagnosing the special needs condition and confirming that it existed before the final order of adoption.
2. The adoptive parent and the Department shall follow the procedures in this Article for processing applications and determining eligibility.
3. If the Department finds that the child has an undiagnosed pre-existing special needs condition that, if diagnosed prior to the adoption, would have met the eligibility criteria listed in R21-5-502, the Department shall grant a new subsidy or amend the adoption subsidy agreement to cover this special needs condition.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-513. Appeals**

Appeals for the Adoption Subsidy Program shall follow the process in 21 A.A.C. 1, Article 3.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

**R21-5-514. Confidentiality**

The Department shall maintain the confidentiality of all information used in the Adoption Subsidy Program according to all applicable federal and state laws.

**Historical Note**

New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

# 8-453. Powers and duties

A. The director shall:

1. Carry out the purposes of the department prescribed in section 8-451.

2. Provide transparency by being open and accountable to the public for the actions of the department.

3. Develop a data system that enables persons and entities that are charged with a responsibility relating to child safety to access all relevant information relating to an abused, neglected or abandoned child as provided by law.

4. Subject to title 41, chapter 4, article 4 and, as applicable, articles 5 and 6, employ deputy directors and other key personnel based on qualifications that are prescribed by the director.

5. Adopt rules to implement the purposes of the department and the duties and powers of the director.

6. Petition, as necessary to implement the case plan established under section 8-824 or 8-845, for the appointment of a guardian or a temporary guardian under title 14, chapter 5 for children who are in the custody of the department pursuant to court order. Persons applying to be guardians or temporary guardians under this section shall be fingerprinted. A foster parent or certified adoptive parent already fingerprinted is not required to be fingerprinted again, if the foster parent or certified adoptive parent is the person applying to be the guardian or temporary guardian.

7. Cooperate with other agencies of this state, county and municipal agencies, faith-based organizations and community social services agencies, if available, to achieve the purposes of this chapter.

8. Exchange information, including case specific information, and cooperate with the department of economic security for the administration of the department of economic security's programs.

9. Administer child welfare activities, including:

(a) Cross-jurisdictional placements pursuant to section 8-548.

(b) Providing the cost of care of:

(i) Children who are in temporary custody, are the subject of a dependency petition or are adjudicated by the court as dependent and who are in out-of-home placement, except state institutions.

(ii) Children who are voluntarily placed in out-of-home placement pursuant to section 8-806.

(iii) Children who are the subject of a dependency petition or are adjudicated dependent and who are in the custody of the department and ordered by the court pursuant to section 8-845 to reside in an independent living program pursuant to section 8-521.

(c) Providing services for children placed in adoption.

10. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

11. Make contracts and incur obligations within the general scope of the department's activities and operations subject to the availability of funds.

12. Coordinate with, contract with or assist other departments, agencies and institutions of this state and local and federal governments in the furtherance of the department's purposes, objectives and programs.

13. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.

14. Collect monies owed to the department.

15. Act as an agent of the federal government in furtherance of any functions of the department.

16. Carry on research and compile statistics relating to the child welfare program throughout this state, including all phases of dependency.

17. Cooperate with the superior court in all matters related to this title and title 13.

18. Provide the cost of care and transitional independent living services for a person under twenty-one years of age pursuant to section 8-521.01.

19. Ensure that all criminal conduct allegations and reports of imminent risk of harm are investigated.

20. Ensure the department's compliance with the Indian child welfare act of 1978 (P.L. 95-608; 92 Stat. 3069; 25 United States Code sections 1901 through 1963).

21. Strengthen relationships with tribal child protection agencies or programs.

B. The director may:

1. Take administrative action to improve the efficiency of the department.

2. Contract with a private entity to provide any functions or services pursuant to this title.

3. Apply for, accept, receive and expend public and private gifts or grants of money or property on the terms and conditions as may be imposed by the donor and for any purpose provided for by this title.

4. Reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business. Volunteers reimbursed for expenses are not eligible for workers' compensation under title 23, chapter 6.

C. The department shall administer individual and family services, including sections on services to children and youth and other related functions in furtherance of social service programs under the social security act, as amended, title IV, parts B and E, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services and other related federal acts and titles.

D. Notwithstanding any other law, a state or local governmental agency or a private entity is not subject to civil liability for the disclosure of information that is made in good faith to the department pursuant to this section.

E. Notwithstanding section 41-192, the department may employ legal counsel to provide legal advice to the director. The attorney general shall represent the department in any administrative or judicial proceeding pursuant to title 41, chapter 1, article 5.

F. The total amount of state monies that may be spent in any fiscal year by the department for foster care as provided in subsection A, paragraph 9, subdivision (b) of this section may not exceed the amount appropriated or authorized by section 35-173 for that purpose. This section does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

# 8-105. Preadoption certification; investigation; central adoption registry

A. Before any prospective adoptive parent may petition to adopt a child the person shall be certified by the court as acceptable to adopt children. A certificate shall be issued only after an investigation conducted by an officer of the court, by an agency, by the department or by an entity contracted by the department to do an investigation and home study for foster home licensing or preadoption certification. A written application for certification shall be made directly to the court, to an agency, to the department or to an entity contracted by the department, in the form and content required by the court, agency or department.

B. The department is not required to accept every application for certification. In determining which applications to accept the department may give priority to applications filed by adult residents of this state who wish to adopt a child who has any special needs as defined in section 8-141.

C. After receiving and accepting the written and completed application of the prospective adoptive parent or parents, which shall include a financial statement and a physician's or a registered nurse practitioner's statement of each applicant's physical health, the department, the agency, an officer of the court or the entity contracted by the department shall conduct or cause to be conducted an investigation of the prospective adoptive parent or parents to determine if they are fit and proper persons to adopt children.

D. The department shall not present for certification a prospective adoptive parent unless that person and each other adult member of the household have a valid fingerprint clearance card issued pursuant to section 41-1758.07. The prospective adoptive parent and each other adult member of the household must certify on forms that are provided by the department and that are notarized whether that person is awaiting trial on or has ever been convicted of any of the criminal offenses listed in section 41-1758.07, subsections B and C in this state or similar offenses in another state or jurisdiction.

E. An officer of the court may obtain a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

F. This investigation and report to the court shall consider all relevant and material facts dealing with the prospective adoptive parents' fitness to adopt children and shall include:

1. A complete social history.

2. The financial condition of the applicant.

3. The moral fitness of the applicant.

4. The religious background of the applicant.

5. The physical and mental health condition of the applicants.

6. Any court action for or adjudication of child abuse, abandonment of children, dependency or termination of parent-child relationship in which the applicant had control, care or custody of the child who was the subject of the action.

7. Whether the person or persons wish to be placed on the central registry established in subsection M of this section.

8. All other facts bearing on the issue of the fitness of the prospective adoptive parents that the court, agency or department may deem relevant.

G. The investigator shall not reveal to the prospective adoptive parents the identity of a child or the child's parent or parents and shall not reveal to the child or the child's parent or parents the identity of the prospective adoptive

parents if these facts are not already known.

H. Within ninety days after the original application prescribed by subsection A of this section has been accepted, the department, the agency or the entity contracted by the department or a person or agency designated by the court to conduct an investigation shall present to the juvenile court the written report required by subsection F of this section, which shall include a definite recommendation for certifying the applicant as being acceptable or nonacceptable to adopt children and the reasons for the recommendation.

I. Within sixty days after receiving the investigation report required by subsections F and H of this section, the court shall certify the applicant as being acceptable or nonacceptable to adopt children based on the investigation report and recommendations of the report. A certification remains in effect for eighteen months from the date of its issuance and may be extended for additional one year periods if after review the court finds that there have been no material changes in circumstances that would adversely affect the acceptability of the applicant to adopt.

J. The court may require additional investigation if it finds that additional information is necessary on which to make an appropriate decision regarding certification.

K. Any applicant who has been certified as nonacceptable may petition the court to review that certification. Notice shall be given to all interested parties and notice may be given to the foster care review board if the child sought to be adopted is in out-of-home placement and is a dependent child or the subject of a dependency action. The matter shall be heard by the court, which may affirm or reverse the certification.

L. If the applicant is certified as nonacceptable, the applicant may not reapply for certification to the court, to any agency, to the department or to an entity contracted by the department for one year.

M. The department shall maintain a central adoption registry that includes the names of all prospective adoptive parents currently certified by the court as acceptable to adopt children, except those who request that their names not be included, the names of all children who are under the jurisdiction of the department and who are currently available for adoption, the names of any other children who are currently available for adoption and whose names are voluntarily entered in the registry by any agency, parent or other person that has the right to give consent to the child's adoption, and other information as the department may elect to include in aid of adoptive placements. Access to information in the registry shall be made available on request to any agency under assurances as the department may require that the information sought is in furtherance of adoptive placements and that confidentiality of the information is preserved.

N. This section does not apply if:

1. The prospective adoptive parent is the spouse of the birth or legal parent of the child to be adopted or is an uncle, aunt, adult sibling, grandparent or great-grandparent of the child of the whole or half-blood or by marriage or adoption.

2. The birth or legal parent is deceased but at the time of death the parent had legal and physical custody of the child to be adopted and the child had resided primarily with the spouse of the birth or legal parent during the twenty-four months before the death of the parent.

3. The grandparent, great-grandparent, uncle, aunt, great-uncle, great-aunt or adult sibling is deceased but at the time of death that person had legal and physical custody of the child to be adopted and the child had resided primarily with the spouse of the grandparent, great-grandparent, uncle, aunt, great-uncle, great-aunt or adult sibling during the twenty-four months before the death of the grandparent, great-grandparent, uncle, aunt, great-uncle, great-aunt or adult sibling.

4. The applicant is a licensed foster parent who is petitioning to adopt a child currently placed by the department in the foster parent's home and the department recommends the adoption of the child by the foster parent applicant.

O. If the applicant is not a licensed foster parent and has adopted a child within three years preceding the current application and is applying to adopt another child, the department, the agency or an entity contracted by the department or a person designated by the court to conduct an investigation shall only provide an update report on any changes in circumstances that have occurred since the previous certification. If the applicant has adopted a child more than three years before the current application and is applying to adopt another child, the department, the agency or an entity contracted by the department or a person designated by the court to conduct an investigation may provide an updated report on any changes in circumstances that have occurred since the previous certification. The court shall certify the applicant as acceptable to adopt unless there are changes in circumstances that adversely affect the applicant's parenting ability. In making this determination, the court shall consider information from the prior certification.

# 8-112. Social studies; requirements

A. The division, an agency or an officer of the court shall conduct and submit a social study to the court ten days before the hearing on the petition to adopt. Notwithstanding any other provisions of this section, the court may order an additional social study or waive the social study if it determines that this is in the child's best interests because of special circumstances.

B. Except as provided in subsection D or E of this section, the social study shall include the following:

1. The social history, heritage and mental and physical condition of the child and the child's birth parents.

2. The child's current placement in the prospective adoptive parent's home and the child's adjustment to that home.

3. The prospective adoptive parent's suitability to adopt.

4. The existing and proposed arrangements regarding the child's custody.

5. Any financial arrangement concerning the proposed adoption made by the birth parents, the division, an agency, an attorney or the prospective adoptive parents.

6. A state and federal criminal records check of the prospective adoptive parent and each adult who is living permanently with the prospective adoptive parent except a birth or legal parent with custody of the child. A valid fingerprint clearance card that is issued pursuant to section 41-1758.07 satisfies this requirement. The court may order an additional state and federal criminal records check for good cause.

7. A central registry records check, including any history of child welfare referrals, with the division of the prospective adoptive parent and each adult who is living permanently with the prospective adoptive parent.

8. Any other information that is pertinent to the adoption proceedings.

C. The social study conducted pursuant to subsection A of this section is part of the case file and shall contain a definite recommendation for or against the proposed adoption and the reasons for that recommendation.

D. The social study conducted pursuant to subsection A of this section shall consist only of the results of the state and federal criminal records check and the central registry records check conducted pursuant to subsection B of this section if either of the following is true:

1. The prospective adoptive parent is the child's stepparent who has been legally married to the child's birth or legal parent for at least one year and the child has resided with the stepparent and parent for at least six months.

2. The prospective adoptive parent is the child's adult sibling, by the whole or half blood, or the child's aunt, uncle, grandparent or great-grandparent and the child has resided with the prospective adoptive parent for at least six months.

E. If the child being considered for adoption has resided with the prospective adoptive parent for at least six months and the prospective adoptive parent either has adopted a child or was appointed the permanent guardian of the child within three years preceding the current application, or is a foster parent who is licensed by this state, the social study conducted pursuant to subsection A of this section may consist only of the following:

1. The results of the central registry records check conducted pursuant to subsection B of this section.

2. A review of any material changes in circumstances that have occurred since the previous adoption, permanent guardianship or license renewal that affect the prospective adoptive parent's ability to adopt the child or for the child to be placed in the prospective adoptive parent's home.

F. The department shall complete any required social study within six months after receiving a completed application to adopt a child if all of the following apply to the child:

1. The child is free for adoption and is at least sixteen years of age.

2. The department has placed the child with a prospective adoptive parent.

3. The child consents to the adoption.

# 8-120. Records; inspection; exception; destruction or transfer of certain records

A. Except as provided in section 8-129, all files, records, reports and other papers compiled under this article, whether filed in or in possession of the court, an agency or any person or association, shall be withheld from public inspection.

B. Such files, records, reports and other papers may be open to inspection by persons and agencies having a legitimate interest in the case and their attorneys and by other persons and agencies having a legitimate interest in the protection, welfare or treatment of the child if so ordered by the court.

C. This section does not prohibit persons employed by the court, the division or an agency from conducting the investigations or performing other duties pursuant to this article within the normal course of their employment.

D. This section does not prohibit persons employed by the court, the division, an attorney participating or assisting in a direct placement adoption pursuant to section 8-130 or an agency from providing partial or complete identifying information between a birth parent and adoptive parent when the parties mutually agree to share specific identifying information and make a written request to the court, the division or the agency.

E. Except for files that belong to an attorney, all files, records, reports and other papers not filed in or in the possession of the court shall not be destroyed until after a ninety-nine year period. The files that belong to an attorney shall not be destroyed until after a seven-year period.

F. If an adoption agency ceases operations, the adoption agency shall do all of the following:

1. Transfer the documents described in subsection A of this section to the division or to another adoption agency in this state if the documents concern a matter that is closed.

2. Transfer the documents described in subsection A of this section to another adoption agency in this state if the documents concern a matter that is open.

3. Notify the division of the transfer of any documents to another adoption agency in this state pursuant to this subsection.

4. Notify all adoptive parents whose files it is transferring pursuant to this subsection of the transfer.

# 8-121. Confidentiality of information; exceptions

A. It is unlawful, except for purposes for which files and records or social records or parts thereof or information therefrom have been released pursuant to subsection C of this section or section 8-120, 8-129, 8-134 or 36-340, or except for purposes allowed by order of the court, for any person to disclose, receive or make use of, or authorize, knowingly allow, participate in or acquiesce in the use of, any information involved in any proceeding under this article directly or indirectly derived from the files, records, reports or other papers compiled pursuant to this article, or acquired in the course of the performance of official duties until one hundred years after the date of the order issued pursuant to section 8-116. After one hundred years has elapsed from the date of the order issued pursuant to section 8-116 the court shall transfer all files, records, reports and other documents in possession of the court relating to the adoption to the Arizona state library, archives and public records. The items transferred pursuant to this subsection shall be available for public inspection during business hours and may be made available in an alternative format.

B. This section does not prohibit persons employed by the court, the division or an agency from conducting the investigations or performing other duties pursuant to this article within the normal course of their employment.

C. This section does not prohibit persons employed by the court, the division, an attorney participating or assisting in a direct placement adoption pursuant to section 8-130 or an agency from providing partial or complete identifying information between a birth parent and adoptive parent when the parties mutually agree to share specific identifying information and make a written request to the court, the division or the agency.

D. A person may petition the court to obtain information relating to an adoption in the possession of the court, the division or any agency or attorney involved in the adoption. Nonidentifying information may be released by the court pursuant to section 8-129. The court shall not release identifying information unless the person requesting the information has established a compelling need for disclosure of the information or consent has been obtained pursuant to subsection E of this section or from the birth parent pursuant to section 8-106. If a compelling need for disclosure of information is established, the court may decide what information, if any, should be disclosed and to whom and under what conditions disclosure may be made.

E. An adoptee who is eighteen years of age or older or a birth parent may file at any time with the court and the agency, division or attorney who participated in the adoption a notarized statement granting consent, withholding consent or withdrawing a consent previously given for the release of confidential information. If an adoptee who is eighteen years of age or older and the birth mother or birth father have filed a notarized statement granting consent to the release of confidential information, the court may disclose information, except identifying information relating to a birth parent who did not grant written consent, to the adoptee or birth parent.

F. This section does not prohibit a person from notifying a birth parent of the death of a child that the birth parent has placed for adoption.

# 8-130. Consent to licensed agency or division; attorneys; affidavits

A. A consent to adoption of a child shall not be granted to an agency unless the agency is licensed to place children for adoption under this article. A consent may be granted to the division, which is exempt from licensure. An agency or the division may conduct both agency placement adoptions and direct placement adoptions. An agency placement adoption shall only be made by an agency or the division.

B. Except as provided in subsection C, a person shall not do any of the following unless the person is employed or engaged by and acting on behalf of a licensed adoption agency:

1. Solicit or accept employment or engagement, for compensation, by or on behalf of a parent or guardian for assistance in the placement of a child for adoption.

2. Solicit or accept employment or engagement, for compensation, by or on behalf of any person to locate or obtain a child for adoption.

C. An attorney licensed to practice law in this state may assist and participate in direct placement adoptions and may receive compensation to the extent the court finds reasonable under section 8-114 if the person granting consent to the adoption has made a choice of the specific adopting parent without prior involvement of the attorney or if the choice is made only from among persons currently certified by the court as acceptable to adopt children pursuant to section 8-105.

D. Before a petition to adopt is granted and as a condition of the entry of an order of adoption:

1. An attorney participating or assisting in a direct placement adoption shall file with the court an affidavit confirming that there has been, to the best of his knowledge and belief, compliance with subsection B of this section and with section 8-114, subsection B, section 8-129 and, if fictitious names have been used, section 8-107, subsection E.

2. An attorney representing petitioners in an agency placement adoption and the agency shall file with the court an affidavit confirming that there has been, to the best of the petitioner's, agency's and attorney's knowledge and belief, compliance with subsections A and B of this section and sections 8-114 and 8-129.

# 8-171. Definitions

In this article, unless the context otherwise requires:

1. "Adoption assistance" means payments, medical assistance or benefits provided by an adoption assistance state pursuant to applicable federal and state laws.

2. "Adoption assistance state" means a state that is a signatory to an interstate adoption assistance compact.

3. "State" means a state, district, commonwealth or territory of the United States.

# 8-172. Interstate compacts; requirements; optional contents

The department may enter into a compact with other states to provide for the reciprocal enforcement of adoption assistance agreements. A compact entered into pursuant to this section shall contain the following:

1. A provision making it available for joinder by all states.

2. A provision or provisions for withdrawal from the compact on written notice to the parties no sooner than one year from the date of the notice.

3. A requirement that the protections afforded by or pursuant to the compact continue in force for the duration of the adoption assistance and are applicable to all children and their adoptive parents who on the effective date of the state's withdrawal from the compact are receiving adoption assistance from a party state other than the one in which they are residents and have their principal place of abode.

4. A requirement that each instance of adoption assistance to which the compact applies is covered by an adoption assistance agreement in writing between the adoptive parents and the state child welfare agency of the state that provides the adoption assistance and that this agreement is expressly for the benefit of the adopted child and is enforceable by the adoptive parents and the state agency providing the adoption assistance.

5. Other provisions necessary to implement the compact.

# 8-173. Adoption assistance agreements; reciprocity conditions; violation; classification

A. A child who resides in this state and who is the subject of an adoption assistance agreement with a state that has entered into a compact with this state is entitled to receive medical assistance from this state if the adoption assistance agreement provides categorical eligibility for federally funded medical assistance. This entitlement begins on the filing with the department of a certified copy of the adoption assistance agreement obtained from the adoption assistance state. In accordance with department rules, the adoptive parents shall show at least annually that the agreement with the other adoption assistance state is still in force or has been renewed.

B. The department and the Arizona health care cost containment system administration shall consider the holder of an adoption assistance agreement, as provided in subsection A of this section, as any other eligible medical assistance person under the laws of this state and shall make medical assistance payments pursuant to the same conditions and procedures for other recipients of medical assistance.

C. A person who knowingly submits a claim for payment or reimbursement for services or benefits pursuant to this section or who makes a statement in connection with a claim that is false, misleading or fraudulent is guilty of a class 6 felony.

**DEPARTMENT OF ECONOMIC SECURITY**
Title 6, Chapter 14

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 9, 2025

**SUBJECT:** **DEPARTMENT OF ECONOMIC SECURITY**
Title 6, Chapter 14

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**Summary**

This Five-Year Review Report (5YRR) from the Department of Economic Security (Department) relates to thirty-six (36) rules in Title 6, Chapter 14, Articles 1, 3, 4, and 5. Specifically, the rules in Title 6, Chapter 14 relate to the Nutrition Assistance Program including the following articles:

- Article 1 - Food Stamps - General Information and Provisions
- Article 3 - Claims Against Households
- Article 4 - Appeals and Fair Hearings
- Article 5 - Intentional Program Violation

In the prior 5YRR for these rules, which was approved by the Council in February 2020, the Department indicated it intended to amend rule R6-14-111 to align definitions contained therein with changes made to rules in Articles 3, 4, and 5, which became effective in January 2020. However, the Department indicates the onset of the COVID-19 pandemic in early 2020 forced the Department to focus on immediate pandemic response efforts, including implementation of waivers and an increased benefit amount for this program, and was not able to complete the latter part of the proposed course of action to address rule R6-14-111. The Department indicates it coordinated with its federal agency partners to implement certain

flexibilities to manage the surge in Nutrition Assistance applications from those impacted by sudden business closures and job losses. The Department states staff involved in the rulemaking process were tapped to develop interim guidelines and procedures. Nevertheless, the Department indicates approval to proceed with rulemaking was received from the Governor's Office on March 4, 2024, and the Department has been working diligently to advance this rulemaking in a timely manner.

**Proposed Action**

The Department proposes to amend several rules that are not clear, concise, understandable and effective as described in more detail below. The Department received approval to engage in rulemaking from the Governor's Office in March 2024, and is currently in the process of amending the rules. The draft rules were posted on the Department website for a 60-day informal stakeholder review on December 20, 2024. The Department anticipates filing a Notice of Final Rulemaking for the proposed rules to the Council by December 2025.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

The Department states that an economic impact statement (EIS) was not prepared when Article 1 was adopted in 1996, and references an EIS completed by the Department on Articles 3, 4, and 5 when the rules were adopted in January 2020. The Department comparison indicated collection of $742,974 SNAP overpayments from the EIS during FFY 2018, to the $4,707,494 SNAP overpayment collections reported in FFY 2024. To explain the large disparity reported in FFY 2024 compared to the 2020 EIS, the Department states a dedicated SNAP overpayment team was able to work through a backlog of unprocessed overpayment referrals. There were 4,588 SNAP-related appeal hearings and 34 Intentional Program Violation (IPV) hearings during the State Fiscal Year (SFY) 2018. In SFY2024, the Department conducted 11,628 SNAP-related hearings, and 410 IPV hearings.

Stakeholders include the Department and claimants of the Nutrition Assistance Program.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes that the rules impose the least burden and costs to persons regulated by these rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objectives. It states that these rules do not impose any cost to consumers or small businesses, and updates to the rules identified in this report outweigh any potential costs incurred from the proposed revisions.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Department indicates it has not received any written criticisms of the rule in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rules are clear, concise, and understandable except for the following:

- **R6-14-111:** Some terms defined in this rule are outdated or no longer used.
- **R6-14-302:** The description of the method to determine the date of discovery and when the overpayment period begins for each type of claim is not clearly written and difficult to understand in the rule.
- **R6-14-303:** The methods to determine the amount of a claim are not clearly explained in the rule and the rule contains statements that are irrelevant to the rule and could cause confusion.
- **R6-14-304:** The rule contains grammatical errors and does not describe what a cost-effectiveness plan is.
- **R6-14-307:** The language in R6-14-307(B) contains calculations that may be used in a negotiated repayment agreement, which may be confusing to the public. R6-14-307(D) includes an incomplete list of collection methods the state may use under 7 CFR 273.18(g)(8).
- **R6-14-308:** The rule does not clearly explain the circumstances under which the Department may reduce or eliminate a claim and contains redundant information already stated in other rules within the Article.
- **R6-14-502:** The rule does not clearly explain the process by which an appellant may waive the administrative disqualification hearing.
- **R6-14-504:** The rule is not clear and concise when explaining what occurs when an appellant fails to appear for an administrative disqualification hearing. The rule contains redundancies in R6-14-504(B) and (F).
- **R6-14-506:** R6-14-506(B) & (C) are inaccurate and inconsistent with 7 CFR 273.16(e)(8)(ii). There is no further administrative appeal process for Intentional Program Violation (IPV) administrative disqualification hearings, and if a party wishes to appeal a determination through a signed waiver or a hearing officer's decision, they must seek judicial review. The Department refers to federal regulations with regard to the IPV process.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rules are consistent with other rules and statutes except for the following:

- **R6-14-506:** R6-14-506(B) & (C) are inaccurate and inconsistent with 7 CFR 273.16(e)(8)(ii). There is no further administrative appeal process for Intentional Program Violation (IPV) administrative disqualification hearings, and if a party wishes to appeal a determination through a signed waiver or a hearing officer's decision, they must seek judicial review. The Department refers to federal regulations with regard to the IPV process.

**7. <u>Has the agency analyzed the rules' effectiveness in achieving its objectives?</u>**

The Department indicates the rules are effective in achieving their regulatory objectives except for the following:

- **R6-14-111:** Some terms defined in this rule are outdated or no longer used.
- **R6-14-302:** The description of the method to determine the date of discovery and when the overpayment period begins for each type of claim is not clearly written and difficult to understand in the rule.
- **R6-14-303:** The methods to determine the amount of a claim are not clearly explained in the rule and the rule contains statements that are irrelevant to the rule and could cause confusion.
- **R6-14-304:** The rule contains grammatical errors and does not describe what a cost-effectiveness plan is.
- **R6-14-307:** The language in R6-14-307(B) contains calculations that may be used in a negotiated repayment agreement, which may be confusing to the public. R6-14-307(D) includes an incomplete list of collection methods the state may use under 7 CFR 273.18(g)(8).
- **R6-14-308:** The rule does not clearly explain the circumstances under which the Department may reduce or eliminate a claim and contains redundant information already stated in other rules within the Article.
- **R6-14-502:** The rule does not clearly explain the process by which an appellant may waive the administrative disqualification hearing.
- **R6-14-504:** The rule is not clear and concise when explaining what occurs when an appellant fails to appear for an administrative disqualification hearing. The rule contains redundancies in R6-14-504(B) and (F).
- **R6-14-506:** R6-14-506(B) & (C) are inaccurate and inconsistent with 7 CFR 273.16(e)(8)(ii). There is no further administrative appeal process for Intentional Program Violation (IPV) administrative disqualification hearings, and if a party wishes to appeal a determination through a signed waiver or a hearing officer's decision, they must seek judicial review. The Department refers to federal regulations with regard to the IPV process.

**8. <u>Has the agency analyzed the current enforcement status of the rules?</u>**

The Department indicates the rules are currently enforced as written except for the following:

- **R6-14-506:** R6-14-506(B) & (C) are inaccurate and inconsistent with 7 CFR 273.16(e)(8)(ii). There is no further administrative appeal process for Intentional Program Violation (IPV) administrative disqualification hearings, and if a party wishes to appeal a determination through a signed waiver or a hearing officer's decision, they must seek judicial review. The Department refers to federal regulations with regard to the IPV process

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates 7 U.S.C. Chapter 51: Supplemental Nutrition Assistance Program is applicable to these rules. The Department states the rules are not more stringent than the corresponding federal laws.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department states A.R.S. § 41-1037 does not apply to these rules because they do not require a regulatory permit, license, or agency authorization.

**11. Conclusion**

This 5YRR from the Department relates to thirty-six (36) rules in Title 6, Chapter 14, Articles 1, 3, 4, and 5. Specifically, the rules in Title 6, Chapter 14 relate to the Nutrition Assistance Program including the following articles: Article 1 - Food Stamps - General Information and Provisions; Article 3 - Claims Against Households; Article 4 - Appeals and Fair Hearings; and Article 5 - Intentional Program Violation.

The Department proposes to amend several rules that are not clear, concise, understandable and effective as described above. The Department received approval to engage in rulemaking from the Governor's Office in March 2024, and is currently in the process of amending the rules. The draft rules were posted on the Department website for a 60-day informal stakeholder review on December 20, 2024. The Department anticipates filing a Notice of Final Rulemaking for the proposed rules to the Council by December 2025.

Council staff recommends approval of this report.

ARIZONA
DEPARTMENT OF
ECONOMIC SECURITY

Katie Hobbs
Governor

Michael Wisehart
Director

February 26, 2025

Ms. Jessica Klein
Council Chair
Governor's Regulatory Review Council
Department of Administration
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

Dear Ms. Klein:

Attached is the Arizona Department of Economic Security (Department) Five-Year Review Report for Arizona Administrative Code (A.A.C.) Title 6, Chapter 14, Nutrition Assistance Program.

Pursuant to A.R.S. § 41-1056(A) and A.A.C. R1-6-301(C)(4), the Department certifies that it is in compliance with A.R.S. § 41-1091.

Thank you for your attention to this report. The Department will be present at the Council meetings to respond to any questions the Council members may have about the report.

If you have any questions, please contact Hiroko Flores, Deputy Rules Administrator, at (480) 487-7694 or hflores@azdes.gov.

Sincerely,

Nicole Davis

Nicole Davis
General Counsel/Chief Governance Officer

Attachment

**DEPARTMENT OF ECONOMIC SECURITY**

**FIVE-YEAR REVIEW REPORT**

**Title 6, Chapter 14 - Nutrition Assistance Program**

## 1. Authorization of the rule by existing statutes:

General Statutory Authority: A.R.S. §§ 41-1954(A)(3), 46-134(1), and 46-134(10)

Specific Statutory Authority: A.R.S. §§ 41-1954(A)(1)(c), 46-136(B) and (C); 7 U.S.C. § 2013

## 2. Analysis of rules:

**Rule** **Analysis**

R6-14-111 Title: Definitions

Objective: The objective of this rule is to define words and phrases used in Chapter 14 to promote a uniform understanding of terms used by the Nutrition Assistance Program.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: Some terms defined in this rule are outdated or no longer used.

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**Rule** **Analysis**

R6-14-301 Title: Purpose and Definitions

Objective: The objective of this rule is to explain the Department's purpose in establishing and collecting claims against households, and to define terms specific to this purpose.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

**Rule** **Analysis**

R6-14-302 Title: Claim Calculation; Date of Discovery; Overpayment Period

Objective: The objective of this rule is to explain how the Department determines the overpayment period used to calculate the claim.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The description of the method to determine the date of discovery and when the overpayment period begins for each type of claim is not clearly written and difficult to understand in the rule.

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**Rule** **Analysis**

R6-14-303 Title: Determining a Claim Amount

Objective: The objective of this rule is to explain the methods by which the Department calculates the claim.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The methods to determine the amount of a claim are not clearly explained in the rule and the rule contains statements that are irrelevant to the rule and could cause confusion.

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**Rule** **Analysis**

R6-14-304 Title: Pre-establishment Cost Effective Determination

Objective: The objective of this rule is to inform the public that the Department does not establish claims that are not cost-effective to collect.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The rule contains grammatical errors and does not describe what a cost-effectiveness plan is.

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**Rule** **Analysis**

R6-14-305 Title: Notice of Claim

Objective: The objective of this rule is to inform the public that the Department shall notify a recipient in writing that it has established a claim against them before attempting to collect on the claim.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-306 Title: Acceptable Forms of Payment

Objective: The objective of this rule is to notify the public of acceptable forms of payment for an established claim.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-307 Title: Collection Methods

Objective: The objective of this rule is to notify the public of the Department's methods for collecting claims.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The language in R6-14-307(B) contains calculations that may be used in a negotiated repayment agreement, which may be confusing to the public. R6-14-307(D) includes an incomplete list of collection methods the state may use under 7 CFR 273.18(g)(8).

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**Rule** **Analysis**

R6-14-308 Title: Claim Compromise

Objective: The objective of this rule is to notify the public of the conditions under which the Department may agree to reduce or eliminate its claim.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The rule does not clearly explain the circumstances under which the Department may reduce or eliminate a claim and contains redundant information already stated in other rules within the Article.

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**Rule** **Analysis**

R6-14-309 Title: Reinstatement of a Compromised Claim

Objective: The objective of this rule is to notify the public the conditions under which the Department may elect to reestablish its claim.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-310 Title: Terminating and Writing Off a Claim

Objective: The objective of this rule is to notify the public of the conditions under which the Department may terminate a claim.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-311 Title: Claims Established in Another State

Objective: The objective of this rule is to inform the public that the Department may elect to accept and collect on a claim established by another state.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-401 Title: Entitlement to a Fair Hearing; Appealable Action

Objective: The objective of this rule is to notify the public of their right to appeal a decision made by the Department and request a hearing.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-402 Title: Computation of Time

Objective: The objective of this rule is to outline how the Department determines when a timeframe begins and ends.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-403 Title: Request for Hearing; Form; Time Limits; Presumptions

Objective: The objective of this rule is to inform the public how they may appeal a Department decision and request a hearing.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-404 Title: Stay of Action Pending Appeal

Objective: The objective of this rule is to inform the public that when an appeal is filed, the Department will take no action on its decision until the appeal is resolved.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-405 Title: Hearings: Location; Notice; Time

Objective: The objective of this rule is to explain the Office of Appeals' responsibilities to schedule the hearing and notify all parties within specific timeframes, and to describe the information included in the notice of hearing.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-406 Title: Postponing the Hearing

Objective: The objective of this rule is to explain how the appellant may request a postponement of the hearing and the process to do so.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-407 Title: Hearing Officer: Duties and Qualifications

Objective: The objective of this rule is to inform the public of the hearing officer's role in the hearing process.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-408 Title: Change of Hearing Officer; Challenges for Cause

Objective: The objective of this rule is to inform the public of the process for changing the assigned hearing officer.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-409 Title: Subpoenas

Objective: The objective of this rule is to inform the public of the process through which they may request a subpoena.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-410 Title: Parties' Rights

Objective: The objective of this rule is to inform the parties of their rights during the appeal process.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-411 Title: Withdrawal of an Appeal

Objective: The objective of this rule is to inform the public of the process through which they may withdraw their appeal.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-412 Title: Failure to Appear; Default; Reopening

Objective: The objective of this rule is to inform the public what occurs when they fail to appear for a scheduled hearing.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-413 Title: Hearing Proceedings

Objective: The objective of this rule is to inform the public of the bases upon which the hearing is conducted.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-414 Title: Hearing Decision

Objective: The objective of this rule is to inform the public when the hearing officer must render a decision and the decision's contents.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-415 Title: Effect of Decision

Objective: The objective of this rule is to inform the public of what occurs after the hearing officer renders a decision.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-416 Title: Further Administrative Appeal

Objective: The objective of this rule is to inform the public of the right to appeal a hearing officer's decision.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-417 Title: Appeals Board

Objective: The objective of this rule is to inform the public of the Appeals Board's role in the appeal process.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-501 Title: Intentional Program Violations (IPV); Defined

Objective: The objective of this rule is to describe an Intentional Program Violation.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-502 Title: IPV Administrative Disqualification Hearings; Hearing Waiver

Objective: The objective of this rule is to inform the public of the option to sign a waiver of administrative disqualification hearing or to request a hearing.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The rule does not clearly explain the process by which an appellant may waive the administrative disqualification hearing.

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**Rule** **Analysis**

R6-14-503 Title: Administrative Disqualification Hearings

Objective: The objective of this rule is to inform the public of the process for Intentional Program Violation administrative disqualification hearings.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-504 Title: Failure to Appear; Default; Reopening

Objective: The objective of this rule is to inform the public of what occurs if they fail to appear for an administrative disqualification hearing.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: The rule is not clear and concise when explaining what occurs when an appellant fails to appear for an administrative disqualification hearing. The rule contains redundancies in R6-14-504(B) and (F).

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**Rule** **Analysis**

R6-14-505 Title: Disqualification Sanctions; Notice

Objective: The objective of this rule is to inform the public of the program sanctions imposed on a person who is found to have committed an Intentional Program Violation.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**Rule** **Analysis**

R6-14-506 Title: Administrative Disqualification Hearings or Waiver of the Right to a Hearing; Appeal

Objective: The objective of this rule is to inform the public that there is no further administrative appeal process if they have signed a waiver of the administrative disqualification hearing or disagree with the hearing officer's decision.

- Is this rule effective in meeting the objective? ☐ Yes ☑ No
- Is this rule consistent with other rules and statutes? ☐ Yes ☑ No
- Is this rule enforced as written? ☐ Yes ☑ No
- Is this rule clear, concise, and understandable? ☐ Yes ☑ No

Explanation: R6-14-506(B) & (C) are inaccurate and inconsistent with 7 CFR 273.16(e)(8)(ii). There is no further administrative appeal process for Intentional Program Violation administrative disqualification hearings, and if a party wishes to appeal a determination through a signed waiver or a hearing officer's decision, they must seek judicial review. The Department refers to federal regulations with regard to the IPV process.

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**Rule** **Analysis**

R6-14-507 Title: Honoring Out-of-State IPV Determinations and Sanctions

Objective: The objective of this rule is to inform the public that the Department considers Intentional Program Violation sanctions issued by

another state when determining sanctions for an Intentional Program Violation committed in Arizona.

- Is this rule effective in meeting the objective? ☑ Yes ☐ No
- Is this rule consistent with other rules and statutes? ☑ Yes ☐ No
- Is this rule enforced as written? ☑ Yes ☐ No
- Is this rule clear, concise, and understandable? ☑ Yes ☐ No

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**3. Has the Department received written criticisms of the rules within the last five years?**

☐ Yes ☑ No

**4. Economic, small business, and consumer impact comparison:**

An Economic, Small Business, and Consumer Impact Statement (EIS) was not prepared when Article 1 was adopted in 1996; however, the Department completed an EIS on Articles 3, 4, and 5 when the rules were adopted in January 2020. The EIS from January 2020 indicated that the Department collected $742,974 in total Supplemental Nutrition Assistance Program (SNAP) overpayments during the Federal Fiscal Year (FFY) 2018. In FFY2024, the Department reported $4,707,494 in total SNAP overpayment collections. Overpayment collection numbers are significantly larger in FFY2024 than reported in the EIS conducted in 2020, because a dedicated SNAP overpayment team was able to work through a backlog of unprocessed overpayment referrals. There were 4,588 SNAP-related appeal hearings and 34 Intentional Program Violation (IPV) hearings during the State Fiscal Year (SFY) 2018. In SFY2024, the Department conducted 11,628 SNAP-related hearings, and 410 IPV hearings.

**5. Has the agency received any business competitiveness analyses of the rules?**

☐ Yes ☑ No

**6. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

☐ Yes ☑ No

In the prior Five-Year Review Report, the Department proposed to file a Notice of Final Rulemaking with the Council in November 2019 to address the three priority topics: 1) Claims Against Households, 2) Hearings and Appeals, and 3) Intentional Program Violations. The

Department further proposed to complete an additional rulemaking to address other topics that would incorporate options chosen by the state and waivers granted by the federal government relative to the administration of the Nutrition Assistance Program.

The Department completed rulemaking on the three priority topics; new Articles 3, 4 and 5 became effective through final rulemaking on January 21, 2020. However, the onset of the COVID-19 pandemic in early 2020 forced the Department to focus on immediate pandemic response efforts, including implementation of waivers and an increased benefit amount for this program, and was not able to complete the latter part of the proposed course of action. The Department coordinated with its federal agency partners to implement certain flexibilities to manage the surge in Nutrition Assistance applications from those impacted by sudden business closures and job losses. Staff involved in the rulemaking process were tapped to develop interim guidelines and procedures. Approval to proceed with rulemaking was received from the Governor's Office on March 4, 2024, and the Department has been working diligently to advance this rulemaking in a timely manner.

**7. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department believes that the rules impose the least burden and costs to persons regulated by these rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objectives. These rules do not impose any cost to consumers or small businesses. Updates to the rules identified in this report outweigh any potential costs incurred from the proposed revisions.

**8. Are the rules more stringent than corresponding federal laws?**

*Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of the federal law(s)?*

☐ Yes ☑ No

7 U.S.C. Chapter 51: Supplemental Nutrition Assistance Program
The rules are not more stringent than the corresponding federal laws.

**For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

The Department has determined that A.R.S. § 41-1037 does not apply to these rules because they do not require a regulatory permit, license, or agency authorization.

**10. Proposed course of action:**

The Department proposes to update the rules in Chapter 14 to address issues identified in Section 2 of this report. The Department received approval to engage in rulemaking from the Governor's Office in March 2024, and is currently in the process of amending the rules. The draft rules were posted on the Department website for a 60-day informal stakeholder review on December 20, 2024. The Department anticipates filing a Notice of Final Rulemaking for the proposed rules to the Council by December 2025.

Arizona Administrative CODE

6 A.A.C. 14 Supp. 20-1

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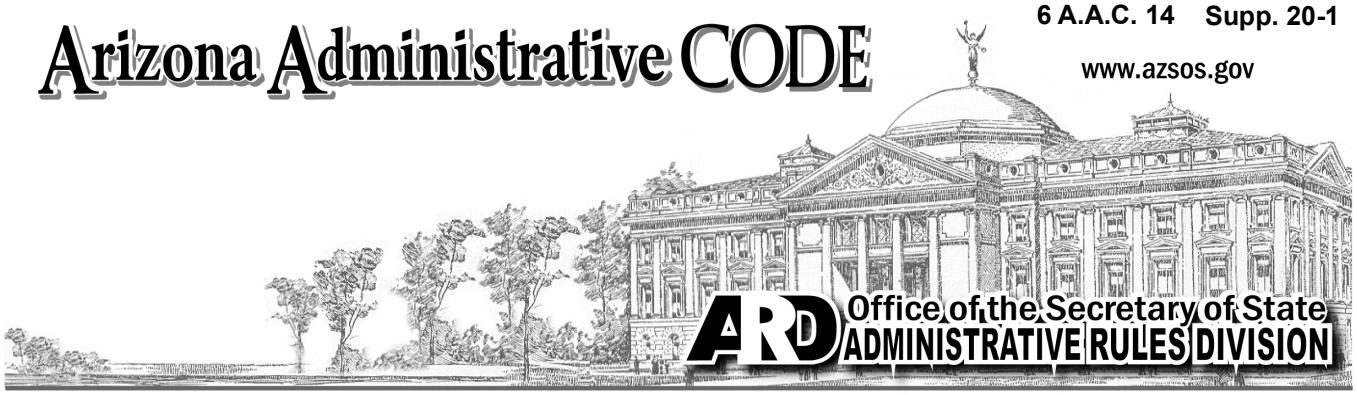


# TITLE 6. ECONOMIC SECURITY

## CHAPTER 14. DEPARTMENT OF ECONOMIC SECURITY - NUTRITION ASSISTANCE PROGRAM

The table of contents on the first page contains quick links to the referenced page numbers in this Chapter. Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

Sections, Parts, Exhibits, Tables or Appendices codified in this supplement. The list provided contains quick links to the updated rules.

This Chapter contains rule Sections that were filed to be codified in the Arizona Administrative Code between the dates of January 1, 2020 through March 31, 2020.



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**The release of this Chapter in Supp. 20-1 replaces Supp. 18-4, 1-16 pages**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. "'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into titles. Titles are divided into chapters. A chapter includes state agency rules. Rules in chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each chapter.
First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31
For example, the first supplement for the first quarter of 2019 is cited as Supp. 19-1.

Please note: The Office publishes by chapter, not by individual rule section. Therefore there might be only a few sections codified in each chapter released in a supplement. Historical notes at the end of a section provide an effective date and information when a rule was last updated.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate chapters of the *Administrative Code* in Supp. 18-1 to comply with A.R.S. § 41-1012(B) and A.R.S. § 5302(1), (2)(d) through (e), and (3)(d) through (e).

A certification verifies the authenticity of each *Code* chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a chapter can be found at the Secretary of State's website, under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a chapter provide information about rulemaking sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### EXEMPTIONS AND PAPER COLOR

At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

### PERSONAL USE/COMMERCIAL USE

This chapter is posted as a public courtesy online, and is for private use only. Those who wish to use the contents for resale or profit should contact the Office about Commercial Use fees. For information on commercial use fees review A.R.S. § 39-121.03 and 1 A.A.C. 1, R1-1-113.

*Rhonda Paschal, managing rules editor, assisted with the editing of this chapter.*

Arizona Secretary of State
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Administrative Rules Division
The Arizona Secretary of State electronically publishes each A.A.C. Chapter with a digital certificate. The certificate-based signature displays the date and time the document was signed and can be validated in Adobe Acrobat Reader.

# TITLE 6. ECONOMIC SECURITY

# CHAPTER 14. DEPARTMENT OF ECONOMIC SECURITY - NUTRITION ASSISTANCE PROGRAM

***Editor's Note: The Chapter heading was amended from the Food Stamps Program to the Nutrition Assistance Program by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).***

## ARTICLE 1. FOOD STAMPS - GENERAL INFORMATION AND PROVISIONS

*Article 1, consisting of Sections R6-14-101 through R6-14-111 recodified from A.A.C. R6-3-1901 through R6-3-1911 effective February 13, 1996 (Supp. 96-1).*

Section



## ARTICLE 2. EXPIRED

*Article 2, consisting of Sections R6-14-201 through R6-14-218, expired effective February 28, 2005 (Supp. 05-1).*

*Article 2, consisting of Sections R6-14-201 through R6-14-218, recodified effective February 13, 1996 (Supp. 96-1).*

Section



## ARTICLE 3. CLAIMS AGAINST HOUSEHOLDS

*Article 3, consisting of emergency Sections R6-14-301 through R6-14-308, expired; new Article 3, consisting of Sections R6-14-301 through R6-14-311 made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).*

*New Article 3, consisting of Sections R6-14-301 through R6-14-308, renewed by emergency rulemaking effective January 2, 2019 for 180 days (Supp. 18-4).*

*New Article 3, consisting of Sections R6-14-301 through R6-14-308, made by emergency rulemaking effective July 6, 2018 for 180 days (Supp. 18-3).*

*Article 3, consisting of Sections R6-14-301 through R6-14-327, expired effective February 28, 2005 (Supp. 05-1).*

*Article 3, consisting of Sections R6-14-301 through R6-14-320 and R6-14-322 through R6-14-327 recodified from A.A.C. R6-3-2101 through R6-3-2120 and R6-3-2122 through R6-3-2128, recodified effective February 13, 1996 (Supp. 96-1).*

Section



## ARTICLE 4. APPEALS AND FAIR HEARINGS

*Article 4, consisting of emergency Sections R6-14-401 through R6-14-417, expired; new Article 4, consisting of Sections R6-14-401 through R6-14-417, made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).*

*New Article 4, consisting of Sections R6-14-401 through R6-14-417, renewed by emergency rulemaking effective January 2, 2019 for 180 days (Supp. 18-4).*

*New Article 4, consisting of Sections R6-14-401 through R6-14-417, made by emergency rulemaking effective July 6, 2018 for 180 days (Supp. 18-3).*

*Article 4, consisting of Sections R6-14-401 and R6-14-402, expired effective February 28, 2005 (Supp. 05-1).*

CHAPTER 14. DEPARTMENT OF ECONOMIC SECURITY - NUTRITION ASSISTANCE PROGRAM

*Article 4, consisting of Sections R6-14-401 and R6-14-402, recodified from A.A.C. R6-3-2201 and R6-3-2203 effective February 13, 1996 (Supp. 96-1).*



## ARTICLE 5. INTENTIONAL PROGRAM VIOLATION

*Article 5, consisting of emergency Sections R6-14-501 through R6-14-507, expired; new Article 5, consisting of Sections R6-14-501 through R6-14-507 made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).*

*New Article 5, consisting of Sections R6-14-501 through R6-14-507, renewed by emergency rulemaking effective January 2, 2019 for 180 days (Supp. 18-4).*

*New Article 5, consisting of Sections R6-14-501 through R6-14-507, made by emergency rulemaking effective July 6, 2018 for 180 days (Supp. 18-3).*

*Article 5, consisting of Sections R6-14-501 through R6-14-507, expired effective February 28, 2005 (Supp. 05-1).*

*Article 5, consisting of Sections R6-14-501 through R6-14-507, recodified from A.A.C. R6-3-2301 through R6-3-2307 effective February 13, 1996 (Supp. 96-1).*



## ARTICLE 6. EXPIRED

*Article 6, consisting of Sections R6-14-601 through R6-14-610, expired effective February 28, 2005 (Supp. 05-1).*

*Article 6, consisting of Sections R6-14-601, R6-14-602, R6-14-604 through R6-14-608, and R6-14-610, recodified from A.A.C. R6-3-2401, R6-3-2402, R6-3-2404 through R6-3-2408, and R6-3-2410 effective February 13, 1996 (Supp. 96-1).*

CHAPTER 14. DEPARTMENT OF ECONOMIC SECURITY - NUTRITION ASSISTANCE PROGRAM

## ARTICLE 1. FOOD STAMPS - GENERAL INFORMATION AND PROVISIONS

**R6-14-101. Expired**

**Historical Note**

Section R6-14-101 recodified from A.A.C. R6-3-1901 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-102. Expired**

**Historical Note**

Section R6-14-102 recodified from A.A.C. R6-3-1902 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-103. Expired**

**Historical Note**

Section R6-14-103 recodified from A.A.C. R6-3-1903 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-104. Expired**

**Historical Note**

Section R6-14-104 recodified from A.A.C. R6-3-1904 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-105. Expired**

**Historical Note**

Section R6-14-105 recodified from A.A.C. R6-3-1905 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-106. Expired**

**Historical Note**

Section R6-14-106 recodified from A.A.C. R6-3-1906 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-107. Expired**

**Historical Note**

Section R6-14-107 recodified from A.A.C. R6-3-1907 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-108. Expired**

**Historical Note**

Section R6-14-108 recodified from A.A.C. R6-3-1908 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-109. Expired**

**Historical Note**

Section R6-14-109 recodified from A.A.C. R6-3-1909 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-110. Expired**

**Historical Note**

Section R6-14-110 recodified from A.A.C. R6-3-1910 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-111. Definitions**

For purposes of this Section, the following terms are defined as follows:

1. "Adjusted net income". Income remaining after all deductions from gross income.
2. "Adverse action". The reduction or termination of program benefits within the certification period.
3. "Alien lawfully admitted to the United States". An alien legally admitted to the United States by the U.S. Immigration and Naturalization Service. An alien legally admitted to the United States may or may not be legally admitted for permanent residence or residing under color of law.
4. "Alien lawfully admitted to the United States for permanent residence". An alien permitted to reside continuously in the United States, as specified by appropriate documentation which the alien must have in the alien's possession at all times.
5. "Allotment". The total value of coupons a household is authorized to receive during each month or any specified time period.
6. "Annualization of income". The division of yearly gross income by 12 to arrive at the monthly average.
7. "Anticipated income". Income which is not yet available to meet needs but which is expected to become available.
8. "Appeal". An individual's written statement requesting a hearing to contest action to be taken or previously taken by the Department.
9. "Applicant". A person who applies for program benefits for the that person and/or others.
10. "Assets". All items owned by an individual which have a monetary value.
11. "A.T.P.". Authorization to Participate in the Food Stamp Program.
12. "Authorized representative". A person authorized by an individual to act in the individual's behalf.
13. "Basis of issuance or benefit level". The amount of coupons for which the household is eligible, based on household size and adjusted net income.
14. "Boarding house". A commercial enterprise which offers meals and lodging for compensation.
15. "Certification". Approval of the household's application and determination of basis of issuance and period of eligibility.
16. "Citizen". An individual born or naturalized in the United States, which is defined, for program purposes, as the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, and Swain's Island.
17. "Collateral contact". An individual, agency, or organization contacted to confirm statements presented by the applicant and/or participant.
18. "Color of Law". A legal status which a lawfully admitted alien may claim if the alien can satisfactorily prove that the alien has continuously resided in the United States since June 30, 1948.
19. "Coupon". Any coupon, stamp, or certification provided pursuant to the Food Stamp Act of 1977 for the purchase of eligible food.
20. "Denial". The formal disapproval of an application for program benefits.

21. "Department". The Department of Economic Security.
22. "Drug and/or alcoholic treatment and rehabilitation center". A center providing treatment and rehabilitation programs by a private nonprofit organization.
23. "Earned income". Compensation received as wages, salaries, commissions, or profit, through employment or self-employment.
24. "Eligible food". Any food for human consumption; seeds and plants to grow foods for the personal consumption of the eligible household; delivered meals and meals served at approved communal dining facilities and rehabilitation treatment centers.
25. "Eligibility worker". Department employee responsible for the determination of eligibility of the applicant households.
26. "Equity value". The fair market value less encumbrances.
27. "F.N.S.". Food and Nutrition Service, a division of the United States Department of Agriculture.
28. "Fraud". An action, punishable by law, in which a person has knowingly, willfully, and with deceitful intent obtained benefits for which the person was not eligible.
29. "Hearing". The process of reviewing a client's situation for the purpose of deciding whether or not action taken or intended action by the Department is correct.
30. "Home visit". A visit by an Eligibility Worker to the client's place of residence to verify eligibility factors for program benefits.
31. "Home and land contiguous thereto". The residential real property owned by a client, both land improvements on which client is living, as well as any land immediately touching which is also owned by the client.
32. "Identification card". A card which identifies the bearer as eligible to receive and use food coupons.
33. "In kind". Any gain or benefit which is not in the form of money payable directly to the household, such as meals, clothing, public housing, produce from a garden, and vendor payments.
34. "Institution of higher education". Any institution providing post-high-school education, including, but not limited to, colleges, universities, and vocational or technical schools at the post-high-school level.
35. "Liquid resources". Financial instruments which can be converted to cash quickly (such as stocks, bonds, savings certificates, notes, sales contracts, etc.).
36. "Minor child". A person under age 18 and under parental control.
37. "Non-eligible food". Hot foods and hot food products prepared for immediate over-the-counter service, alcoholic beverages, tobacco, pet foods and supplies, soap, and paper products.
38. "Overissuance". The amount of a coupon allotment received by a household which is in excess of what it was eligible to receive.
39. "Parental control". A child under the age of 18 years and under the control of the parent or any adult other than natural parents (in loco parentis).
40. "Project area". The county or geographic entity designated as the administrative unit for program operations.
41. "Recertification". A re-evaluation of all eligibility factors.
42. "Restoration of lost benefits". Issuance of coupons to an eligible household that did not receive benefits or the correct amount of benefits due to an error caused by the Department.
43. "Retroactive benefits". An issuance of coupons to an eligible household who experienced a delay in the processing of the application.
44. "Roomer". Individual to whom lodging is furnished for compensation.
45. "Spouse". One of 2 individuals who are married to each other under applicable state law or who are living together and holding themselves out to the community as husband and wife.
46. "Student". An individual 18 years of age or older and attending, at least half time, a post-high-school institution of higher education (as defined for program purposes).
47. "United States citizen". A person who was born in the United States or naturalized in the United States and has maintained United States citizenship status.
48. "U.S.D.A.". United States Department of Agriculture.
49. "Vendor payments". Money payments made on behalf of the household to another by a 3rd party.

**Historical Note**
Section R6-14-111 recodified from A.A.C. R6-3-1911 effective February 13, 1996 (Supp. 96-1).

## ARTICLE 2. EXPIRED

**R6-14-201. Expired**

**Historical Note**
R6-14-201 recodified from A.A.C. R6-3-2001 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-202. Expired**

**Historical Note**
R6-14-202 recodified from A.A.C. R6-3-2002 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-203. Expired**

**Historical Note**
R6-14-203 recodified from A.A.C. R6-3-2003 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-204. Expired**

**Historical Note**
R6-14-204 recodified from A.A.C. R6-3-2004 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-205. Expired**

**Historical Note**
R6-14-205 recodified from A.A.C. R6-3-2005 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-206. Expired**

**Historical Note**
R6-14-206 recodified from A.A.C. R6-3-2006 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-207. Expired**

**Historical Note**
R6-14-207 recodified from A.A.C. R6-3-2007 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-208. Expired**

**Historical Note**
R6-14-208 recodified from A.A.C. R6-3-2008 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-209. Expired**

**Historical Note**
R6-14-209 recodified from A.A.C. R6-3-2009 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-210. Expired**

**Historical Note**
R6-14-210 recodified from A.A.C. R6-3-2010 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-211. Expired**

**Historical Note**
R6-14-211 recodified from A.A.C. R6-3-2011 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-212. Expired**

**Historical Note**
R6-14-212 recodified from A.A.C. R6-3-2012 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-213. Expired**

**Historical Note**
R6-14-213 recodified from A.A.C. R6-3-2013 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-214. Expired**

**Historical Note**
R6-14-214 recodified from A.A.C. R6-3-2014 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-215. Expired**

**Historical Note**
R6-14-215 recodified from A.A.C. R6-3-2015 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-216. Expired**

**Historical Note**
R6-14-216 recodified from A.A.C. R6-3-2016 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-217. Expired**

**Historical Note**
R6-14-217 recodified from A.A.C. R6-3-2017 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-218. Expired**

**Historical Note**
R6-14-218 recodified from A.A.C. R6-3-2018 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

## ARTICLE 3. CLAIMS AGAINST HOUSEHOLDS

**R6-14-301. Purpose and Definitions**

**A.** The Department establishes and collects claims under 7 CFR 273.18, Claims against households. This Article clarifies the Department's policies and procedures as permitted in federal regulation.

**B.** The definitions in R6-14-111 and the following definitions apply to this Article:

1. "Agency error" or "AE claim" means any claim for an overpayment caused by an action or failure to take action by the Department.
2. "Claim" means the amount of a federal debt owed because Nutrition Assistance benefits were overpaid or benefits were trafficked.
3. "Household" means one of the following individuals or groups of individuals, unless otherwise specified under 7 CFR 273.1(b):
   a. Except as contained in (B)(3)(b):
      i. An individual living alone;
      ii. An individual living with others, but customarily purchasing food and preparing meals for home consumption separate and apart from others; or
      iii. A group of individuals who live together and customarily purchase food and prepare meals together for home consumption.
   b. Specific to the Claim Compromise process in R6-14-308, the following persons who are residing together:
      i. Adults who were members of the Nutrition Assistance household for which the claim was established, and who were adults at the time the claim was established, and
      ii. Minor children for whom adult household members are responsible.
4. "Inadvertent household error" or "IHE claim" means any claim for an overpayment resulting from a misunderstanding or unintended error on the part of the Nutrition Assistance household. This includes instances when the household received more benefits than it was entitled to receive because the household requested a continuation of benefits, pending a fair hearing decision.
5. "Intentional Program Violation" or "IPV claim" means any claim for an overpayment resulting from an individ-

ual committing and intending to commit, an IPV under 7 CFR 273.16.

6. "Trafficking claim" means any claim for the value of benefits that are trafficked, under 7 CFR 273.18. Trafficking is defined under 7 CFR 271.2.

**Historical Note**

R6-14-301 recodified from A.A.C. R6-3-2101 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-302. Claim Calculation; Date of Discovery; Overpayment Period**

Under 7 CFR 273.18, the Department shall calculate an overpayment of benefits claim by:

**A.** Date of discovery. The date of discovery is determined when the Department becomes aware of the overpayment.
   1. For AE claims, the date of discovery is the date the overpayment has been verified or the date the household ultimately fails to respond to or satisfy an overpayment inquiry.
   2. For IHE and IPV claims, the date that the Department obtains verification used to calculate the over-issuance.
   3. For claims resulting from trafficking, the date of the court decision, or the date the household signed a waiver of administrative disqualification hearing form or a disqualification consent agreement.

**B.** For AE and IHE claims, calculate a claim for the month of the date of discovery and for each prior month, not to exceed 36 months prior to the date of discovery.

**C.** For an IPV claim not related to trafficking, calculate a claim back to the month that the IPV first occurred, not to exceed 72 months prior to the date of discovery.

**D.** For a claim resulting from trafficking, calculate a claim for the value of the trafficked benefits, as determined under 7 CFR 273.18(c)(2).

**Historical Note**

R6-14-302 recodified from A.A.C. R6-3-2102 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-303. Determining a Claim Amount**

**A.** For all claims other than a claim resulting from trafficking:
   1. The Department shall determine whether the overpayment of benefits occurred at the time an eligibility determination was rendered for a new or recertification application or whether the overpayment occurred during an eligible certification period.
   2. When it is discovered that the Department rendered an incorrect eligibility determination or issued an incorrect benefit amount because the Department failed to correctly act on information provided on the application or reported by the applicant, or because the applicant failed to provide correct information on the application or prior to application approval, the Department shall re-determine eligibility and a benefit amount for that application and for the months in the certification period, using the application approval or denial policies and procedures that were in effect at the time the eligibility determination for the application was rendered. The Department will not consider information that was not previously reported by the household that would have resulted in an increase in the benefit allotment at the time of initial approval of benefits.
      a. When it is determined that the household was ineligible, the Department shall establish a claim based on the amount of benefits issued for each month during the certification period that was established when the application was originally approved, minus the amount of benefits that the Department has expunged from the household's EBT benefit account, for each of the corresponding overpaid months.
      b. When it is determined that the household was eligible, the Department shall establish a claim based on the amount of benefits that were paid in excess of the correct benefit amount in each month of the certification period, minus the amount of benefits that the Department has expunged from the household's EBT benefit account, for each of the corresponding overpaid months.
      c. When it is determined that the household was eligible and received a smaller benefit amount than it was eligible to receive because the Department failed to correctly act on information provided on the application or reported by the applicant prior to application approval, the Department shall issue a supplement for each month in the certification period that the household was paid less than the correct benefit amount as provided in 7 CFR 273.17.
   3. When a change occurred during an eligible certification period:
      a. The Department shall process any change that was reported and re-determine a new benefit allotment amount for each affected month in the certification period using the change processing policies and procedures that were in effect for those months under 7 CFR 273.12(c).
         i. The Department shall establish a claim based on the amount of benefits that were paid in excess of the new benefit amount in each affected month of the certification period, minus the amount of benefits that the Department has expunged from the household's EBT benefit account.
         ii. The Department shall issue a supplement for each month the household was paid less than the new benefit amount.
      b. When the Department discovers a change which was not reported by the household, the Department shall determine whether the change was required to be reported based on the change reporting requirement assigned to the household for the certification period.
         i. When the change was not required to be reported the Department shall not process the

change for the months in the certification period.

ii. When the change was required to be reported the Department shall re-determine eligibility and a new benefit allotment amount for each affected month in the certification period using the change processing policies and procedures that were in effect for those months under 7 CFR 273.12(c). The Department shall establish a claim based on the amount of benefits that were paid in excess of the correct benefit amount in each month of the certification period, minus the amount of benefits that the Department has expunged from the household's EBT benefit account.

**B.** For a claim resulting from trafficking, the Department shall calculate a claim amount based on the entire value of the trafficked benefits.

**Historical Note**

R6-14-303 recodified from A.A.C. R6-3-2103 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-304. Pre-establishment Cost Effectiveness Determination**

The Department shall not establish an overpayment that is not cost effective using the threshold at 7 CFR 273.18(e)(2)(ii), unless the Department establishes and collects claims under a cost-effectiveness plan approved by the Food and Nutrition Service of the U.S. Department of Agriculture under 7 CFR 273.18(e)(2)(i) that establishes a different threshold.

**Historical Note**

R6-14-304 recodified from A.A.C. R6-3-2104 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-305. Notice of Claim**

To begin collection on a claim, the Department shall send the household a Notice of Claim. At a minimum, the notice shall include all elements required under 7 CFR 273.18(e)(3)(iv).

**Historical Note**

R6-14-305 recodified from A.A.C. R6-3-2105 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-306. Acceptable Forms of Payment**

The Department may accept all forms of payment, including the methods listed in 7 CFR 273.18(f) to collect a claim.

**Historical Note**

R6-14-306 recodified from A.A.C. R6-3-2106 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-307. Collection Methods**

**A.** Allotment reduction. When a household is receiving Nutrition Assistance benefits, the Department may use the allotment reduction in 7 CFR 273.18(g)(1).

**B.** As provided under 7 CFR 273.18(g)(5), the Department may allow a household that is not participating in the Nutrition Assistance program to pay a claim in equal monthly payments in a negotiated repayment agreement. The household shall be responsible to pay a monthly payment in one of the following amounts until the claim is paid in full:

1. An amount equal to the balance of the claim at the time the negotiated repayment agreement is made, divided by 36.
2. When the amount in (B)(1) is equal to or less than $10.00, the monthly repayment amount shall be $10.00.

**C.** Under 7 CFR 273.18(g)(6), the Department may arrange with a liable individual to intercept his or her unemployment compensation benefits. This collection option may be included as part of a repayment agreement. The Department may also intercept an individual's unemployment compensation benefits by obtaining a court order.

**D.** Under 7 CFR 273.18(g)(8), the Department may use other collection methods that include:

1. Submitting the claim to the Arizona Department of Revenue for payment through a state tax refund.
2. Submitting the claim to the Arizona Lottery Commission for payment through a lottery winnings offset.
3. Submitting the claim to the federal Treasury Offset Program under 7 CFR 273.18(n).
4. A wage garnishment established through a civil judgment or criminal restitution order. When the Department has obtained a judgment or order, the Department shall:
   a. Send the household a Pre-Garnishment Notice to allow the household to agree to pay the claim in a manner other than wage garnishment; and
   b. If the household fails to arrange for payment in response to the Pre-Garnishment Notice, the Department may request the Arizona Attorney General's Office to initiate a wage garnishment under A.R.S. Title 12, Chapter 9, Article 4.1, and that garnishment may continue until the claim is paid in full.
5. Garnishment or levy of monies or property per A.R.S. Title 12, Chapter 9, Article 4.
6. Imposition or enforcement of all liens, including judgment liens imposed under A.R.S. § 33-961.
7. Any other legal or equitable remedy for the collection of debts and judgments.

**E.** Under 7 CFR 273.18(j) and at the Arizona Attorney General's direction, the Department shall act on behalf of the Food and Nutrition Service of the U.S. Department of Agriculture in any bankruptcy proceeding against a household subject to a claim.

**Historical Note**

R6-14-307 recodified from A.A.C. R6-3-2107 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-308. Claim Compromise**

**A.** In accordance with the Department's Claim Compromise policy and procedures as contained in the Arizona Cash and Nutrition Assistance Policy manual, the Department may compromise an entire claim or any portion of a claim if it can be reasonably determined that a household's economic circumstances dictate that the claim will not be paid in three years.

**B.** For purposes of a claim compromise "household" means the following persons who are residing together:
1. Adults who were members of the Nutrition Assistance household for which the claim was established, and who were adults at the time the claim was established, and
2. Minor children for whom adult household members are responsible.

**C.** When a household reports that it is unable to pay the claim in the equal monthly increments specified in R6-14-307(A) or (B), the Department shall inform the household that it may request a one-time compromise of the claim and shall provide the household with instructions for requesting a compromise. The Department may compromise the claim by reducing the claim amount and the resulting monthly payment amount when:
1. The household contacts the Department, orally or in writing, and requests a compromise of the claim,
2. The claim was established as an Agency Error claim or an Inadvertent Household Error claim,
3. There is no pending Appeal of the claim,
4. The Department has not previously approved a compromise of the claim, and
5. The Department approves the compromise request as provided in this Section.

**D.** When the Department receives a compromise request, and there is no pending appeal of the claim for which the compromise is requested, the Department shall send the household a Financial Statement form requesting necessary information and verification required for the Department to determine eligibility for a claim compromise.

**E.** The household must return the completed Financial Statement with requested information and verification to the Department no later than the thirtieth calendar day following the date that the Department mailed or otherwise transmitted the Financial Statement to the household. When the household requests assistance or additional time, the Department shall allow an additional thirty calendar days for the household to provide a completed Financial Statement. The Department shall deny the compromise claim request when the Financial Statement is not provided by the household by the thirtieth calendar day or the agreed upon extension date, unless the delay was for good cause. Good cause includes circumstances beyond the household's reasonable control such as illness, illness of another household member requiring the presence of the adult member, or a household emergency.

**F.** When the Financial Statement is timely provided to the Department, and all information and verification is complete, the Department shall complete the determination of eligibility for a compromise and send a notice no later than the twentieth working day, as defined in R6-14-402, following the date that the Department received the Financial Statement and all required information and verification.

**G.** When the compromise request is approved the Department shall notify the household of the compromised claim amount, the repayment plan for the new claim amount, and the household's right to file an appeal of the Department's action. The compromised claim amount shall be final unless modified by an appeal hearing decision.
1. The household shall pay a monthly payment in one of the following amounts until the compromised claim balance is paid in full:
   a. An amount equal to the balance of the compromised claim amount, divided by 36.
   b. When the amount in (G)(1)(a) is equal to or less than $10.00, the monthly payment shall be $10.00.
   c. When the household is currently participating in the Nutrition Assistance program, the Department shall reduce the household's monthly Nutrition Assistance benefit allotment by the greater of $10 or 10 percent.
   d. When the household is no longer participating in the Nutrition Assistance program, the household shall be responsible to pay the original claim compromise monthly payment amount calculated in accordance with (G)(1)(a) and (b). The Department shall notify the household of the claim compromise monthly payment obligation.
2. The approval of a compromise request shall apply only to the household that requested the compromise and does not affect the responsibility of any person:
   a. Who is not a member of the household that requested the compromise, and
   b. Who is responsible for paying the claim under 7 CFR 273.18(a)(4).

**H.** When the compromise request is denied the Department shall notify the household of the denial and the household's right to file an appeal of the Department's action.

**I.** The household may appeal the following actions or inaction related to a request for a compromise:
1. The Department's inaction or untimely action on processing the compromise request;
2. The amount of the approved compromise balance; or
3. A denial of the compromise request.

**Historical Note**

R6-14-308 recodified from A.A.C. R6-3-2108 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-309. Reinstatement of a Compromised Claim**

The Department shall reinstate any compromised portion of a claim when either of the following occurs:

1. A claim becomes delinquent under 7 CFR 273.18(e)(5).
2. The Department approved a compromise for a claim that was originally established as an Inadvertent Household Error claim and the original claim is later determined to have resulted from an Intentional Program Violation, as evidenced by a signed waiver of an Administrative Disqualification Hearing, an Administrative Disqualification Hearing decision, or a decision rendered by a state or federal court in a civil or criminal action.

**Historical Note**

R6-14-309 recodified from A.A.C. R6-3-2109 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-310. Terminating and Writing Off a Claim**

The Department shall terminate and write off a claim as required under 7 CFR 273.18(e)(8)(ii)(A through E), and may terminate and write off a claim as allowed under 7 CFR 273.18(e)(8)(ii)(F) and (G).

**Historical Note**

R6-14-310 recodified from A.A.C. R6-3-2110 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-311. Claims Established in Another State**

Under 7 CFR 273.18(i)(2), the Department may accept a claim from another state if the household subject to the claim receives Nutrition Assistance benefits in Arizona, when:

1. The Department confirms that the household was notified by the other state of the overpayment, and
2. There is no pending or unresolved Fair Hearing or Appeal of the overpayment in the other state, and
3. The Department determines with reasonable certainty that the household is able to repay the outstanding claim balance in full within the Nutrition Assistance certification period assigned to the household in Arizona.

**Historical Note**

R6-14-311 recodified from A.A.C. R6-3-2111 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-312. Expired**

**Historical Note**

R6-14-312 recodified from A.A.C. R6-3-2112 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-313. Expired**

**Historical Note**

R6-14-313 recodified from A.A.C. R6-3-2113 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-314. Expired**

**Historical Note**

R6-14-314 recodified from A.A.C. R6-3-2114 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-315. Expired**

**Historical Note**

R6-14-315 recodified from A.A.C. R6-3-2115 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-316. Expired**

**Historical Note**

R6-14-316 recodified from A.A.C. R6-3-2116 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-317. Expired**

**Historical Note**

R6-14-317 recodified from A.A.C. R6-3-2117 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-318. Expired**

**Historical Note**

R6-14-318 recodified from A.A.C. R6-3-2118 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-319. Expired**

**Historical Note**

R6-14-319 recodified from A.A.C. R6-3-2119 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-320. Expired**

**Historical Note**

R6-14-320 recodified from A.A.C. R6-3-2120 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-321. Expired**

**Historical Note**

R6-14-321 reserved; Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-322. Expired**

**Historical Note**

R6-14-322 recodified from A.A.C. R6-3-2122 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-323. Expired**

**Historical Note**
R6-14-323 recodified from A.A.C. R6-3-2123 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-324. Expired**

**Historical Note**
R6-14-324 recodified from A.A.C. R6-3-2124 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-325. Expired**

**Historical Note**
R6-14-325 recodified from A.A.C. R6-3-2125 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-326. Expired**

**Historical Note**
R6-14-326 recodified from A.A.C. R6-3-2126 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-327. Expired**

**Historical Note**
R6-14-327 recodified from A.A.C. R6-3-2127 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

## ARTICLE 4. APPEALS AND FAIR HEARINGS

**R6-14-401. Entitlement to a Fair Hearing; Appealable Action**
Any applicant or recipient who disagrees with any action or inaction by the Department which affects the participation of the household in the program has the right to challenge the action or inaction by requesting an administrative or fair hearing. Administrative hearings are conducted by the Department's Office of Appeals. In this Article, "hearing" refers to a Fair Hearing as required in 7 CFR 273.15.

**Historical Note**
R6-14-401 recodified from A.A.C. R6-3-2201 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-402. Computation of Time**
**A.** In computing any time period:
1. "Day" means a calendar day;
2. "Working day" means Monday through Friday, excluding federal or Arizona state holidays;
3. The Department does not count the date of the act, event, notice, or default from which a designated time period begins to run as part of the time period; and
4. The Department counts the last day of the designated time period. When the day is a Saturday, Sunday, federal holiday or Arizona state holiday, the last day is the first working day following that day.

**B.** Documents sent by the Department are received by an applicant or recipient on the date sent to the applicant or recipient's last known street or e-mail address, plus an additional five calendar days only when sent by U.S. mail. The send date is the date shown on the document unless the facts show otherwise.

**Historical Note**
R6-14-402 recodified from A.A.C. R6-3-2203 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-403. Request for Hearing: Form; Time Limits; Presumptions**
**A.** As contained in 7 CFR 273.15(h) a request for a hearing is defined as a clear expression, oral or written, by the household or its representative to the effect that it wishes to appeal a decision or that an opportunity to present its case to a higher authority is desired.

**B.** An applicant or recipient who wishes to appeal an action or inaction shall make an oral or written request for a hearing to the Department within 90 days of the notice date advising the applicant or recipient of the action, except that a recipient may appeal the current level of benefits at any time within a certification period. Action by the Department shall include a denial of a request for restoration of any benefits lost more than 90 days but less than one year prior to the request for a hearing. An applicant or recipient may file a request for hearing in-person or by mail, fax, phone, or Internet. The Department shall provide a form for this purpose. Upon request, the Department shall help an applicant or recipient to file an appeal. If the applicant or recipient makes an oral request for a hearing, the Department shall accept the oral request, record in writing the date of the request and the stated reasons for the hearing, and forward the request to the Office of Appeals. The freedom to make a request for a hearing shall not be limited or interfered with in any way.

**C.** An appellant is an applicant or recipient who files an appeal.

**D.** The Department shall process any oral or written request for a hearing that contains sufficient information for the Department to determine the appellant's identity.

**E.** The Department deems a request for hearing filed:
1. If the appellant sends the request for hearing by first-class mail through the United States Postal Service to the Department:
   a. On the mailing date as shown by the postmark;
   b. In the absence of a postmark, on the postage meter mark on the envelope in which it is received; or
   c. If not postmarked or postage meter marked or if the mark is illegible, on the date entered on the document as the date of completion.
2. The date the Department actually receives the request, if not mailed.

**F.** A document is timely filed if the appellant can demonstrate that any delay in submission was due to any of the following reasons:
1. Department error or misinformation:
2. Delay or other action by the United States Postal Service: or
3. Delay due to the appellant's changing mailing addresses at a time when the appellant had no duty to notify the Department of the change.

**G.** When the Office of Appeals receives an untimely request for a hearing, the Office of Appeals shall determine whether the delay in submission is excusable, as provided in subsection (F). The Department shall consider an untimely request for a hearing as a request for restoration of lost benefits in accordance with 7 CFR 273.17.

**H.** An appellant whose appeal the Office of Appeals denies as untimely may petition for review of this issue as provided in R6-14-416.

**I.** The Department shall expedite a hearing request for any person covered by 7 CFR 273.15(i)(2).

**J.** The Department shall provide interpreters or other language services at no cost to persons whose primary language is other than English. This shall include explaining the hearing procedures orally in the person's language if the materials are not translated into the person's language.

**K.** The Department shall offer an agency conference as provided by 7 CFR 273.15(d) to those persons denied expedited service and to any person who requests a conference.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-404. Stay of Action Pending Appeal**

As provided by 7 CFR 273.15(k), if the appellant timely requests a fair hearing, the Department shall stay the implementation of an action until the hearing officer renders a final decision on the appeal and the person receives the decision, unless the appellant signs a waiver of continuation of benefits.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-405. Hearings: Location; Notice; Time**

**A.** The Office of Appeals shall schedule the hearing. The Office of Appeals may schedule a telephonic hearing instead of an in-person hearing or permit a witness or party, upon request, to appear telephonically.

**B.** Unless the appellant requests an earlier hearing date, the Office of Appeals shall schedule the hearing no earlier than 20 days from the date the Department receives the appellant's request for hearing.

**C.** The Office of Appeals shall send a notice of hearing to all parties at least 20 days before the hearing date, unless a request for an earlier hearing date is granted under subsection (B).

**D.** The notice of hearing shall be in writing and shall:
1. Include information on how to request an in-person hearing;
2. Advise the appellant or the appellant's representative of the name, address, and phone number to notify the Office of Appeals in the event it is not possible for the appellant to attend the hearing;
3. Specify that the Office of Appeals will dismiss the hearing request if the appellant or the appellant's representative fails to appear for the hearing without good cause;
4. Include the Office of Appeals hearing procedures and any other information that would provide the appellant with an understanding of the proceedings and that would contribute to the effective presentation of the appellant's case; which shall include a pre-hearing summary prepared by the Department, and
5. Explain that the appellant or the appellant's representative shall be given adequate opportunity to:
   a. Examine the case file prior to the hearing. The contents of the case file including the application form and documents of verification used by the Department to establish the household's ineligibility or eligibility and allotment shall be made available, provided that confidential information, such as the names of individuals who have disclosed information about the household without its knowledge or the nature or status of pending criminal prosecutions, is protected from release. If requested by the household or its representative, the Department shall provide a free copy of the portions of the case file that are relevant to the hearing. Confidential information that is protected from release and other documents or records which the household will not otherwise have an opportunity to contest or challenge shall not be introduced at the hearing or affect the hearing official's decision.
   b. Present the case or have it presented by legal counsel or another person.
   c. Bring witnesses.
   d. Advance arguments without undue interference.
   e. Question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.
   f. Submit evidence to establish all pertinent facts and circumstances in the case.
6. The notice shall include information about the availability of free legal services.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-406. Postponing the Hearing**

**A.** The appellant may request and is entitled to receive one postponement of the first scheduled hearing. The postponement shall not exceed 30 days and the time limit for action on the decision may be extended for as many days as the hearing is postponed. The Office of Appeals may grant subsequent postponements upon a showing of good cause.

**B.** When the Office of Appeals reschedules a hearing under this Section, the Office of Appeals shall send the notice of rescheduled hearing at least 11 days prior to the date of the rescheduled hearing, unless the appellant agrees to shorter notice.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-407. Hearing Officer: Duties and Qualifications**

**A.** An impartial hearing officer in the Office of Appeals shall conduct all hearings.

**B.** The hearing officer shall:

1. Administer oaths and affirmations;
2. Regulate the conduct and course of the hearing consistent with due process to insure an orderly hearing;
3. Consider all relevant issues;
4. Request, receive, and admit into the record all evidence determined necessary to decide the issues being raised;
5. Order, where relevant and useful, an independent medical assessment or professional evaluation from a source mutually satisfactory to the household and the Department. The hearing officer shall decide on the source of the medical assessment or professional evaluation when the household and the Department are unable to agree on a mutually satisfactory source. The Department shall pay for the medical assessment or professional evaluation when such services are not available to the household as part of the household's current health insurance coverage;
6. As provided under 7 CFR 273.15(m)(2)(vi), render a hearing decision and issue a written decision reversing, affirming, modifying or remanding the agency's decision; and
7. Issue subpoenas under R6-14-409.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-408. Change of Hearing Officer; Challenges for Cause**

**A.** A party may request a change of hearing officer as prescribed in A.R.S. § 41-1992(B) by filing an affidavit that includes:

1. The case name and number:
2. The hearing officer assigned to the case: and
3. The name and signature of the party requesting the change.

**B.** The party requesting the change shall file the affidavit with the Office of Appeals and send a copy to all other parties at least five days before the hearing date.

**C.** A party shall request only one change of hearing officer unless that party is challenging a hearing officer for cause under subsection (E).

**D.** A party may not request a change of hearing officer once the hearing officer has heard and decided a motion except as provided in subsection (E).

**E.** At any time before a hearing officer renders a final decision under R6-14-414, a party may challenge a hearing officer on the grounds that the hearing officer is not impartial or disinterested in the case.

**F.** A party who brings a challenge for cause shall file an affidavit as provided in subsection (A) and send a copy of the affidavit to all other parties. The affidavit shall explain the reason why the assigned hearing officer is not impartial or disinterested.

**G.** When a party files an affidavit for a change in hearing officer as provided in subsection (F), the Office of Appeals shall assign another hearing officer to determine whether the hearing officer being challenged shall be removed, unless the hearing officer recuses himself or herself.

**H.** The Office of Appeals shall transfer the case to another hearing officer when:

1. A party requests a change as provided in subsections (A) through (D); or
2. The hearing officer is removed for cause, as provided in subsections (E) through (G).

**I.** The Office of Appeals shall send the parties written notice of the new hearing officer assignment.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-409. Subpoenas**

**A.** A party may ask the assigned hearing officer to issue a subpoena for a witness, document, or other physical evidence or to otherwise obtain the requested evidence. Subpoena forms are available to the appellant under R6-14-410(D).

**B.** The party seeking the subpoena shall send the hearing officer a written request for a subpoena. The request shall include:

1. The case name and number;
2. The name of the party requesting the subpoena;
3. The name and address of any person to be subpoenaed;
4. A description of any documents or physical evidence the appellant desires the hearing officer to subpoena, including the title, appearance, and location of the item if the appellant knows its location, and the name and address of the person in possession of the item; and
5. A statement about the expected substance of the testimony or other evidence as well as the relevance and importance of the requested testimony or other evidence.

**C.** A party shall request a subpoena at least five working days before the hearing date. A party who is unable to request a subpoena at least five days before the hearing date may request a postponement of the hearing. A party may raise the denial of a subpoena request in a petition for review to the Appeals Board, pursuant to R6-14-416.

**D.** The hearing officer shall deny the request if the witness's testimony or the physical evidence is not relevant to an issue in the case or is duplicative.

**E.** The Office of Appeals shall prepare all subpoenas and serve them by mail, except that the Office of Appeals may serve subpoenas on state employees who are appearing in the course of their jobs, by regular mail, hand-delivered mail, e-mail, or interoffice mail.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-410. Parties' Rights**

The appellant and the Department have the following rights:

1. The right to request a postponement of the hearing;

2. The right to receive before and during the hearing documents the Department may use at the hearing and a free copy of any documents in the Department's file on the appellant, except documents protected by the attorney-client or work-product privilege or as otherwise protected by federal or state confidentiality laws;
3. The right to request a change of hearing officer;
4. The right to request subpoenas for witnesses and evidence;
5. The right to be represented by an authorized representative, subject to any limitations on the unauthorized practice of law in the Rules of the Supreme Court of Arizona, Rule 31;
6. The right to bring witnesses, present evidence and to confront and cross-examine adverse witnesses;
7. The right to advance arguments without undue interference, to question or refute any testimony or evidence; and
8. The right to further appeal, as provided in R6-14-416 and R6-14-417, if dissatisfied with the Office of Appeals decision.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-411. Withdrawal of an Appeal**

**A.** An appellant may withdraw an appeal at any time prior to the time the hearing officer issues a decision.
1. An appellant may withdraw an appeal orally, either in person or by telephone. The Department may record the audio of the withdrawal. The Department is prohibited from coercion or actions that would influence the person or their representative to withdraw the fair hearing request. The Department must provide a written notice within 10 days of the oral request confirming the withdrawal request and providing the person an opportunity to request to reinstate the hearing within 10 days of the date the notice is received as provided in R6-14-402(B).
2. An appellant may withdraw an appeal by signing a written statement expressing the intent to withdraw. The Department shall make a withdrawal form available for this purpose.

**B.** The Office of Appeals shall dismiss the appeal when the appellant or the appellant's representative provides a signed withdrawal request to the Department or to the hearing officer prior to the issuance of a hearing decision or when the appellant or the appellant's representative makes such a request on the record during a hearing, or orally as provided in subsection (A)(1).

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-412. Failure to Appear; Default; Reopening**

**A.** If an appellant fails to appear at the hearing, the hearing officer shall:
1. Enter a default and issue a decision dismissing the appeal, except as provided in subsection (B);
2. Rule summarily on the available record; or
3. Adjourn the hearing to a later date and time.

**B.** The hearing officer shall not enter a default or rule summarily if the appellant notifies the Office of Appeals before the scheduled time of hearing that the appellant cannot attend the hearing because of good cause and still desires a hearing or wishes to have the matter considered on the available record. Good cause includes circumstances beyond the household's reasonable control such as, but not limited to, illness, illness of another household member requiring the presence of the adult member, or a household emergency.

**C.** A party who did not appear at the hearing may file a request to reopen the proceedings no later than 10 days after the hearing. The request shall be in writing, by mail or e-mail, or be made in person or by telephone and shall demonstrate good cause for the party's failure to appear.

**D.** If the hearing officer finds that the party had good cause for failure to appear, the hearing officer shall reopen the proceedings and schedule a new hearing with notice to all interested parties as prescribed in R6-14-405.

**E.** If the hearing officer cannot grant or deny the request to reopen the proceedings based on the information provided, the hearing officer shall set the matter for a hearing to determine whether the party had good cause for failure to appear.

**F.** Good cause, for the purpose of reopening a hearing, is established if the failure to appear at the hearing and the failure to timely notify the hearing officer were beyond the reasonable control of the nonappearing party. Good cause also exists when the nonappearing party demonstrates excusable neglect, as used in Arizona Rules of Civil Procedure, Rule 60(b)(1) for both the failure to appear and the failure to timely notify the hearing officer. "Excusable neglect" means an action involving an error such as might be made by a reasonably prudent person who attempts to handle a matter in a prompt and diligent fashion.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-413. Hearing Proceedings**

**A.** The hearing is a de novo proceeding. The Department has the initial burden of presenting the evidence to support the adverse action being appealed.

**B.** The standard of proof is a preponderance of the evidence.

**C.** The Arizona Rules of Evidence do not apply at the hearing. The hearing officer may admit and give probative effect to evidence as prescribed in A.R.S. § 41-1062(A).

**D.** The Office of Appeals shall audio record all hearings. The Office of Appeals shall also transcribe the proceedings when a transcription is requested by the Appeals Board or when a transcription is required for judicial review under A.R.S. § 41-1993. If a transcript is prepared for any purpose, the appellant is entitled to a copy of the transcription at no cost.

**E.** A party may, at the party's own expense, arrange to have a court reporter present to transcribe the hearing, provided that such transcription does not delay or interfere with the hearing. The Office of Appeal's recording of the hearing shall constitute the official record of the hearing.

**F.** The hearing officer shall call the hearing to order and dispose of any prehearing motions or issues.
**G.** With the consent of the hearing officer, the parties may stipulate to factual findings or legal conclusions.
**H.** A party may advance arguments without undue interference.
**I.** A party may testify, present evidence, call witnesses, cross-examine adverse witnesses, and object to evidence. The hearing officer may also take witness testimony or admit evidence on the hearing officer's own motion.
**J.** The hearing officer shall keep a complete record of all proceedings in connection with an appeal.
**K.** The hearing officer may request the parties to submit memoranda on issues in the case if the hearing officer finds that the memoranda would assist the hearing officer in deciding the case. The hearing officer shall establish a briefing schedule for any required memoranda.
**L.** The recording of the hearing, all the evidence presented at the hearing and all papers and requests filed shall constitute the record and shall be available to the household or its representative at any reasonable time for copying and inspection.

**Historical Note**
New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-414. Hearing Decision**
**A.** No later than 60 days after the date the appellant files a request for hearing with the Department, the hearing officer shall render a decision based solely on the evidence and testimony produced at the hearing and the applicable law. The 60-day time limit is extended for any delay necessary to accommodate hearing continuances or extensions, or postponements requested by a party.
**B.** The hearing decision shall include:
1. Findings of fact concerning the issue on appeal;
2. Citations to the law and authority applicable to the issue on appeal;
3. A statement of the conclusions derived from the controlling facts and law and the reasons for the conclusions;
4. The name of the hearing officer;
5. The date of the decision;
6. A statement of further appeal rights, a statement of the process required to initiate a further appeal, and the time period for exercising those rights; and
7. That an appeal may result in a reversal of the decision.

**C.** The Office of Appeals shall send a copy of the decision to each party or the party's representative.
**D.** When requested by the appellant, the Department, or upon the hearing officer's own motion, the Office of Appeals may amend or vacate a decision to correct clerical errors, including typographical and computational errors.

**Historical Note**
New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-415. Effect of the Decision**
**A.** If the hearing officer affirms the adverse action against the appellant, the adverse action is effective as of the date of the initial determination of adverse action by the Department. The adverse action remains effective until the appellant appeals and obtains a higher administrative or judicial decision reversing or vacating the hearing officer's decision.
**B.** If the hearing officer vacates or reverses the Department's decision to take adverse action, the Department shall not take the action or shall reverse any adverse action, unless the Department appeals and obtains a higher administrative or judicial decision reversing or vacating the hearing officer's decision.
**C.** As specified in 7 CFR 273.15(c) the Department shall:
1. For decisions that result in an increase in household benefits:
   a. Authorize and deposit a benefit supplement in the household's EBT benefit account within 10 days of the receipt of the hearing decision; or
   b. The Department may take longer than 10 days if it elects to make the decision effective in the household's normal issuance cycle, provided that the issuance will occur within 60 days from the household's request for the hearing.
2. For decisions that result in a decrease in household benefits the Department shall authorize and deposit a decreased benefit amount in the household's EBT benefit account for the next scheduled issuance following receipt of the hearing decision.

**Historical Note**
New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-416. Further Administrative Appeal**
**A.** A party can appeal an adverse decision issued by a hearing officer to the Department's Appeals Board as prescribed in A.R.S. § 41-1992(C) and (D) by filing a written petition for review with the Office of Appeals within 15 days of the mailing or transmittal date of the hearing officer's decision.
**B.** The petition for review shall:
1. Be in writing and filed in person or by mail or fax;
2. Describe why the party disagrees with the hearing officer's decision; and
3. Be signed and dated by the party or the party's representative.

**Historical Note**
New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-417. Appeals Board**
**A.** The Appeals Board shall conduct proceedings in accordance with A.R.S. §§ 41-1992(D) and 23-672.
**B.** The Appeals Board shall issue to all parties a final written decision affirming, reversing, setting aside, or modifying the hearing officer's decision based on the complete record, including the audio recording or the transcript of the hearing.

The decision of the Appeals Board shall specify the right to further review and the time for filing an application for appeal.

**C.** A household appellant adversely affected by an Appeals Board decision may seek judicial review under A.R.S. § 41-1993.

**Historical Note**

New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

## ARTICLE 5. INTENTIONAL PROGRAM VIOLATION

**R6-14-501. Intentional Program Violations (IPV); Defined**

**A.** An Intentional Program Violation (IPV) consists of having intentionally:

1. Made a false or misleading statement, or misrepresented, concealed or withheld facts; or
2. Committed any act that constitutes a violation of the Food and Nutrition Act, the Supplemental Nutrition Assistance Program Regulations, or any State statute for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of Supplemental Nutrition Assistance Program benefits or Electronic Benefit Transfer (EBT) cards. In Arizona, the name of the Supplemental Nutrition Assistance Program is the Nutrition Assistance Program.

**B.** For the purpose of imposing sanctions as prescribed in R6-14-505, a person is considered to have committed an IPV if:

1. A person signs a waiver of an Administrative Disqualification Hearing,
2. A person is found to have committed an IPV by an Administrative Disqualification Hearing, or
3. A person is convicted of a criminal offense the elements of which would constitute an IPV under subsection A above or enters into a disqualification consent agreement for deferred prosecution for fraud in a court of law.

**Historical Note**

R6-14-501 recodified from A.A.C. R6-3-2301 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-502. IPV Administrative Disqualification Hearings; Hearing Waiver**

**A.** Upon receipt of sufficient documentary evidence substantiating that a person has committed an IPV, the Department shall initiate either an Administrative Disqualification Hearing, or a referral for prosecution.

**B.** When the Department initiates an Administrative Disqualification Hearing, the Department shall mail the person suspected of an IPV written notice of the right to waive the Administrative Disqualification Hearing. This notice shall be sent either by first class mail or certified mail – return receipt requested.

**C.** The waiver notice of the Administrative Disqualification Hearing shall include the following information as well as the information described in R6-14-503(D):

1. A statement that the Department has determined that the individual suspected of the IPV committed, and intended to commit, one or more acts described in R6-14-501(A) and that the Department has initiated an Administrative Disqualification Hearing against the individual suspected of the IPV.
2. A summary of the allegations and evidence against the individual suspected of the IPV and notification that the individual suspected of the IPV has the right to examine the case file prior to the hearing and, when requested by the individual or representative, be provided a free copy of any documents in the case file, except documents protected by the attorney-client or work-product privilege or as otherwise protected by federal or state confidentiality laws.
3. A statement of the right of the individual suspected of the IPV to remain silent concerning the allegation of an IPV, and that anything said or signed by the individual concerning the allegations can be used against the individual suspected of the IPV in a court of law, including signing any part of the waiver.
4. A statement that signing a waiver of the Administrative Disqualification Hearing will result in disqualification periods as determined by section R6-14-505, a statement of the penalty the Department believes is applicable to the case scheduled for a hearing and a reduction in benefits for the period of disqualification, even if the individual suspected of the IPV does not admit to the facts as presented by the Department.
5. A statement that the individual suspected of the IPV does not have to sign a waiver of the Administrative Disqualification Hearing, return the waiver form to the Department or speak to anyone at the Department.
6. A statement of the fair hearing rights of the individual suspected of the IPV and notification that these rights are waived when the individual suspected of the IPV submits a signed waiver of the Administrative Disqualification Hearing form.
7. A statement that waiver of the Administrative Disqualification Hearing does not preclude the State or Federal Government from prosecuting the individual suspected of the IPV for the IPV in a civil or criminal court action, or from collecting any over issuance of Nutrition Assistance benefits.
8. A statement that the individual suspected of the IPV may wish to consult an attorney and a list of any individuals or organizations that provide free legal representation.
9. A statement that Nutrition Assistance benefits will continue and will only be terminated if the following occurs:
   a. The individual suspected of the IPV signs a notice to waive their rights to an Administrative Disqualification Hearing,
   b. There is an Administrative Disqualification Hearing decision that the individual suspected of the IPV is disqualified,
   c. The individual is determined to no longer be eligible on other grounds, or
   d. The individual requests that the Nutrition Assistance benefits not be continued in order to avoid a potential over issuance of benefits.
10. A statement that the remaining adult household members, if any, will be held responsible for repayment of the resulting over issuance claim.
11. An opportunity for the individual suspected of the IPV to specify whether or not the individual admits to the facts as presented by the Department. This opportunity shall

consist of the following statements, and a method for the individual suspected of the IPV to designate the individual's waiver choice:

a. I admit to the facts as presented and understand that a disqualification penalty will be imposed if I sign this waiver. I understand that if I sign this waiver, there will not be an Administrative Disqualification Hearing; or

b. I do not admit that the facts as presented are correct in my Nutrition Assistance case. However, I have chosen to sign this waiver of the Administrative Disqualification Hearing. I also understand that a disqualification penalty will be imposed. I understand that if I mark this box, I will not be able to submit additional evidence, have an Administrative Disqualification Hearing, or have the right to administrative appeal; or

c. I do not admit that the facts as presented are correct in my Nutrition Assistance case. I do not waive my right to require an Administrative Disqualification Hearing where the Department must prove by clear and convincing evidence that I committed, and intended to commit, an Intentional Program Violation.

12. A statement that if the individual suspected of the IPV does not waive their right to an Administrative Disqualification Hearing, then the Department must prove by clear and convincing evidence that the person committed and intended to commit, an Intentional Program Violation. The statement shall also advise the person that they may attend the hearing but are not required to attend. If the person opts to attend the hearing, they may talk to the judge about what happened and present additional evidence to the judge if they want to. The person also has the right to remain silent. The judge will decide if the person will be disqualified from participating in the Nutrition Assistance program.
13. The telephone number of the appropriate Department unit that the individual may contact to obtain additional information.
14. A due date that the signed waiver of an Administrative Disqualification Hearing must be provided to the Department so that a hearing will not be held and a signature block for the individual suspected of the IPV, along with a statement that the head of household must also sign the waiver if the individual suspected of the IPV is not the head of household, with an appropriately designated signature block.
15. If the signed waiver of the Administrative Disqualification Hearing is not returned by the due date, the Department shall schedule the Administrative Disqualification Hearing and shall send the individual suspected of the IPV a written hearing notice as contained in R6-14-503(C).

**D.** For the purpose of imposing sanctions as prescribed in R6-14-505, a timely signed waiver of an Administrative Disqualification Hearing shall have the same effect as an administrative adjudication that an IPV occurred.

**Historical Note**

R6-14-502 recodified from A.A.C. R6-3-2302 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-503. Administrative Disqualification Hearings**

**A.** The rules on fair hearings contained in Article 4 of this Chapter apply to Intentional Program Violation (IPV) Administrative Disqualification Hearings, except as provided in this Article.

**B.** All IPV Administrative Disqualification Hearings are conducted by the Department's Office of Appeals.

**C.** If the individual suspected of an IPV does not sign and return the waiver of Administrative Disqualification Hearing by the return date set in the waiver notice, or returns the waiver notice stating they do not waive the Administrative Disqualification Hearing, the Office of Appeals shall send the individual a written hearing notice. The Office of Appeals shall send the notice by first class mail, certified mail - return receipt requested, or any other reliable method, no later than 30 days before the scheduled hearing date.

**D.** The hearing notice shall include the following information:

1. The date, time, and place of the hearing;
2. The allegations of an IPV against the individual;
3. A summary of the evidence, how and where the evidence can be examined, and that the individual suspected of the IPV has the right to examine the case file prior to the hearing. When requested by the household or its representative, the Department shall provide a free copy of any documents in the case file, except documents protected by the attorney-client or work-product privilege or as otherwise protected by federal or state confidentiality laws;
4. A notice that the decision will be based solely on information provided by the Department if the individual suspected of the IPV fails to appear at the hearing;
5. A statement that the individual or representative will, upon receipt of the notice, have 10 days from the date of the scheduled hearing to present good cause for failure to appear in order to receive a new hearing;
6. A warning that a determination of IPV will result in disqualification periods as defined by R6-14-505, and a statement of which penalty the Department believes is applicable to the case scheduled for a hearing;
7. A listing of the individual's rights as contained in R6-14-410;
8. A statement that the Administrative Disqualification Hearing does not preclude the State or Federal Government from prosecuting the individual for the IPV in a civil or criminal court action, or from collecting any over issuance of Nutrition Assistance benefits;
9. A statement that the individual suspected of the IPV may consult with an attorney and a list of any individuals or organizations known to the Department that provide free legal representation; and
10. A notice that the individual suspected of the IPV has the right to obtain a copy of the Department's published hearing procedures together with an explanation of how the individual suspected of the IPV can obtain these procedures.

**E.** The hearing officer shall postpone a hearing for up to 30 days if the individual suspected of the IPV files a written or oral request for postponement with the hearing officer no later than 10 days before the hearing date. Any such postponement shall increase the time by which the hearing officer shall issue a decision, as provided in subsection (J).

**F.** The time and place for the hearing shall be arranged so that the hearing is accessible to the individual suspected of the IPV,

including making reasonable accommodations for a person with a disability.

**G.** At the start of the Administrative Disqualification Hearing, the hearing officer shall advise the individual suspected of the IPV or representative of the right to remain silent during the hearing. The hearing officer shall also advise that if the individual suspected of the IPV or representative chooses not to exercise the right to remain silent, anything they say may be used against them.

**H.** A hearing officer, as prescribed in R6-14-407, shall conduct the Administrative Disqualification Hearing pursuant to the procedures set forth in R6-14-408, R6-14-409, R6-14-410 and R6-14-413, except as prescribed in this subsection.

**I.** The Department shall prove by clear and convincing evidence that the household member committed, and intended to commit, an IPV.

**J.** No later than 90 days from the date of the notice of hearing, as increased by any postponement days, the hearing officer shall send to the individual suspected of the IPV a written decision. The hearing officer shall find whether the evidence shows by clear and convincing evidence that the person committed, and intended to commit, an IPV. The decision shall specify the reasons for the decision, identify the supporting evidence, identify the pertinent regulation, respond to reasoned arguments made by the individual suspected of the IPV or representative, and include appeal rights.

**Historical Note**

R6-14-503 recodified from A.A.C. R6-3-2303 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-504. Failure to Appear; Default; Reopening**

**A.** If the individual suspected of the IPV fails to appear at the Administrative Disqualification Hearing without good cause, the hearing officer shall conduct the hearing.

**B.** The hearing officer shall not conduct the hearing if the individual suspected of the IPV notifies the Office of Appeals before the hearing that the individual cannot attend the hearing because of good cause and still desires a hearing. Good cause includes circumstances beyond the household's reasonable control such as illness, illness of another household member requiring the presence of the adult member, or a household emergency.

**C.** An individual suspected of the IPV who did not appear at the hearing may file a request to reopen the Administrative Disqualification Hearing. The request shall be in writing and shall demonstrate good cause for the party's failure to appear.

1. The individual suspected of the IPV has 30 days after the date of the written notice of the hearing decision to file a request to reopen the Administrative Disqualification Hearing if the individual did not receive a hearing notice.
2. In all other instances, the individual suspected of the IPV has 10 days from the hearing date to show good cause why the individual failed to appear.

**D.** The hearing officer shall review the good cause reason submitted by the individual suspected of the IPV and unless the hearing officer can grant or deny the request based on the information provided, shall set the matter for a hearing to determine whether the individual suspected of the IPV had good cause for failing to appear.

**E.** If the hearing officer finds that the individual suspected of the IPV had good cause for failure to appear, the previous decision shall be vacated and the hearing officer shall reopen the Administrative Disqualification Hearing and schedule a new hearing with notice to all parties. The hearing officer must enter the good cause decision on the record.

**F.** Good cause, for the purpose of reopening an Administrative Disqualification Hearing, is established if the failure to appear at the hearing and the failure to timely notify the hearing officer were beyond the reasonable control of the individual suspected of the IPV. Good cause also exists when the individual suspected of the IPV demonstrates excusable neglect for both the failure to appear and the failure to timely notify the hearing officer. "Excusable neglect" means an action involving an error such as might be made by a reasonably prudent person who attempts to handle a matter in a prompt and diligent fashion.

**Historical Note**

R6-14-504 recodified from A.A.C. R6-3-2304 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-505. Disqualification Sanctions; Notice**

**A.** A person found to have committed an IPV is disqualified from program participation:

1. For a period of 12 months for the first IPV, except as provided under subsections (B) through (E);
2. For a period of 24 months for the second IPV, except as provided in subsections (B) through (E); and
3. Permanently for the third IPV.
4. The same act of IPV repeated over a period of time shall not be separated so that separate penalties can be imposed.

**B.** Individuals found by any court to have used or received benefits in a transaction involving the sale of a controlled substance, as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802), shall be ineligible to participate in the program:

1. For a period of 24 months for the first violation; and
2. Permanently upon the second violation.

**C.** Individuals found by any court to have used or received benefits in a transaction involving the sale of firearms, ammunition or explosives shall be permanently ineligible to participate in the program upon the first violation.

**D.** An individual convicted by any court of having trafficked benefits for an aggregate amount of $500 or more shall be permanently ineligible to participate in the program upon the first violation.

**E.** Except as provided under subsection (A)(3), an individual found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple Nutrition Assistance benefits simultaneously shall be ineligible to participate in the program for 10 years.

**F.** Upon a determination of IPV, the Department shall notify the disqualified person in writing of the pending disqualification. The written notice shall:
1. Inform the disqualified person of the decision and the reasons for the decision; and
2. Inform the disqualified person of the date the disqualification will take effect and the duration of the disqualification.

**G.** Under 7 CFR 273.11(c)(1), when determining the eligibility and benefit level for the remaining eligible members of the household, the Department shall count the income and resources of the disqualified person in their entirety and the entire household's allowable earned income, standard, medical, dependent care, child support, and excess shelter deductions shall continue to apply to the remaining household members. The Department shall not include the ineligible member when determining the household's size for the purposes of:
1. Assigning a benefit level to the household;
2. Assigning a standard deduction to the household;
3. Comparing the household's monthly income with the income eligibility standards; or
4. Comparing the household's resources with the resource eligibility limits.

**H.** Under 7 CFR 273.11 (c)(4) and 7 CFR §273.16(e)(9)(ii) and (f)(3), the Department shall notify the remaining members of their eligibility and benefit level at the same time the excluded member is notified of his or her disqualification.

**Historical Note**
R6-14-505 recodified from A.A.C. R6-3-2305 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-506. Administrative Disqualification Hearings or Waiver of the Right to a Hearing; Appeal**

**A.** Upon a determination of IPV through a signed waiver of an Administrative Disqualification Hearing, the individual has no right to further administrative appeal. The individual may seek relief in a court having jurisdiction and may seek a stay or other injunctive relief of a period of disqualification.

**B.** A party may appeal a Hearing Officer's Administrative Disqualification Hearing decision as provided in R6-14-416(A) to the Appeals Board as provided in R6-14-417.

**C.** An individual adversely affected by an Appeals Board decision may seek judicial review under A.R.S. § 41-1993.

**Historical Note**
R6-14-506 recodified from A.A.C. R6-3-2306 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

**R6-14-507. Honoring Out-of-State IPV Determinations and Sanctions**

The Department shall honor sanctions imposed against an applicant or recipient by the agency of another state that administers the Supplemental Nutrition Assistance Program and shall consider prior violations committed in another state when determining the appropriate sanction.

**Historical Note**
R6-14-507 recodified from A.A.C. R6-3-2307 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1). New Section made by emergency rulemaking at 24 A.A.R. 2081, effective July 6, 2018 for 180 days (Supp. 18-3). Emergency renewed at 24 A.A.R. 3591, effective January 2, 2019 for an additional 180 days (Supp. 18-4). Emergency expired; new Section made by final rulemaking at 26 A.A.R. 263, with an immediate effective date of January 21, 2020 (Supp. 20-1).

## ARTICLE 6. EXPIRED

**R6-14-601. Expired**

**Historical Note**
R6-14-601 recodified from A.A.C. R6-3-2401 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-602. Expired**

**Historical Note**
R6-14-602 recodified from A.A.C. R6-3-2402 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-603. Expired**

**Historical Note**
R6-14-603 reserved; Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-604. Expired**

**Historical Note**
R6-14-604 recodified from A.A.C. R6-3-2404 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-605. Expired**

**Historical Note**
R6-14-605 recodified from A.A.C. R6-3-2405 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-606. Expired**

**Historical Note**
R6-14-606 recodified from A.A.C. R6-3-2406 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-607. Expired**

**Historical Note**

R6-14-607 recodified from A.A.C. R6-3-2407 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-608. Expired**

**Historical Note**

R6-14-608 recodified from A.A.C. R6-3-2408 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-609. Expired**

**Historical Note**

R6-14-609 reserved; Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

**R6-14-610. Expired**

**Historical Note**

R6-14-610 recodified from A.A.C. R6-3-2410 effective February 13, 1996 (Supp. 96-1). Section expired under A.R.S. § 1056(E) at 11 A.A.R. 1450, effective February 28, 2005 (Supp. 05-1).

# 41-1954. Powers and duties

A. In addition to the powers and duties of the agencies listed in section 41-1953, subsection E, the department shall:

1. Administer the following services:

(a) Employment services, including manpower programs and work training, field operations, technical services, unemployment compensation, community work and training and other related functions in furtherance of programs under the social security act, as amended, the Wagner-Peyser act, as amended, the federal unemployment tax act, as amended, 33 United States Code, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(b) Individual and family services, which shall include a section on aging, services to children, youth and adults and other related functions in furtherance of social service programs under the social security act, as amended, title IV, except parts B and E, grants to states for aid and services to needy families with children and for child welfare services, title XX, grants to states for services, the older Americans act, as amended, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(c) Income maintenance services, including categorical assistance programs, special services unit, child support collection services, establishment of paternity services, maintenance and operation of a state case registry of child support orders, a state directory of new hires, a support payment clearinghouse and other related functions in furtherance of programs under the social security act, title IV, grants to states for aid and services to needy families with children and for child welfare services, title XX, grants to states for services, as amended, and other related federal acts and titles.

(d) Rehabilitation services, including vocational rehabilitation services and sections for the blind and visually impaired, communication disorders, correctional rehabilitation and other related functions in furtherance of programs under the vocational rehabilitation act, as amended, the Randolph-Sheppard act, as amended, and other related federal acts and titles.

(e) Administrative services, including the coordination of program evaluation and research, interagency program coordination and in-service training, planning, grants, development and management, information, legislative liaison, budget, licensing and other related functions.

(f) Manpower planning, including a state manpower planning council for the purposes of the federal-state-local cooperative manpower planning system and other related functions in furtherance of programs under the comprehensive employment and training act of 1973, as amended, and other related federal acts and titles.

(g) Economic opportunity services, including the furtherance of programs prescribed under the economic opportunity act of 1967, as amended, and other related federal acts and titles.

(h) Intellectual disability and other developmental disability programs, with emphasis on referral and purchase of services. The program shall include educational, rehabilitation, treatment and training services and other related functions in furtherance of programs under the developmental disabilities services and facilities construction act (P.L. 91-517) and other related federal acts and titles.

(i) Nonmedical home and community based services and functions, including department-designated case management, housekeeping services, chore services, home health aid, personal care, visiting nurse services, adult day care or adult day health, respite sitter care, attendant care, home delivered meals and other related services and functions.

2. Provide a coordinated system of initial intake, screening, evaluation and referral of persons served by the department.

3. Adopt rules it deems necessary or desirable to further the objectives and programs of the department.

4. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

5. Employ and determine the conditions of employment and prescribe the duties and powers of administrative, professional, technical, secretarial, clerical and other persons subject to chapter 4, article 4 and, as applicable, article 5 of this title as may be necessary in the performance of its duties, contract for the services of outside advisors, consultants and aides as may be reasonably necessary and reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business.

6. Make contracts and incur obligations within the general scope of its activities and operations subject to the availability of funds.

7. Contract with or assist other departments, agencies and institutions of the state, local and federal governments in the furtherance of its purposes, objectives and programs.

8. Be designated as the single state agency for the purposes of administering and in furtherance of each federally supported state plan.

9. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.

10. Provide information and advice on request by local, state and federal agencies and by private citizens, business enterprises and community organizations on matters within the scope of its duties subject to the departmental rules on the confidentiality of information.

11. Establish and maintain separate financial accounts as required by federal law or regulations.

12. Advise and make recommendations to the governor and the legislature on all matters concerning its objectives.

13. Have an official seal that is judicially noticed.

14. Annually estimate the current year's population of each county, city and town in this state, using the periodic census conducted by the United States department of commerce, or its successor agency, as the basis for such estimates and deliver such estimates to the economic estimates commission before December 15.

15. Estimate the population of any newly annexed areas of a political subdivision as of July 1 of the fiscal year in which the annexation occurs and deliver such estimates as promptly as is feasible after the annexation occurs to the economic estimates commission.

16. Establish and maintain a statewide program of services for persons who are both hearing impaired and visually impaired and coordinate appropriate services with other agencies and organizations to avoid duplication of these services and to increase efficiency. The department of economic security shall enter into agreements for the utilization of the personnel and facilities of the department of economic security, the department of health services and other appropriate agencies and organizations in providing these services.

17. Establish and charge fees for deposit in the department of economic security prelayoff assistance services fund to employers who voluntarily participate in the services of the department that provide job service and retraining for persons who have been or are about to be laid off from employment. The department shall charge only those fees necessary to cover the costs of administering the job service and retraining services.

18. Establish a focal point for addressing the issue of hunger in this state and provide coordination and assistance to public and private nonprofit organizations that aid hungry persons and families throughout this state. Specifically such activities shall include:

(a) Collecting and disseminating information regarding the location and availability of surplus food for distribution to needy persons, the availability of surplus food for donation to charity food bank organizations, and the needs of charity food bank organizations for surplus food.

(b) Coordinating the activities of federal, state, local and private nonprofit organizations that provide food assistance to the hungry.

(c) Accepting and disbursing federal monies, and any state monies appropriated by the legislature, to private nonprofit organizations in support of the collection, receipt, handling, storage and distribution of donated or surplus food items.

(d) Providing technical assistance to private nonprofit organizations that provide or intend to provide services to the hungry.

(e) Developing a state plan on hunger that, at a minimum, identifies the magnitude of the hunger problem in this state, the characteristics of the population in need, the availability and location of charity food banks and the potential sources of surplus food, assesses the effectiveness of the donated food collection and distribution network and other efforts to alleviate the hunger problem, and recommends goals and strategies to improve the status of the hungry. The state plan on hunger shall be incorporated into the department's state comprehensive plan prepared pursuant to section 41-1956.

(f) Establishing a special purpose advisory council on hunger pursuant to section 41-1981.

19. Establish an office to address the issue of homelessness and to provide coordination and assistance to public and private nonprofit organizations that prevent homelessness or aid homeless individuals and families throughout this state. These activities shall include:

(a) Promoting and participating in planning for the prevention of homelessness and the development of services to homeless persons.

(b) Identifying and developing strategies for resolving barriers in state agency service delivery systems that inhibit the provision and coordination of appropriate services to homeless persons and persons in danger of being homeless.

(c) Assisting in the coordination of the activities of federal, state and local governments and the private sector that prevent homelessness or provide assistance to homeless people.

(d) Assisting in obtaining and increasing funding from all appropriate sources to prevent homelessness or assist in alleviating homelessness.

(e) Serving as a clearinghouse on information regarding funding and services available to assist homeless persons and persons in danger of being homeless.

(f) Developing an annual state comprehensive homeless assistance plan to prevent and alleviate homelessness.

(g) Submitting an annual report to the governor, the president of the senate and the speaker of the house of representatives on the status of homelessness and efforts to prevent and alleviate homelessness. The department shall provide a copy of this report to the secretary of state.

20. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.

21. Exchange information, including case specific information, and cooperate with the department of child safety for the administration of the department of child safety's programs.

B. If the department of economic security has responsibility for the care, custody or control of a child or is paying the cost of care for a child, it may serve as representative payee to receive and administer social security and United States department of veterans affairs benefits and other benefits payable to such child. Notwithstanding any law to the contrary, the department of economic security:

1. Shall deposit, pursuant to sections 35-146 and 35-147, such monies as it receives to be retained separate and apart from the state general fund on the books of the department of administration.

2. May use such monies to defray the cost of care and services expended by the department of economic security for the benefit, welfare and best interests of the child and invest any of the monies that the director determines are not necessary for immediate use.

3. Shall maintain separate records to account for the receipt, investment and disposition of funds received for each child.

4. On termination of the department of economic security's responsibility for the child, shall release any funds remaining to the child's credit in accordance with the requirements of the funding source or in the absence of such requirements shall release the remaining funds to:

(a) The child, if the child is at least eighteen years of age or is emancipated.

(b) The person responsible for the child if the child is a minor and not emancipated.

C. Subsection B of this section does not pertain to benefits payable to or for the benefit of a child receiving services under title 36.

D. Volunteers reimbursed for expenses pursuant to subsection A, paragraph 5 of this section are not eligible for workers' compensation under title 23, chapter 6.

E. In implementing the temporary assistance for needy families program pursuant to Public Law 104-193, the department shall provide for cash assistance to two-parent families if both parents are able to work only on documented participation by both parents in work activities described in title 46, chapter 2, article 5, except that payments may be made to families who do not meet the participation requirements if:

1. It is determined on an individual case basis that they have emergency needs.

2. The family is determined to be eligible for diversion from long-term cash assistance pursuant to title 46, chapter 2, article 5.

F. The department shall provide for cash assistance under temporary assistance for needy families pursuant to Public Law 104-193 to two-parent families for no longer than six months if both parents are able to work, except that additional assistance may be provided on an individual case basis to families with extraordinary circumstances. The department shall establish by rule the criteria to be used to determine eligibility for additional cash assistance.

G. The department shall adopt the following discount medical payment system for persons who the department determines are eligible and who are receiving rehabilitation services pursuant to subsection A, paragraph 1, subdivision (d) of this section:

1. For inpatient hospital admissions and outpatient hospital services the department shall reimburse a hospital according to the rates established by the Arizona health care cost containment system administration pursuant to section 36-2903.01, subsection G.

2. The department's liability for a hospital claim under this subsection is subject to availability of funds.

3. A hospital bill is considered received for purposes of paragraph 5 of this subsection on initial receipt of the legible, error-free claim form by the department if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

4. The department shall require that the hospital pursue other third-party payors before submitting a claim to the department. Payment received by a hospital from the department pursuant to this subsection is considered payment by the department of the department's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For inpatient hospital admissions and outpatient hospital services rendered on and after October 1, 1997, if the department receives the claim directly from the hospital, the department shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the department shall pay ninety-nine percent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the department shall pay one hundred percent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the department shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. For medical services other than those for which a rate has been established pursuant to section 36-2903.01, subsection G, the department shall pay according to the Arizona health care cost containment system capped fee-for-service schedule adopted pursuant to section 36-2904, subsection K or any other established fee schedule the department determines reasonable.

H. The department shall not pay claims for services pursuant to this section that are submitted more than nine months after the date of service for which the payment is claimed.

I. To assist in the location of persons or assets for the purpose of establishing paternity, establishing, modifying or enforcing child support obligations and other related functions, the department has access, including automated access if the records are maintained in an automated database, to records of state and local government agencies, including:

1. Vital statistics, including records of marriage, birth and divorce.

2. State and local tax and revenue records, including information on residence address, employer, income and assets.

3. Records concerning real and titled personal property.

4. Records of occupational and professional licenses.

5. Records concerning the ownership and control of corporations, partnerships and other business entities.

6. Employment security records.

7. Records of agencies administering public assistance programs.

8. Records of the motor vehicle division of the department of transportation.

9. Records of the state department of corrections.

10. Any system used by a state agency to locate a person for motor vehicle or law enforcement purposes, including access to information contained in the Arizona criminal justice information system.

J. Notwithstanding subsection I of this section, the department or its agents shall not seek or obtain information on the assets of an individual unless paternity is presumed pursuant to section 25-814 or established.

K. Access to records of the department of revenue pursuant to subsection I of this section shall be provided in accordance with section 42-2003.

L. The department also has access to certain records held by private entities with respect to child support obligors or obligees, or individuals against whom such an obligation is sought. The information shall be obtained as follows:

1. In response to a child support subpoena issued by the department pursuant to section 25-520, the names and addresses of these persons and the names and addresses of the employers of these persons, as appearing in customer records of public utilities, cable operators and video service providers.

2. Information on these persons held by financial institutions.

M. Pursuant to department rules, the department may compromise or settle any support debt owed to the department if the director or an authorized agent determines that it is in the best interest of this state and after considering each of the following factors:

1. The obligor's financial resources.

2. The cost of further enforcement action.

3. The likelihood of recovering the full amount of the debt.

N. Notwithstanding any law to the contrary, a state or local governmental agency or private entity is not subject to civil liability for the disclosure of information made in good faith to the department pursuant to this section.

# 46-134. Powers and duties; expenditure; limitation

The state department shall:

1. Administer all forms of public relief and assistance except those that by law are administered by other departments, agencies or boards.

2. Develop a section of rehabilitation for the visually impaired that shall include a sight conservation section, a vocational rehabilitation section in accordance with the federal vocational rehabilitation act, a vending stand section in accordance with the federal Randolph-Sheppard act and an adjustment service section that shall include rehabilitation teaching and other social services deemed necessary, and shall cooperate with similar agencies already established. The administrative officer and staff of the section for the blind and visually impaired shall be employed only in the work of that section.

3. Assist other departments, agencies and institutions of the state and federal governments, when requested, by performing services in conformity with the purposes of this title.

4. Act as agent of the federal government in furtherance of any functions of the state department.

5. Carry on research and compile statistics relating to the entire public welfare program throughout this state, including all phases of dependency and defectiveness.

6. Cooperate with the superior court in cases of delinquency and related problems.

7. Develop plans in cooperation with other public and private agencies for the prevention and treatment of conditions giving rise to public welfare and social security problems.

8. Make necessary expenditures in connection with the duties specified in paragraphs 5, 6, 7, 13 and 14 of this subsection.

9. Have the power to apply for, accept, receive and expend public and private gifts or grants of money or property on the terms and conditions as may be imposed by the donor and for any purpose provided for by this chapter.

10. Make rules, and take action necessary or desirable to carry out the provisions of this title, that are not inconsistent with this title.

11. Administer any additional welfare functions required by law.

12. If a tribal government elects to operate a cash assistance program in compliance with the requirements of the United States department of health and human services, with the review of the joint legislative budget committee, provide matching monies at a rate that is consistent with the applicable fiscal year budget and that is not more than the state matching rate for the aid to families with dependent children program as it existed on July 1, 1994.

13. Furnish a federal, state or local law enforcement officer, at the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the recipient and notifies the agency that the recipient is a fugitive felon or a probation, parole or community supervision violator or has information that is necessary for the officer to conduct the official duties of the officer and the location or apprehension of the recipient is within these official duties.

14. In conjunction with Indian tribal governments, request a federal waiver from the United States department of agriculture that will allow tribal governments that perform eligibility determinations for temporary assistance for needy families programs to perform the food stamp eligibility determinations for persons who apply for services pursuant to section 36-2901, paragraph 6, subdivision (a). If the waiver is approved, the state shall provide the

state matching monies for the administrative costs associated with the food stamp eligibility based on federal guidelines. As part of the waiver, the department shall recoup from a tribal government all federal fiscal sanctions that result from inaccurate eligibility determinations.

# 46-136. Powers of state department regarding work projects for unemployed persons

A. The state department may institute work projects for the employment of needy unemployed persons being granted public assistance. The nature of the work projects shall be determined by the state department and the governing body of the county, municipal government or school district involved to be projects necessary and desirable to the community including projects designed to improve health and public safety. County or municipal governments, including school districts, shall cooperate in such projects by furnishing supervision, transportation and payment of industrial commission insurance.

B. The state department shall act as the official agency for the state in any social welfare activity initiated by the federal government and shall administer state funds appropriated or made available for the relief of dependent persons, except as otherwise provided by law.

C. The state department shall expend from any amounts otherwise available by law amounts that, in the discretion of the director, are determined necessary for such purpose in conjunction with any agency or department of the federal government for the purpose of receiving and distributing food stamps offered to public welfare agencies for needy persons. The amount so determined may be expended by the department in payment of expenses necessarily incurred by reason of the receipt or distribution of such food stamps.

**7 USC 2013: Establishment of program**
Text contains those laws in effect on January 2, 2001

**From Title 7-AGRICULTURE**
CHAPTER 51-FOOD STAMP PROGRAM
**Jump To:**


# §2013. Establishment of program

**(a) Use of coupons; redeemability**

Subject to the availability of funds appropriated under section 2027 of this title, the Secretary is authorized to formulate and administer a food stamp program under which, at the request of the State agency, eligible households within the State shall be provided an opportunity to obtain a more nutritious diet through the issuance to them of an allotment, except that a State may not participate in the food stamp program if the Secretary determines that State or local sales taxes are collected within that State on purchases of food made with coupons issued under this chapter. The coupons so received by such households shall be used only to purchase food from retail food stores which have been approved for participation in the food stamp program. Coupons issued and used as provided in this chapter shall be redeemable at face value by the Secretary through the facilities of the Treasury of the United States.

**(b) Distribution of federally donated foods**

Distribution of commodities, with or without the food stamp program, shall be made whenever a request for concurrent or separate food program operations, respectively, is made by a tribal organization. In the event of distribution on all or part of an Indian reservation, the appropriate agency of the State government in the area involved shall be responsible for such distribution, except that, if the Secretary determines that the tribal organization is capable of effectively and efficiently administering such distribution, then such tribal organizations shall administer such distribution: *Provided*, That the Secretary shall not approve any plan for such distribution which permits any household on any Indian reservation to participate simultaneously in the food stamp program and the distribution of federally donated foods. The Secretary is authorized to pay such amounts for administrative costs of such distribution on Indian reservations as the Secretary finds necessary for effective administration of such distribution by a State agency or tribal organization.

**(c) Regulations; transmittal of copy of regulations to Congressional committees prior to issuance**

The Secretary shall issue such regulations consistent with this chapter as the Secretary deems necessary or appropriate for the effective and efficient administration of the food stamp program and shall promulgate all such regulations in accordance with the procedures set forth in section 553 of title 5. In addition, prior to issuing any regulation, the Secretary shall provide the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate a copy of the regulation with a detailed statement justifying it.

( Pub. L. 88–525, §4, Aug. 31, 1964, 78 Stat. 704 ; Pub. L. 91–671, §3, Jan. 11, 1971, 84 Stat. 2049 ; Pub. L. 95–113, title XIII, §1301, Sept. 29, 1977, 91 Stat. 961 ; Pub. L. 99–198, title XV, §§1505(a), 1506, Dec. 23, 1985, 99 Stat. 1567 .)

## Amendments

**1985**-Subsec. (a). Pub. L. 99–198, §1505(a), inserted ", except that a State may not participate in the food stamp program if the Secretary determines that State or local sales taxes are collected within that State on purchases of food made with coupons issued under this chapter" at end of first sentence.

Subsec. (b). Pub. L. 99–198, §1506, struck out first sentence which directed that in jurisdictions where the food stamp program is in operation, there shall be no distribution of federally donated foods to households under the authority of any law, except that distribution may be made (1) on a temporary basis under programs authorized by law to meet disaster relief needs, or (2) for the purpose of the commodity supplemental food program, and struck out "also" after "shall" in second sentence.

**1977**-Subsec. (a). Pub. L. 95–113 made establishment of food stamp program subject to availability of funds appropriated under section 2027 of this title.

Subsec. (b). Pub. L. 95–113 inserted provisions relating to requests by tribal organizations.

Subsec. (c). Pub. L. 95–113 inserted provisions relating to transmittal of regulations and accompanying statement of justification to Congressional committees.

**1971**-Subsec. (a). Pub. L. 91–671 substituted "the State agency" and "the charge to be paid for such allotment by eligible households" for "an appropriate State agency" and "their normal expenditures for

food", respectively, and struck out "more nearly" before "to obtain".

Subsec. (b). Pub. L. 91–671 substituted "operation" for "effect", "federally donated foods" for "federally owned foods" where first appearing, and exception provision for distributions to households: during temporary emergency situations, for period of time necessary to effect transition to a food stamp program as a replacement of distribution of federally donated foods, or on request of the State agency without simultaneous participation in both the food stamp program and distribution of federally donated foods for prior exception during emergency situations caused by a national or other disaster.

## Effective Date of 1985 Amendment

Section 1505(b) of Pub. L. 99–198 provided that:

"(1) Except as provided in paragraph (2), the amendment made by subsection (a) [amending this section] shall take effect with respect to a State beginning on the first day of the fiscal year that commences in the calendar year during which the first regular session of the legislature of such State is convened following the date of enactment of this Act [Dec. 23, 1985].

"(2) Upon a showing by a State, to the satisfaction of the Secretary, that the application of paragraph (1), without regard to this paragraph, would have an adverse and disruptive effect on the administration of the food stamp program in such State or would provide inadequate time for retail stores to implement changes in sales tax policy required as a result of the amendment made by subsection (a) [amending this section], the Secretary may delay the effective date of subsection (a) with respect to such State to a date not later than October 1, 1987."

## Effective Date of 1977 Amendment

Section 1301 of Pub. L. 95–113 provided that the amendment made by that section is effective Oct. 1, 1977.

## Section Referred to in Other Sections

This section is referred to in sections 2012, 2014, 4004a, 7509 of this title; title 8 section 1615.

**F-6.**

**ARIZONA LEAFY GREENS FOOD SAFETY COMMITTEE**
Title 3, Chapter 9, Article 6

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** July 1, 2025

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 17, 2025

**SUBJECT:** **ARIZONA LEAFY GREENS FOOD SAFETY COMMITTEE**
Title 3, Chapter 9, Article 6

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**Summary**

This Five-Year Review Report (5YRR) from the Leafy Greens Food Safety Committee ("Committee") covers six (6) rules in Title 3, Chapter 9, Article 6. . The Committee administers and enforces the Arizona Leafy Green Products Shipper Marketing Agreement. The agreement requires all shippers of leafy green vegetables who are signatories to the agreement to follow best practices with handling the products. The rules incorporate by reference the best practice guidelines, provide requirements for proper usage of the service mark, and outline ramifications for violations of the rules.

In the previous report approved by the Council in May 2020, the Committee did not propose any course of action.

**Proposed Action**

The Committee is not proposing any amendments to these rules.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Committee cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

According to the Department of Agriculture ("Department"), the economic, small business, and consumer impact of the rules is positive. The Arizona lettuce industry is one of Arizona's most economically significant agricultural sectors, bringing an estimated $2 billion to the state in the way of jobs and revenues. The marketing agreement and these rules were put in place at the request of Arizona lettuce industry. Industry members voluntarily sign on and agree to follow the rules. The assessment signatories are charged is calculated on a per unit basis so that smaller businesses pay less. Safe production and handling practices are key to the success of the lettuce industry. These rules increase the economic welfare of the state by creating commodity specific food safety guidelines, which both increases the quality of products and adds value to them in the marketplace.

Stakeholders include the Department, signatories of the Arizona Leafy Green Products Shipper Marketing Agreement, and the general public.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department believes the rules impose the least burden and costs to persons regulated by the rules necessary to achieve the underlying regulatory objective. Industry requested the marketing agreement and rules be created and has been extensively involved in the development and implementation process. The Leafy Green Food Safety Committee members directly represent signatories to the agreement. The Committee ensure the rules and guidance appropriately reflect common business practices and do not include unnecessary burdens.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Committee indicates it received no written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Committee indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Committee indicates the rules consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Committee indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Committee indicates the rules are enforced as written

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Committee states that there is no corresponding federal law for the rules.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Committee has indicated that the rules do not require a license or permit.

**11. Conclusion**

This Five-Year Review Report (5YRR) from the Leafy Greens Food Safety Committee ("Committee") covers six (6) rules in Title 3, Chapter 9, Article 6. Like with the previous report, the Committee is not proposing to make any changes to the rules. The rules are clear, concise, understandable, and effective. Council staff recommends approval of this report.

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends approval of this report.

KATIE HOBBS
Governor

PAUL E. BRIERLEY
Director

# ARIZONA DEPARTMENT OF AGRICULTURE

## Plant and Produce Services Division

Physical: 1110 W. Washington St, Ste. 450 Phoenix, AZ 85007
Mailing: 1802 W Jackson St, #78 Phoenix, AZ 85007
(602) 542-0990

March 14, 2025

grrc@azdoa.gov
Jessica Klein, Chair
Governor's Regulatory Review Council
100 N. 15th Avenue, Suite 302
Phoenix, Arizona 85007

**RE: Arizona Department of Agriculture, Title 3, Chapter 9, Article 6, Five Year Review Report**

Dear Ms. Klein:

Please find enclosed the Five-Year Review Report of the Arizona Department of Agriculture's ("Department") for Title 3, Chapter 9, Article 6, which is due March 30, 2025.

The Department reviewed all the rules in Article 6. The Department does not intend for any rules to expire under A.R.S. § 41-1056(J).

The Department certifies it is in compliance with A.R.S. § 41-1091.

Please contact Teressa Lopez at (602) 542-0945 or tlopez@azda.gov with any questions about this report.

Sincerely,

Paul E. Brierley
Director

cc: Teressa Lopez, Assistant Director
Megan Chedwick, FSC Chairwoman

**Arizona Department of Agriculture**

**5 YEAR RULE REVIEW REPORT**

**Chapter 9. Department of Agriculture – Agricultural Councils and Commissions**

**Article 6. Leafy Greens Food Safety Committee**

**March 30, 2025**

1. **Authorization of the rule by existing statutes**

General Statutory Authority: A.R.S. § 3-414(C)(11)

Specific Authority: A.R.S. § 3-401 - A.R.S. § 3-404(B)

2. **The objective of each rule:**

General Objective of the Rules:
The Leafy Greens Food Safety Committee administers and enforces the Arizona Leafy Green Products Shipper Marketing Agreement. This marketing agreement requires shippers of leafy green vegetables who are signatories to the agreement to follow best practices with respect to the handling of those products in order to enhance food safety and prevent the outbreak of illnesses stemming from the consumption of leafy green vegetables. Signatories may use the Leafy Green Food Safety Committee's collective service mark on their product as long as they are in compliance with the best practices incorporated by reference into these rules. The rules in this article incorporate by reference the best practice guidelines, provide the requirements for proper usage of the service mark, and outline the ramifications for violations of the rules.

| Rule | Objective |
|---|---|
| R3-9-601 | The objective is to establish definitions of terms for the Article |
| R3-9-602 | Requires signatories of the marketing agreement to comply with the best practices guidelines, maintain a trace-back system, and be subject to periodic audits. It also requires signatories to only buy or handle leafy green product grown in Arizona from a shipper or producer that meets these same requirements. Finally, it clarifies that if the best practices require a Standard Operating Procedure (SOP) the signatory must have and must follow the SOP. |
| R3-9-603 | Sets the requirements for usage of the service mark |
| R3-9-604 | Describes the conduct that may result in loss or suspension of a signatory's privilege to use the service mark, and establishes an enforcement system used to determine length of suspension and requirements for reinstatement in relation to seriousness and type of violation. It also provides signatories with an opportunity for hearing prior to loss of the privilege unless the Committee determines public health, safety, or welfare requires summary suspension. |
| R3-9-605 | Establishes and defines four levels of violations: flagrant violations, major deviations, minor deviations, and minor infractions. |
| R3-9-606 | Requires signatories who commit a flagrant violation, major deviation, or minor deviation to complete a corrective action plan process, as set forth in the rule. |

3. **Are the rules effective in achieving their objectives?** **Yes** X **No** __
The rules in Article 6 are effective in achieving their objectives.

4. **Are the rules consistent with other rules and statutes?** **Yes** X **No** ___
The rules in Article 6 are consistent with other rules and statutes.

5. **Are the rules enforced as written?** **Yes** X **No** ____
The rules in Article 6 are enforced as written.

6. **Are the rules clear, concise, and understandable?** **Yes** X **No** ____
The rules in Article 6 are clear, concise, and understandable.

7. **Has the agency received written criticisms of the rules within the last five years?** **Yes** ___ **No** X
The Department has not received any written criticisms of the rules within the last 5 years.

8. **Economic, small business, and consumer impact comparison:**
The economic, small business, and consumer impact of the rules is positive. The Arizona lettuce industry is one of Arizona's most economically significant agricultural sectors, bringing an estimated $2 billion to the state in the way of jobs and revenues. The marketing agreement and these rules were put in place at the request of Arizona lettuce industry. Industry members voluntarily sign on and agree to follow the rules. The assessment signatories are charged is calculated on a per unit basis so that smaller businesses pay less. Safe production and handling practices are key to the success of the lettuce industry. These rules increase the economic welfare of the state by creating commodity specific food safety guidelines, which both increases the quality of products and adds value to them in the marketplace.

9. **Has the agency received any business competitiveness analyses of the rules?** **Yes** ___**No** X

10. **Has the agency completed the course of action indicated in the agency's previous five-year-review report?**
No course of action was indicted at the last five-year review.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

The Department believes the rules impose the least burden and costs to persons regulated by the rules necessary to achieve the underlying regulatory objective. Industry requested the marketing agreement and rules be created and has been extensively involved in the development and implementation process. The Leafy Green Food Safety Committee members directly represent

signatories to the agreement. The Committee ensures the rules and guidance appropriately reflect common business practices and do not include unnecessary burdens.

**12.** **Are the rules more stringent than corresponding federal laws?** **Yes ___No** X

There is no specific federal law that corresponds with these rules. These rules are not more stringent than other similar federal laws related to marketing orders and agreements. See Marketing Agreements and Orders: Fruits, Vegetables, Nuts, 7 C.F.R. Parts 900-999. http://www.gpo.gov/fdsys/pkg/CFR-2010-title7-vol8/pdf/CFR-2010-title7-vol8-subtitleB-chapIX.pdf

**13.** **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. §41-1037 or explain why the agency believes an exception applies:**

These rules to do not require a regulatory permit or license.

**14.** **Proposed course of action**

The Department intends to maintain the rules as currently written.

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# TITLE 3. AGRICULTURE

## CHAPTER 9. DEPARTMENT OF AGRICULTURE - AGRICULTURAL COUNCILS AND COMMISSIONS

### ARTICLE 6. LEAFY GREENS FOOD SAFETY COMMITTEE

Section


### ARTICLE 6. LEAFY GREENS FOOD SAFETY COMMITTEE

**R3-9-601. Definitions**

"Act" means A.R.S. Title 3, Chapter 3, Article 1.

"Auditor" or "Inspector" means a state or federal agricultural regulatory agency or their designee(s), or a private entity contracted by the Committee to perform inspections authorized by the Act.

"Best practices" means the "Commodity Specific Food Safety Guidelines for the Production and Harvest of Lettuce and Leafy Greens, as amended by the Committee. This document is incorporated by reference and is available for review online at the Arizona Leafy Greens Marketing Agreement website and at the Arizona Department of Agriculture, 1688 W. Adams Street, Phoenix, Arizona 85007.

"Committee" means the Leafy Greens Food Safety Committee established pursuant to the Marketing Agreement.

"LGMA" or "Marketing Agreement" means the Arizona Leafy Green Products Shipper Marketing Agreement approved pursuant to the Act. This document is incorporated by reference and is available for review online at the Arizona Leafy Greens Marketing Agreement website and at the Arizona Department of Agriculture, 1688 W. Adams Street, Phoenix, Arizona 85007.

"SOP" means standard operating procedure.

**R3-9-602. Best Practices; LGMA Compliance**

**A.** Signatories shall comply with the best practices, maintain a trace-back system, and be subject to periodic audit by an auditor.

**B.** Signatories shall only buy, consign, or otherwise accept or handle leafy green products (grown in Arizona) from a shipper or producer who is in compliance with the best practices (including recordkeeping requirements), maintains a trace-back system, and is subject to periodic audit by an auditor.

**C.** When the best practices require a SOP, there shall be an appropriate SOP and that SOP shall be followed.

**R3-9-603. Service Mark Usage**

**A.** A signatory's compliance with the LGMA and R3-9-602 is a condition precedent and subsequent to the signatory's privilege to use the service mark.

**B.** An authorized signatory may use the service mark on all bills of lading and on other documents.

**C.** A signatory shall:

1. Use the service mark without reference to a private brand or label.
2. Provide reasonable assurances that the signatory has a system in place to comply with this Section, maintain records sufficient to audit the system for the duration of the LGMA, and make those records available to the Committee upon request.

**D.** A signatory shall not:

1. Use the service mark on packaging or product or as a certification mark to certify product.
2. Use the service mark as the signatory's own mark or as the exclusive representation of its business entity.
3. Insert within or overlap the boundaries of the service mark with the signatory's name or trademark.
4. Alter the service mark in any way other than proportionately adjusting the size of the service mark.

**R3-9-604. Loss of Use of Service Mark**

**A.** A signatory shall lose the privilege to use the service mark if the signatory:

1. Commits a flagrant violation or repeated major deviation;
2. Fails to comply with R3-9-603;
3. Has not paid assessments due for the prior fiscal year; or
4. Withdraws from participation in the LGMA pursuant to Article XVI, section C of the LGMA.

**B.** The first flagrant violation or repeated major deviation shall result in a suspension of the privilege to use the service mark for a minimum two-week period.

**C.** A flagrant violation or repeated major deviation following the first flagrant violation or repeated major deviation shall result in an indefinite suspension of the privilege to use the service mark.

**D.** A flagrant violation or repeated major deviation following a suspension pursuant to subsection (C) shall result in an indefinite revocation of the privilege to use the service mark. The privilege to use the service mark shall not be restored to the signatory for a minimum of two years unless the signatory demonstrates to the satisfaction of the auditor and the Committee a significant change in management and brand.

**E.** A signatory whose privilege to use the service mark is suspended or revoked pursuant to subsections (B) through (D) shall not use the service mark until the signatory has undergone at least one new audit without the finding of any major deviations or flagrant violations and has evidenced that the signatory has corrected any minor deviations found.

**F.** At least two weeks of any suspension of the privilege to use the service mark under subsections (B) through (D) shall occur between December 1 and March 31.

**G.** The Committee may accelerate the progression of penalties under this Section if the signatory's product seriously affects a person's health and the signatory handled the product with intentional, knowing or reckless disregard for the signatory's obligations under the LGMA and best practices.

**H.** A signatory shall not lose the privilege to use the service mark under subsections (A)(1) and (2) without an opportunity for a hearing under A.R.S. Title 41, Chapter 6, Article 10, except if the Committee finds that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the Committee may order summary suspension of a signatory's privilege to use the service mark.

**I.** A signatory that loses the privilege to use the mark under subsection (A)(3) shall pay all assessments due from prior fiscal years, including penalties and interest, before regaining the privilege to use the service mark.

**J.** The Committee may publish a list of signatories whose privilege to use the service mark has been suspended.

**R3-9-605. Violation Levels; Repeated Violations**

**A.** Violations of R3-9-602 fall into four levels: flagrant violations, major deviations, minor deviations, and minor infractions. The Committee or its designee shall determine the level of a violation consistent with this Section.

**B.** A flagrant violation occurs when a signatory buys, consigns, or otherwise accepts or handles a leafy green product and knows or should have known the product was grown, packed, shipped, processed or handled in violation of R3-9-602 and the violation:
1. Significantly increases the risk of delivering unsafe product into commerce;
2. Affects the integrity of the LGMA's food safety program; or
3. In the Committee's judgment, merits more serious treatment than a major deviation based on the consideration of, as relevant:
   a. The position of the employee responsible for the violation,
   b. Whether the employee responsible for the violation knowingly committed the violation,
   c. The circumstances surrounding the violation,
   d. Whether the signatory took prompt corrective action,
   e. Whether the signatory has committed the same or a similar violation previously, and
   f. Any other relevant facts.

**C.** A major deviation is a violation of R3-9-602 that may inhibit the maintenance of food safety, but that does not necessarily result in unsafe product.

**D.** The following violations constitute at least major deviations and are potentially flagrant violations:
1. Falsification of any record for any reason;
2. Spitting in the field;
3. Unclean sanitation facilities, including the presence of soiled toilet paper;
4. Failure to:
   a. Properly wash hands after using a restroom or returning to the field;
   b. Follow the best practices with respect to feces or fecal matter found in the field;
   c. Follow the best practices with respect to the use of compost or animal manure, including creating and maintaining proper records related to that use;
   d. Have a trace-back system;
   e. Sanitize gloves and knives;
   f. Follow a work health practices program concerning the transfer of human pathogens by workers; or
   g. Provide a Compliance Plan, as defined in the best practices, to an auditor;
5. Refusing an audit; and
6. Conditions for which an automatic "unsatisfactory" would be assessed by USDA if performing a GAP/GHP audit.

**E.** Violations constituting flagrant violations or major deviations are not limited to those listed in subsection (D).

**F.** A minor deviation is a violation of R3-9-602 that the signatory can correct within five business days of the audit and that does not necessarily increase the risk of a food borne illness.

**G.** A minor infraction is a violation of R3-9-602 that the signatory corrects before the auditor leaves the audited premises and that does not necessarily increase the risk of a food borne illness.

**H.** The Committee or its designee may assess a signatory with a major deviation if an auditor discovers several minor deviations or minor infractions of the same type or if a signatory fails to timely submit a corrective action plan.

**I.** Repeated major violations are limited to violations occurring during the current and prior fiscal year.

**R3-9-606. Corrective Action Plans**

**A.** A signatory who commits a flagrant violation, major deviation, or minor deviation shall correct the violation and submit a corrective action plan to the Committee or its designee within five business days of receipt of the audit report noting the violation. If the Committee or its designee rejects the corrective action plan, the signatory has 24 hours to submit a revised corrective action plan.

**B.** In the case of a flagrant violation or major deviation, once the Committee or its designee accepts the signatory's corrective action plan, an auditor shall perform an unannounced audit of the signatory within three business days.

**C.** The signatory shall comply with the corrective action plan.

**D.** Notwithstanding subsection (A), in the case of a violation that creates an immediate danger to public health, the signatory shall submit a correction action plan immediately and take necessary action to minimize the threat to public health.

Arizona Administrative CODE

3 A.A.C. 9 Supp. 21-4

www.azsos.gov

Office of the Secretary of State
ADMINISTRATIVE RULES DIVISION

# TITLE 3. AGRICULTURE

## CHAPTER 9. DEPARTMENT OF AGRICULTURE - AGRICULTURAL COUNCILS AND COMMISSIONS

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of October 1, 2021 through December 31, 2021



**Questions about these rules? Contact:**

| | |
|---|---|
| Department: | Arizona Department of Agriculture |
| Address: | 1688 W. Adams St.<br>Phoenix, AZ 85007 |
| Website: | www.azda.gov |
| Name: | Teressa Lopez |
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**The release of this Chapter in Supp. 21-4 replaces Supp. 19-4, 1-10 pages**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2021 is cited as Supp. 21-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the Code in Supp. 18-1 to comply with A.R.S. § 41-1012(B) and A.R.S. § 5302(1), (2)(d) through (e), and (3)(d) through (e).

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document's content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State's website, www.azsos.gov under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

Arizona Secretary of State
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Administrative Rules Division
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# TITLE 3. AGRICULTURE

## CHAPTER 9. DEPARTMENT OF AGRICULTURE - AGRICULTURAL COUNCILS AND COMMISSIONS

Authority: A.R.S. § 3-414(C)(11)

**Supp. 21-4**

***Chapter 9 heading amended by final rulemaking at 5 A.A.R. 4439, effective November 3, 1999 (Supp. 99-4).***

***Former Title 3, Chapter 9, Articles 1 through 7, Sections 3-9-101 through R3-9-703, renumbered to Title 3, Chapter 2, Articles 1 through 7, Sections 3-2-101 through R3-2-703 (Supp. 91-4).***

### CHAPTER TABLE OF CONTENTS

## ARTICLE 1. ARIZONA ICEBERG LETTUCE RESEARCH COUNCIL

**R3-9-101. Definitions**

In addition to the definitions in A.R.S. § 3-526, the following terms apply to this Article:

1. "AILRC" means the Arizona Iceberg Lettuce Research Council.
2. "Authorized signature" means the signature of an individual authorized to receive funds on behalf of the applicant and responsible for the execution of the applicant's project.
3. "Awardee" means a successful applicant to whom the AILRC awards grant funds for research on a specific project.
4. "Department" means the Arizona Department of Agriculture.
5. "Governmental unit" means any department, commission, council, board, bureau, committee, institution, agency, government corporation, or other establishment or official of the executive branch or corporation commission of this state, another state, or the federal government.
6. "Grant" means an award of financial support to an applicant according to A.R.S. § 3-526.02(B) and (C)(5).
7. "Grant award agreement" means a document that advises an applicant of the amount of money awarded following receipt by the AILRC of the applicant's signed acceptance.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3658, effective November 8, 2008 (Supp. 08-3).

**R3-9-102. Elections**

**A.** The AILRC shall elect officers as specified in A.R.S. § 3-526.02(A)(2) during the first quarter of each calendar year.

**B.** Officers continue in office until the next annual election.

**C.** An officer may be reelected successively.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

**R3-9-103. Hearings and Rehearings**

**A.** The AILRC shall follow the Uniform Administrative Procedure Act, A.R.S. Title 41, Chapter 6, Article 10, for a hearing before the AILRC.

**B.** A party may file a motion for rehearing or review under A.R.S. § 41-1092.09.

**C.** The AILRC shall grant a rehearing or review of a decision for any of the following causes materially affecting the moving party's rights:

1. The decision is not justified by the evidence or is contrary to law;
2. There is newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original proceeding;
3. One or more of the following deprived the party of a fair hearing:
   a. Irregularity or abuse of discretion in the conduct of the proceeding;
   b. Misconduct of the AILRC, the administrative law judge, or the prevailing party; or
   c. Accident or surprise that could not have been prevented by ordinary prudence; or
4. Excessive or insufficient sanction.

**D.** The AILRC may grant a rehearing or review to any or all of the parties. The rehearing or review may cover all or part of the issues for any of the reasons stated in subsection (C). An order granting a rehearing or review shall particularly state the grounds for granting the rehearing or review, and the rehearing or review shall cover only the grounds stated.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

**R3-9-104. Annual Report**

The AILRC shall prepare a report according to A.R.S. § 3-526.02(A)(5), by October 31 of each year.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

**R3-9-105. Expired**

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 1393, effective January 31, 2016 (Supp. 16-2).

**R3-9-106. Grants**

**A.** Grant application process.

1. The AILRC shall award grants according to the competitive grant solicitation requirements of this Article.
2. The AILRC shall post the grant application and manual on the AILRC's web site at least four weeks before the due date of a grant application.
3. The AILRC shall ensure that the grant application manual contains the following items:
   a. Grant topics related to AILRC programs specified by A.R.S. § 3-526.02(B) and (C)(5);
   b. A statement that the information contained in an application is not confidential;
   c. A statement that the AILRC funding source is primarily from per carton assessments on iceberg lettuce grown in Arizona;
   d. An application form including sections about the description of the grant project, scope of work to be performed, an authorized signature line, and a sample budget form;
   e. A statement that the applicant shall not include overhead expenses in the budget for the proposed project;
   f. The criteria that the AILRC shall use to evaluate an application;
   g. The date and time by which the applicant shall submit an application;
   h. The anticipated date of the AILRC award;
   i. A copy of the AILRC grant solicitation rules; and
   j. Any other information necessary for the grant application.
4. The AILRC shall not consider an application received by the AILRC after the due date and time.

**B.** Criteria. The AILRC shall consider the following when reviewing a grant application and deciding whether to award AILRC funds:

1. The applicant's successful completion of prior research projects,
2. The extent to which the proposed project identifies solutions to current issues facing the iceberg lettuce industry,
3. The extent to which the proposed project addresses future issues facing the iceberg lettuce industry,

4. The extent to which the proposed project addresses the findings of any industry surveys conducted within the previous year,
5. The appropriateness of the budget request in achieving the project objectives,
6. The appropriateness of the proposal time-frame to the stated project objectives, and
7. Relevant experience and qualifications of the applicant.

**C.** Public participation.
1. The AILRC shall make all applications available for public inspection by the business day following the application due date.
2. Before awarding a grant, the AILRC shall discuss and evaluate grant applications and proposed projects at a meeting conducted under A.R.S. § 38-431 et seq.

**D.** Evaluation of grant applications.
1. The AILRC may allow applicants to make oral or written presentations at the public meeting if time, applicant availability, and meeting space permit.
2. The AILRC may modify an applicant's proposed project in awarding funding.
3. The AILRC shall notify an applicant in writing of the AILRC's decision to fund, modify, or deny funding for a proposed project within 10 business days of the AILRC decision. The AILRC shall notify applicants by the U.S. Postal Service, commercial delivery, electronic mail, or facsimile.

**E.** Awards and project monitoring.
1. Before releasing grant funds, the AILRC shall execute a grant award agreement with the awardee. The awardee shall agree to accept the grant's legal requirements and conditions and authorize the AILRC to monitor the progress of the project by signing a grant award agreement.
2. The AILRC shall pay no more than 50% of the grant in the initial payment to the awardee.
3. During the term of the project, the awardee shall inform the AILRC of changes to the awardee's address, telephone number, or other contact information.
4. The AILRC may require an interim written report or oral presentation from the awardee during the pendency of the project.
5. The AILRC shall not award grant funds remaining after the initial payment until the awardee submits to the AILRC:
   a. A final research report, and
   b. An invoice for actual final project expenses not exceeding the remaining portion of the award.
6. The AILRC shall make research findings and reports resulting from any grant awarded by the AILRC available to Arizona iceberg lettuce producers.

**F.** Repayment. If the awardee does not complete the project as specified in the grant award agreement, the awardee shall return all unexpended grant funds within 30 days after receipt of a written request by the AILRC.

**G.** Governmental units.
1. The AILRC may request one or more governmental units to submit grant applications as prescribed in subsection (G)(3), without regard to subsections (A), (E)(2), and (E)(5).
2. The AILRC may issue grants to governmental units without regard to subsections (A), (E)(2), and (E)(5).
3. A governmental unit may apply to the AILRC for a grant when there is no pending request for grant applications under subsection (A) under the following conditions:
   a. The application shall include a description of the project, the scope of work to be performed, a budget that does not include overhead expenses, and an authorized signature.
   b. The application shall be available for public inspection upon receipt by the AILRC.

**Historical Note**
New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3658, effective November 8, 2008 (Supp. 08-3).

## ARTICLE 2. ARIZONA GRAIN RESEARCH AND PROMOTION COUNCIL

**R3-9-201. Definitions**

In addition to the definitions in A.R.S. § 3-581, the following term applies to this Article:

"AGRPC" means the Arizona Grain Research and Promotion Council.

"Department" means the Arizona Department of Agriculture.

**Historical Note**
Adopted effective August 28, 1986 (Supp. 86-4). Section R3-9-201 renumbered from R3-13-201 (Supp. 91-4). Amended effective December 22, 1993 (Supp. 93-4). Former Section R3-9-201 renumbered to R3-9-202; new Section R3-9-201 made by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

**R3-9-202. Fees; Grain Assessment and Refund**

**A.** The AGRPC shall annually prescribe the fee to be assessed per hundredweight of grain sold in Arizona within the limitations established under A.R.S. § 3-587.

**B.** The person who pays the fee required under subsection (A) shall ensure that:
1. The grain assessment fee is remitted to the AGRPC; and
2. The following information is provided to the AGRPC on a form obtained from the Department:
   a. First buyer's name, address, and telephone number;
   b. Report date and months covered by the report;
   c. Total amount remitted to the AGRPC for the reporting period;
   d. Producer's name, address, and telephone number;
   e. Type of grain and tonnage by grain type; and
   f. First buyer's or designee's signature.

**C.** Refund.
1. A producer may request a refund as prescribed under A.R.S. § 3-592 and shall provide the following information to the AGRPC on a form obtained from the Department:
   a. Producer's name, address, telephone number, and signature;
   b. Name of the first buyer;
   c. Amount of grain sold subject to the refund request; and
   d. First buyer's or designee's notarized signature confirming the purchase, funds withheld, and date remitted to the AGRPC.
2. An executive committee member shall authorize a refund as prescribed in A.R.S. § 3-592 if the person requesting the refund complies with the requirements of subsection (B)(1).

**Historical Note**
Section R3-9-202 renumbered from R3-9-201 and amended by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final

rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

**R3-9-203. Hearings**

**A.** The AGRPC shall use the uniform administrative procedures of A.R.S. Title 41, Chapter 6, Article 10 to govern any hearing before the AGRPC required under A.R.S. § 3-591.

**B.** A party may file a motion for rehearing or review under A.R.S. § 41-1092.09.

**C.** The AGRPC shall grant a rehearing or review of an administrative law decision for any of the following causes materially affecting the moving party's rights:

1. The decision is not justified by the evidence or is contrary to law;
2. There is newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original proceeding;
3. One or more of the following deprived the party of a fair hearing:
   a. Irregularity or abuse of discretion in the conduct of the proceeding;
   b. Misconduct of the AGRPC, the administrative law judge, or the prevailing party; or
   c. Accident or surprise which could not have been prevented by ordinary prudence; or
4. Excessive or insufficient sanction.

**D.** The AGRPC may grant a rehearing or review to any or all of the parties. The rehearing or review may cover all or part of the issues for any of the reasons stated in subsection (C). An order granting a rehearing or review shall particularly state the grounds for granting the rehearing or review, and the rehearing or review shall cover only the grounds stated.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

**R3-9-204. Records**

The Department shall retain the AGRPC's records as prescribed in A.R.S. § 3-586. A record may be reviewed at the Department's main office, Monday through Friday, except an Arizona legal holiday, during the hours of 8:00 a.m. to 5:00 p.m. A copy of a record will be provided according to the provisions of A.R.S. § 39-121 et seq.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

**R3-9-205. Grants**

**A.** Definitions.

"Authorized signature" means the signature of an individual authorized to receive funds on behalf of an applicant and responsible for the execution of the applicant's project.

"Awardee" means an applicant to whom the AGRPC awards grant funds for a proposed project.

"Governmental unit" means any department, commission, council, board, bureau, committee, institution, agency, government corporation, or other establishment or official of the executive branch or corporation commission of this state, another state, or the federal government.

"Grant" means an award of financial support to an applicant according to A.R.S. § 3-584(C)(5).

"Grant award agreement" means a document advising an applicant of the amount of money awarded following receipt by the AGRPC of the applicant's signed acceptance of the award.

**B.** Grant application process.

1. The AGRPC shall award grants according to the competitive grant solicitation requirements of this Article.
2. The AGRPC shall post the grant application and manual on the AGRPC's web site at least four weeks before the due date of a grant application.
3. The AGRPC shall ensure that the grant application and manual contain the following items:
   a. Grant topics related to AGRPC projects specified in A.R.S. § 3-584(C)(5);
   b. A statement that the information contained in a grant application is not confidential;
   c. A statement that the AGRPC funding source is primarily from assessments on the seed of barley and wheat of all classes produced in Arizona for use as food, feed, or seed or produced for any industrial or commercial use;
   d. An application form including sections about the description of the grant project, scope of work to be performed, an authorized signature line, and a sample budget form;
   e. A statement that the applicant shall not include overhead expenses in the budget for the proposed project;
   f. The criteria that the AGRPC shall use to evaluate an application;
   g. The date and time by which the applicant shall submit an application;
   h. The anticipated date of the AGRPC award;
   i. A copy of this Section consisting of grant solicitation procedures and requirements; and
   j. Any other information necessary for the grant application.
4. The AGRPC shall not evaluate an application received by the AGRPC after the due date and time.

**C.** Criteria. The AGRPC shall consider the following when reviewing a grant application and deciding whether to award AGRPC funds:

1. The applicant's successful completion of prior research projects, if applicable;
2. The extent to which the proposed project identifies solutions to current issues facing the grain industry;
3. The extent to which the proposed project addresses future issues facing the grain industry;
4. The extent to which the proposed project addresses the findings of any industry surveys conducted within the previous year;
5. The appropriateness of the budget request in achieving the project objectives;
6. The appropriateness of the proposal time-frame to the stated project objectives; and
7. Relevant experience and qualifications of the applicant.

**D.** Public participation.

1. The AGRPC shall make all applications available for public inspection by the business day following the application due date.
2. Before awarding a grant, the AGRPC shall discuss, evaluate, and make a decision on grant applications and proposed projects at a meeting conducted under A.R.S. § 38-431 et seq.

**E.** Evaluation of grant applications.

1. The AGRPC may allow applicants to make oral or written presentations at the public meeting if time, applicant availability, and meeting space permit.
2. The AGRPC may modify an applicant's proposed project in awarding funding.
3. The AGRPC shall notify an applicant in writing of the AGRPC's decision to fund, modify, or deny funding for a proposed project within 10 business days of the AGRPC decision. The AGRPC shall notify applicants by the U.S. Postal Service, commercial delivery, electronic mail, or facsimile.

**F.** Awards and project monitoring.
1. Before releasing grant funds, the AGRPC shall execute a grant award agreement with the awardee. The awardee shall agree to accept the grant's legal requirements and conditions and authorize the AGRPC to monitor the progress of the project by signing the grant award agreement.
2. The AGRPC shall pay no more than 50% of the grant in the initial payment to the awardee.
3. During the term of the project, the awardee shall inform the AGRPC of changes to the awardee's address, telephone number, or other contact information.
4. The AGRPC may require an interim written report or oral presentation from the awardee during the term of the project.
5. The AGRPC shall not award the grant funds remaining after the initial payment until the awardee submits to the AGRPC:
   a. A final research report, and
   b. An invoice for actual final project expenses not exceeding the remaining portion of the grant funds.
6. The AGRPC shall make research findings and reports resulting from any grant awarded by the AGRPC available to Arizona grain producers.

**G.** Repayment. If the awardee does not complete the project as specified in the grant award agreement, the awardee shall return all unexpended grant funds within 30 days after receipt of a written request by the AGRPC.

**H.** Governmental units.
1. The AGRPC may request one or more governmental units to submit grant applications as prescribed in subsection (H)(3), without regard to subsections (B), (F)(2), and (F)(5).
2. The AGRPC may issue grants to governmental units without regard to subsections (B), (F)(2), and (F)(5).
3. A governmental unit may apply to the AGRPC for a grant when there is no pending request for grant applications under subsection (B) under the following conditions:
   a. The application shall include a description of the project, the scope of work to be performed, a budget that does not include overhead expenses, and an authorized signature.
   b. The application shall be available for public inspection upon receipt by the AGRPC.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 4684, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

## ARTICLE 3. ARIZONA COTTON RESEARCH AND PROTECTION COUNCIL

### R3-9-301. Ginning and Remittance Forms

**A.** Each September the Arizona Cotton Research and Protection Council shall send the ginning and remittance report forms and a fee schedule to the operator of each gin for which a report was made during the previous year. A gin operator who has not submitted a report in the previous year may obtain the report forms and a fee schedule from the Arizona Cotton Research and Protection Council office.

**B.** Each gin operator who gins for Arizona producers during the current crop year shall complete the following reports and submit them with the appropriate fees, to the Arizona Cotton Research and Protection Council within the times specified below:
1. On or before February 15 of each year:
   a. The name and number of the reporting gin;
   b. The business mailing address, telephone number, and county of the reporting gin;
   c. The name of the authorized agent for the gin;
   d. The crop year;
   e. The name and mailing address of each crop producer;
   f. The Farm Service Agency (FSA) farm number;
   g. An estimate of the number of bales to be ginned by March 15 from cotton grown at or below 2,700 feet elevation; and
   h. An estimate of the number of bales to be ginned by March 15 from cotton grown above 2,700 feet elevation;
2. On or before March 15 of each year:
   a. The information in subsections (B)(1)(a) through (f),
   b. The total number of bales actually ginned and the certification number issued by the Department for meeting the tillage deadline for cotton grown at or below 2,700 feet elevation, and
   c. The total number of bales actually ginned from cotton grown above 2,700 feet elevation.

**Historical Note**

Adopted as an emergency effective September 10, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Adopted as a permanent rule effective March 7, 1985 (Supp. 85-2). Amended subsection (A) as an emergency effective November 5, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Amended subsection (A) as permanent action effective February 5, 1986 (Supp. 86-1). Amended subsection (A) effective September 24, 1986 (Supp 86-5). Former Section R3-12-201 repealed and a new Section R3-12-201 adopted effective December 2, 1987 (Supp. 87-4). Section 3-9-301 renumbered from R3-12-201 (Supp. 91-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 4439, effective November 3, 1999 (Supp. 99-4).

### R3-9-302. Expired

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 4741, effective January 1, 2005 (Supp. 04-4). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 3188, effective October 2, 2019 (Supp. 19-4).

### R3-9-303. Weather Related Extensions

**A.** For the purpose of this Section:
1. "Council" means the Arizona Cotton Research and Protection Council.
2. "Qualifying weather event" means substantial interference with post-harvest activities as outlined in subsection (E)(1) to detach the cotton root from the soil caused by significant rain or moisture or by sustained winds within an established PM10 nonattainment area.

**B.** A cotton producer may request an extension of the tillage deadline in R3-4-204(E) based on a qualifying weather event that has delayed or prevented compliance.

**C.** A cotton producer requesting an extension shall submit the following information to the Council Staff Director:
1. The producer's name, address, and telephone number;
2. The registered Farm Service Agency (FSA) farm names of the farms for which the extension is requested;
3. The legal description of the fields or an accurate scale farm map of the fields for which the extension is requested;
4. A detailed description of the qualifying weather events supporting the extension request, including the dates of the events; and
5. The number of days requested as an extension of the tillage deadline.

**D.** Submission Deadline.
1. Extension requests shall be received a minimum of one business day prior to the tillage deadline.
2. Extension requests that are illegible or missing information required by subsection (C) shall be considered incomplete and returned to the requestor with a written explanation of the deficiencies. Corrected extension requests shall also be received a minimum of one business day prior to the tillage deadline.

**E.** Administrative Review.
1. The Council Staff Director may amend, grant or deny a request for extension based on the information provided and any other relevant information available, including but not limited to data collected from meteorological sources, staff recommendations, field notes and photographs.
2. The Council Staff Director shall issue a written notice granting or denying an extension request within ten business days of receipt of a complete request advising whether or not the request fell within the parameters of a qualified weather event.

**F.** Blanket Extensions. The Council, by vote, may authorize a blanket weather-related extension for a county, cultural zone or a subset of either based on an area-wide qualifying weather event or events.

**Historical Note**
Section made by emergency rulemaking at 20 A.A.R. 124, effective January 10, 2014, for 180 days (Supp. 14-1). Emergency expired; new Section made by final rulemaking at 20 A.A.R. 2521, effective August 18, 2014 2014 (Supp. 14-3).

## ARTICLE 4. EXPIRED

*Article 4, consisting of Sections R3-9-401 through R3-9-405, formerly the rules for the Arizona Wine Commission expired under A.R.S. § 41-1056(E). The rules are no longer authorized as the Commission was terminated on July 1, 2004, under A.R.S. § 41-3004.18. The statutes under which the Commission operated, A.R.S. §§ 3-551 through 3-557, added by Laws 1993, Ch. 40, § 1, were repealed on January 1, 2005, by A.R.S. § 41-3004.18. Accordingly, under A.R.S. § 41-1011(C), the rules of this agency have been removed from the Code. The rescinded Article is on file in the Office of the Secretary of State (Supp. 05-2).*

*Article 4, consisting of Sections R3-9-401 through R3-9-405, made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1).*

**R3-9-401. Expired**

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

**R3-9-402. Expired**

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

**R3-9-403. Expired**

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

**R3-9-404. Expired**

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

**R3-9-405. Expired**

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

## ARTICLE 5. ARIZONA CITRUS RESEARCH COUNCIL

*Article 5, consisting of Sections R3-9-501 through R3-9-505, made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).*

**R3-9-501. Definitions**
*"Department" means the Arizona department of agriculture.* A.R.S. § 3-468(3).

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

**R3-9-502. Elections**

**A.** The Council shall elect officers during the first quarter of each calendar year.

**B.** Officers shall continue in office until the next annual election is held.

**C.** An officer may be successively reelected.

**Historical Note**
New Section made by final rulemaking at 9 A.A.R. 5548,

effective December 2, 2004 (Supp. 03-4).

**R3-9-503. Hearings**

**A.** The Council shall use the uniform administrative procedures of A.R.S. Title 41, Chapter 6, Article 10 to govern any hearing before the Council.

**B.** A party may file a motion for rehearing or review under A.R.S. § 41-1092.09.

**C.** The Council shall grant a rehearing or review of an administrative law decision for any of the following causes materially affecting the moving party's rights:
1. The decision is not justified by the evidence or is contrary to law;
2. There is newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original proceeding;
3. One or more of the following deprived the party of a fair hearing:
   a. Irregularity or abuse of discretion in the conduct of the proceeding;
   b. Misconduct of the Council, the administrative law judge, or the prevailing party; or
   c. Accident or surprise that could not have been prevented by ordinary prudence; or
4. Excessive or insufficient sanction.

**D.** The Council may grant a rehearing or review to any or all of the parties. The rehearing or review may cover all or part of the issues for any of the reasons stated in subsection (C). An order granting a rehearing or review shall particularly state the grounds for granting the rehearing or review, and the rehearing or review shall cover only the grounds stated.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

**R3-9-504. Annual Report**

The Council shall prepare an annual report as prescribed under A.R.S. § 3-468.02(A)(5), by October 31.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

**R3-9-505. Records**

The Department shall retain the Council's records as authorized by A.R.S. § 3-468.02(A)(4). A record may be reviewed at the Department's main office, Monday through Friday, except an Arizona legal holiday, during the hours of 8:00 a.m. to 5:00 p.m. A copy of a record shall be provided according to the provisions of A.R.S. § 39-121 et seq.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

**R3-9-506. Grants**

**A.** Definitions.
1. "ACRC" means the Arizona Citrus Research Council.
2. "Authorized signature" means the signature of an individual authorized to receive funds on behalf of the applicant and responsible for the execution of the applicant's project.
3. "Awardee" means a successful applicant to whom the ACRC awards grant funds for research on a specific project.
4. "Governmental unit" means any department, commission, council, board, bureau, committee, institution, agency, government corporation, or other establishment or official of the executive branch or corporation commission of this state, another state, or the federal government.
5. "Grant" means an award of financial support to an applicant according to A.R.S. § 3-468.02(B) and (C)(5).
6. "Grant award agreement" means a document advising the applicant of the amount of money awarded following receipt by the ACRC of the applicant's signed acceptance.

**B.** Grant application process.
1. The ACRC shall award grants according to the competitive grant solicitation requirements of this Article.
2. The ACRC shall post the grant application and manual on the ACRC's web site at least four weeks before the due date of a grant application.
3. The ACRC shall ensure that the grant application manual contains the following items:
   a. Grant topics related to ACRC programs specified by A.R.S. § 3-468.02(B) and (C)(5);
   b. A statement that the information contained in an application is not confidential;
   c. A statement that the ACRC funding source is primarily from per carton assessments on citrus grown in Arizona;
   d. An application form including sections about the description of the grant project, scope of work to be performed, an authorized signature line, and a sample budget form;
   e. A statement that the applicant shall not include overhead expenses in the budget for the proposed project;
   f. The criteria that the ACRC shall use to evaluate an application;
   g. The date and time by which the applicant shall submit an application;
   h. The anticipated date of the ACRC award;
   i. A copy of the ACRC grant solicitation rules; and
   j. Any other information necessary for the grant application.
4. The ACRC shall not consider an application received by the ACRC after the due date and time.

**C.** Criteria. The ACRC shall consider the following when reviewing a grant application and deciding whether to award ACRC funds:
1. The applicant's successful completion of prior research projects,
2. The extent to which the proposed project identifies solutions to current issues facing the citrus industry,
3. The extent to which the proposed project addresses future issues facing the citrus industry,
4. The extent to which the proposed project addresses the findings of any industry surveys conducted within the previous year,
5. The appropriateness of the budget request in achieving the project objectives,
6. The appropriateness of the proposal time-frame to the stated project objectives, and
7. Relevant experience and qualifications of the applicant.

**D.** Public participation.
1. The ACRC shall make all applications available for public inspection by the business day following the application due date.
2. Before awarding a grant, the ACRC shall discuss and evaluate grant applications and proposed projects at a meeting conducted under A.R.S. § 38-431 et seq.

**E.** Evaluation of grant applications.

1. The ACRC may allow applicants to make oral or written presentations at the public meeting if time, applicant availability, and meeting space permit.
2. The ACRC may modify an applicant's proposed project in awarding funding.
3. The ACRC shall notify an applicant in writing of the ACRC's decision to fund, modify, or deny funding for a proposed project within 10 business days of the ACRC decision. The ACRC shall notify applicants by the U.S. Postal Service, commercial delivery, electronic mail, or facsimile.

**F.** Awards and project monitoring.
1. Before releasing grant funds, the ACRC shall execute a grant award agreement with the awardee. The awardee shall agree to accept the grant's legal requirements and conditions and authorize the ACRC to monitor the progress of the project by signing a grant award agreement.
2. The ACRC shall pay no more than 50% of the grant in the initial payment to the awardee.
3. During the term of the project, the awardee shall inform the ACRC of changes to the awardee's address, telephone number, or other contact information.
4. The ACRC may require an interim written report or oral presentation from the awardee during the pendency of the project.
5. The ACRC shall not award the grant funds remaining after the initial payment until the awardee submits to the ACRC:
   a. A final research report, and
   b. An invoice for actual final project expenses not exceeding the remaining portion of the award.
6. The ACRC shall make research findings and reports resulting from any grant awarded by the ACRC available to Arizona citrus producers.

**G.** Repayment. If the awardee does not complete the project as specified in the grant award agreement, the awardee shall return all unexpended grant funds within 30 days after receipt of written request by the ACRC.

**H.** Governmental units.
1. The ACRC may request one or more governmental units to submit grant applications as prescribed in subsection (H)(3), without regard to subsections (B), (F)(2), and (F)(5).
2. The ACRC may issue grants to governmental units without regard to subsections (B), (F)(2), and (F)(5).
3. A governmental unit may apply to the ACRC for a grant when there is no pending request for grant applications under subsection (B) under the following conditions:
   a. The application shall include a description of the project, the scope of work to be performed, a budget that does not include overhead expenses, and an authorized signature.
   b. The application shall be available for public inspection upon receipt by the ACRC.

**Historical Note**
New Section made by final rulemaking at 12 A.A.R. 176, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3665, effective November 8, 2008 (Supp. 08-3).

## ARTICLE 6. LEAFY GREENS FOOD SAFETY COMMITTEE

### R3-9-601. Definitions

"Act" means A.R.S. Title 3, Chapter 3, Article 1.

"Auditor" or "Inspector" means a state or federal agricultural regulatory agency or their designee(s), or a private entity contracted by the Committee to perform inspections authorized by the Act.

"Best practices" means the "Commodity Specific Food Safety Guidelines for the Production and Harvest of Lettuce and Leafy Greens, as amended by the Committee. This document is incorporated by reference and is available for review online at the Arizona Leafy Greens Marketing Agreement website and at the Arizona Department of Agriculture, 1688 W. Adams Street, Phoenix, Arizona 85007.

"Committee" means the Leafy Greens Food Safety Committee established pursuant to the Marketing Agreement.

"LGMA" or "Marketing Agreement" means the Arizona Leafy Green Products Shipper Marketing Agreement approved pursuant to the Act. This document is incorporated by reference and is available for review online at the Arizona Leafy Greens Marketing Agreement website and at the Arizona Department of Agriculture, 1688 W. Adams Street, Phoenix, Arizona 85007.

"SOP" means standard operating procedure.

**Historical Note**
New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 1767, effective August 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4). Amended by exempt rulemaking at 18 A.A.R. 2928, effective August 1, 2012 (Supp. 12-4). Amended by final exempt rulemaking at 19 A.A.R. 4019, effective October 15, 2013 (Supp. 13-4). Amended by final exempt rulemaking pursuant to A.R.S. § 3-414(C)(11) at 21 A.A.R. 3082, effective August 25, 2015 (Supp. 15-4). Amended by exempt rulemaking at 28 A.A.R. 198 (January 14, 2022), with an effective date of September 17, 2021, as selected by the Department (Supp. 21-4).

### R3-9-602. Best Practices; LGMA Compliance

**A.** Signatories shall comply with the best practices, maintain a trace-back system, and be subject to periodic audit by an auditor.

**B.** Signatories shall only buy, consign, or otherwise accept or handle leafy green products (grown in Arizona) from a shipper or producer who is in compliance with the best practices (including recordkeeping requirements), maintains a trace-back system, and is subject to periodic audit by an auditor.

**C.** When the best practices require a SOP, there shall be an appropriate SOP and that SOP shall be followed.

**Historical Note**
New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4). Amended by final exempt rulemaking at 19 A.A.R. 4019, effective October 15, 2013 (Supp. 13-4).

### R3-9-603. Service Mark Usage

**A.** A signatory's compliance with the LGMA and R3-9-602 is a condition precedent and subsequent to the signatory's privilege to use the service mark.

**B.** An authorized signatory may use the service mark on all bills of lading and on other documents.

**C.** A signatory shall:
1. Use the service mark without reference to a private brand or label.

2. Provide reasonable assurances that the signatory has a system in place to comply with this Section, maintain records sufficient to audit the system for the duration of the LGMA, and make those records available to the Committee upon request.

**D.** A signatory shall not:
1. Use the service mark on packaging or product or as a certification mark to certify product.
2. Use the service mark as the signatory's own mark or as the exclusive representation of its business entity.
3. Insert within or overlap the boundaries of the service mark with the signatory's name or trademark.
4. Alter the service mark in any way other than proportionately adjusting the size of the service mark.

**Historical Note**
New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4).

**R3-9-604. Loss of Use of Service Mark**

**A.** A signatory shall lose the privilege to use the service mark if the signatory:
1. Commits a flagrant violation or repeated major deviation;
2. Fails to comply with R3-9-603;
3. Has not paid assessments due for the prior fiscal year; or
4. Withdraws from participation in the LGMA pursuant to Article XVI, section C of the LGMA.

**B.** The first flagrant violation or repeated major deviation shall result in a suspension of the privilege to use the service mark for a minimum two-week period.

**C.** A flagrant violation or repeated major deviation following the first flagrant violation or repeated major deviation shall result in an indefinite suspension of the privilege to use the service mark.

**D.** A flagrant violation or repeated major deviation following a suspension pursuant to subsection (C) shall result in an indefinite revocation of the privilege to use the service mark. The privilege to use the service mark shall not be restored to the signatory for a minimum of two years unless the signatory demonstrates to the satisfaction of the auditor and the Committee a significant change in management and brand.

**E.** A signatory whose privilege to use the service mark is suspended or revoked pursuant to subsections (B) through (D) shall not use the service mark until the signatory has undergone at least one new audit without the finding of any major deviations or flagrant violations and has evidenced that the signatory has corrected any minor deviations found.

**F.** At least two weeks of any suspension of the privilege to use the service mark under subsections (B) through (D) shall occur between December 1 and March 31.

**G.** The Committee may accelerate the progression of penalties under this Section if the signatory's product seriously affects a person's health and the signatory handled the product with intentional, knowing or reckless disregard for the signatory's obligations under the LGMA and best practices.

**H.** A signatory shall not lose the privilege to use the service mark under subsections (A)(1) and (2) without an opportunity for a hearing under A.R.S. Title 41, Chapter 6, Article 10, except if the Committee finds that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the Committee may order summary suspension of a signatory's privilege to use the service mark.

**I.** A signatory that loses the privilege to use the mark under subsection (A)(3) shall pay all assessments due from prior fiscal years, including penalties and interest, before regaining the privilege to use the service mark.

**J.** The Committee may publish a list of signatories whose privilege to use the service mark has been suspended.

**Historical Note**
New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4). Amended by final exempt rulemaking at 19 A.A.R. 4019, effective October 15, 2013 (Supp. 13-4).

**R3-9-605. Violation Levels; Repeated Violations**

**A.** Violations of R3-9-602 fall into four levels: flagrant violations, major deviations, minor deviations, and minor infractions. The Committee or its designee shall determine the level of a violation consistent with this Section.

**B.** A flagrant violation occurs when a signatory buys, consigns, or otherwise accepts or handles a leafy green product and knows or should have known the product was grown, packed, shipped, processed or handled in violation of R3-9-602 and the violation:
1. Significantly increases the risk of delivering unsafe product into commerce;
2. Affects the integrity of the LGMA's food safety program; or
3. In the Committee's judgment, merits more serious treatment than a major deviation based on the consideration of, as relevant:
   a. The position of the employee responsible for the violation,
   b. Whether the employee responsible for the violation knowingly committed the violation,
   c. The circumstances surrounding the violation,
   d. Whether the signatory took prompt corrective action,
   e. Whether the signatory has committed the same or a similar violation previously, and
   f. Any other relevant facts.

**C.** A major deviation is a violation of R3-9-602 that may inhibit the maintenance of food safety, but that does not necessarily result in unsafe product.

**D.** The following violations constitute at least major deviations and are potentially flagrant violations:
1. Falsification of any record for any reason;
2. Spitting in the field;
3. Unclean sanitation facilities, including the presence of soiled toilet paper;
4. Failure to:
   a. Properly wash hands after using a restroom or returning to the field;
   b. Follow the best practices with respect to feces or fecal matter found in the field;
   c. Follow the best practices with respect to the use of compost or animal manure, including creating and maintaining proper records related to that use;
   d. Have a trace-back system;
   e. Sanitize gloves and knives;
   f. Follow a work health practices program concerning the transfer of human pathogens by workers; or
   g. Provide a Compliance Plan, as defined in the best practices, to an auditor;
5. Refusing an audit; and
6. Conditions for which an automatic "unsatisfactory" would be assessed by USDA if performing a GAP/GHP audit.

**E.** Violations constituting flagrant violations or major deviations are not limited to those listed in subsection (D).
**F.** A minor deviation is a violation of R3-9-602 that the signatory can correct within five business days of the audit and that does not necessarily increase the risk of a food borne illness.
**G.** A minor infraction is a violation of R3-9-602 that the signatory corrects before the auditor leaves the audited premises and that does not necessarily increase the risk of a food borne illness.
**H.** The Committee or its designee may assess a signatory with a major deviation if an auditor discovers several minor deviations or minor infractions of the same type or if a signatory fails to timely submit a corrective action plan.
**I.** Repeated major violations are limited to violations occurring during the current and prior fiscal year.

**Historical Note**
New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4). Amended by final exempt rulemaking at 19 A.A.R. 4019, effective October 15, 2013 (Supp. 13-4).

**R3-9-606. Corrective Action Plans**

**A.** A signatory who commits a flagrant violation, major deviation, or minor deviation shall correct the violation and submit a corrective action plan to the Committee or its designee within five business days of receipt of the audit report noting the violation. If the Committee or its designee rejects the corrective action plan, the signatory has 24 hours to submit a revised corrective action plan.
**B.** In the case of a flagrant violation or major deviation, once the Committee or its designee accepts the signatory's corrective action plan, an auditor shall perform an unannounced audit of the signatory within three business days.
**C.** The signatory shall comply with the corrective action plan.
**D.** Notwithstanding subsection (A), in the case of a violation that creates an immediate danger to public health, the signatory shall submit a correction action plan immediately and take necessary action to minimize the threat to public health.

**Historical Note**
New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 19 A.A.R. 4019, effective October 15, 2013 (Supp. 13-4).

# 3-401. Definitions

In this article, unless the context otherwise requires:

1. "Affected commodity" means the specific citrus, fruit or vegetable that is regulated pursuant to article 2 or 4 of this chapter and that is subject to the marketing agreement or order or the proposed marketing agreement or order.

2. "Affected person" means a producer or shipper of an affected commodity.

3. "Associate director" means the associate director of the citrus, fruit and vegetable division of the department.

4. "Marketing agreement" or "agreement" means an agreement that is developed by producers or shippers of the affected commodity and that is entered into by the director pursuant to this article.

5. "Marketing commission" or "commission" means the marketing commission established under section 3-413.

6. "Marketing committee" or "committee" means a marketing committee established by a marketing agreement according to section 3-426.

7. "Marketing order" or "order" means an order that is developed by producers or shippers of the affected commodity and that is issued by the director pursuant to this article.

8. "Person" means any individual, firm, corporation, trust, association or partnership.

9. "Producer" means a person that has a financial interest in producing or causing citrus, fruit or vegetable commodities to be produced for market in commercial quantities.

10. "Shipper" means a person that engages in shipping, transporting, selling or marketing citrus, fruits or vegetables under the shipper's own registered trademark or label or a person that first markets the fruits or vegetables for the producer.

11. "Volume" means cartons or the equivalent weight of Arizona-grown products marketed in the preceding marketing season.

12. "Written assent" means a signed statement of an affected person consenting to the terms of a marketing order.

# 3-404. Marketing order and marketing agreement programs

A. A marketing order or marketing agreement applies to all producers and shippers included under the terms of the order or agreement.

B. A marketing order or marketing agreement may:

1. Provide for establishing standards for the quality, condition, size or maturity of a commodity marketed in or shipped outside this state. Standards shall not be less than the standards provided by articles 2 and 4 of this chapter and rules adopted pursuant to those articles.

2. Provide for establishing, and verifying compliance with, food safety standards.

3. Provide for plans to conduct programs for advertising and sales promotion.

4. Provide for research studies to improve production, distribution and marketing.

5. Provide for educational programs designed to inform producers and shippers about quality improvement or about practices, procedures and methods used in production, processing and marketing.

6. Provide for research and educational programs concerning health, food, nutritional, therapeutic and dietetic qualities or for developing new food products or new uses for agricultural products.

7. Provide programs to control and eradicate insects, disease and parasites.

8. Provide for establishing and regulating the use of an official brand, trade name or label.

9. Provide programs to gather and disseminate weather data to producers.

10. Provide for developing and funding programs, jointly or cooperatively, with public or private organizations, including funding marketing information services.

11. Authorize persons to participate in hearings regarding agricultural chemicals that are used by the affected commodity.

# 3-414. Powers and duties of a marketing commission or marketing committee

A. A marketing commission or marketing committee shall:

1. Collect, receive and disburse any monies to be used to administer a marketing order or marketing agreement.

2. Annually elect a chairman, secretary and treasurer from among its members.

3. Meet at least twice annually or at additional times called by the chairman or when requested by a quorum of the marketing commission or marketing committee.

4. Keep a permanent record of its proceedings and make these records available for public inspection for any lawful purpose.

5. Prescribe any assessments to be assessed within the limits prescribed in this article, the marketing order or the marketing agreement.

B. A marketing commission shall:

1. Prepare for the regulated commodity an annual report of its activities, receipts and expenditures. A copy of the annual report shall be available to any interested person on request.

2. Organize and administer any election called under this article or the marketing order.

C. A marketing commission or marketing committee may:

1. Sue and be sued as a marketing commission or marketing committee, without individual liability, for acts of the marketing commission or marketing committee within the scope of the powers and duties conferred on it by this article, the marketing order or the marketing agreement.

2. Enter into contracts to carry out the purposes of this article, the marketing order or the marketing agreement.

3. Appoint committees or subcommittees of the marketing commission or marketing committee, ex officio marketing commission or marketing committee members or advisory groups composed of representatives from organizations, institutions or businesses related to or interested in the regulated commodity.

4. Employ or retain and fix the compensation of a qualified person or qualified entity to manage the marketing order or marketing agreement, on behalf of the marketing commission or marketing committee, and other personnel that are necessary to carry out the provisions of this article, the order or the agreement.

5. Cooperate with any local, state or nationwide organization or agency engaged in work or activities similar or related to those of the commission or the committee and enter into contracts with the organizations or agencies for carrying on joint programs.

6. Make grants to research agencies to finance appropriate studies, or to purchase or acquire equipment and facilities consistent with the marketing order or marketing agreement.

7. Act jointly and in cooperation with this state or any other state or the federal government and spend monies to administer any program deemed by the commission or committee to be beneficial to the affected commodity.

8. Accept grants, donations, contributions, gifts, property or services or other assistance from public or private sources.

9. Provide educational materials to:

(a) Interested parties that are not affected persons at a charge fixed by the commission or committee commensurate with the cost of compilation, publication and issuance.

(b) Public officials without charge.

10. Return assessments to affected persons on a pro rata basis to the extent that monies collected exceed budgeted expenses.

11. Adopt rules necessary to promptly and effectively administer this article. Title 41, chapter 6 does not apply to rule making under this article, but the commission or committee shall provide fifteen days' advance notice of the meeting at which rules will be adopted. The commission or committee shall receive public testimony at the meeting regarding the rules.

12. Refer to persons regulated under a marketing order for an advisory vote the question of setting assessments or establishing or continuing any program authorized by the order.

13. Investigate and prosecute in the name of this state any legal action to enforce the collection or ensure payment of the authorized assessments.

14. Gather data or any other information the commission or committee deems necessary to administer and enforce the order or agreement.

15. Receive complaints of violations of the order or agreement and refer the complaints to the proper authorities.

16. Provide for an annual audit of its accounts by a qualified public accounting firm and, if an audit or financial statement is prepared, make the audit or financial statement available to any affected person and the auditor general on request.

**ARIZONA STATE BOARD OF DENTAL EXAMINERS**
Title 4, Chapter 1, Article 11, 12, 14, 15, & 18

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** July 1, 2025

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 17, 2025

**SUBJECT:** **ARIZONA STATE BOARD OF DENTAL EXAMINERS**
Title 4, Chapter 1, Articles 11, 12, 14, 15, and 18

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**Summary**

This Five-Year Review Report (5YRR) from the Arizona State Board of Dental Examiners ("Board") covers twenty-two (22) rules in Title 4, Chapter 11, Articles 11, 12, 14, 15, and 18. The Board states that it protects the health, safety, and welfare of the citizens of Arizona by regulating the practice of dentistry. The rules address the following:

- Article 11: Advertising;
- Article 12: Continuing Dental Education and Renewal Requirements;
- Article 14: Dispensing Drugs and Devices;
- Article 15: Complaints, Investigations, Disciplinary Action; and
- Article 18: Business Entities.

In the previous report approved by the Council, the Board proposed to amend 7 rules by December 2020. The Department completed rulemakings for 6 of the 7 proposed amendments. The Department indicated that they did not complete the rulemaking for R4-11-1102 because the Department prioritized rulemakings that dealt with safety concerns, such as anesthesia and sedation.

**Proposed Action**

The Board did not review R4-11-1406 with the intent that the rule expire because HB2071 amended the authorizing statute A.R.S. § 32-198, and removed the authorizing authority for this rule.

The Board indicates that R4-11-1102 needs to be amended to include Dental Therapists in subsection (D), which is pursuant to A.R.S. § 32-1276 et. seq. This is the same proposed amendment from the 2020 report. The Board does not propose amending any other rule because the Board indicates that the remaining rules are clear, concise, understandable, and meeting their objectives. The Board indicates that they intend on completing a rulemaking by December 2025.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Board cites both general and specific statutory authority for these rules.

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

The Board determined from its analysis that the economic impact is minimal and has not differed from that projected when the rules were amended by final rulemaking. It states that the main costs are born by the agency and include staff time to process new and renewal applications. The Board states further that its analysis indicates that establishing standards of practice is beneficial to society and promotes consistency of service and improvement of outcomes as well as negating the confusion that comes from either too many or nonexistent standards.

Stakeholders include the Board, its licensees, and the general public.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

Yes, the Board believes the rules impose the least burden and probable costs to regulated persons, which are outweighed by the probable benefits.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Board indicates it received no written criticisms of the rules in the last five years.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Board indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Board indicates the rules consistent with other rules and statutes with the exception of R4-11-1102. The Board indicates that this rule is not consistent with A.R.S. Title 32, Chapter 18. More specifically, the Board states that the rule does not properly account for dental therapists.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Board indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Board indicates the rules are enforced as written

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Board states that there is no corresponding federal law for the rules, except for R4-11-1405 (Compliance) and R4-11-1406 (Dispensing for Profit Registration and Renewal). The corresponding federal regulation for these two rules is 21 CFR 1300. The Board states that these two rules are not more stringent than the corresponding federal regulation.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Board has indicated that the rules, with the exception of R4-11-1202, do not require a license or permit. The Board states that this rule is exempt from the general permit requirement of A.R.S. § 41-1037 because it is specifically authorized by A.R.S. Title 31, Chapter 11, Article 2. Council staff agrees with the Board's reasoning and believe that the requirements of §41-1037 do not apply because the license is specifically authorized by statute.

**11. Conclusion**

This Five-Year Review Report (5YRR) from the Arizona State Board of Dental Examiners ("Board") covers twenty-two (22) rules in Title 4, Chapter 11, Articles 11, 12, 14, 15, and 18. The Board completed their proposed course of action for 6 of the 7 rules that were identified to be improved. In this current report, the Board plans on amending the one rule that was not completed by December 2025. Additionally, the board did not review R4-11-406 with the intent the rule expire because the Department lost statutory authority for the rule in 2024 via the passage of HB 2071

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends approval of this report.

**Arizona State Board of Dental Examiners**
"Caring for the Public's Dental Health
and Professional Standards"

1740 West Adams Street, Suite 2470
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March 21, 2025

Jessica Klein, Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Ave., Ste. 402
Phoenix, AZ 85007

***Re: Five-year-review Report for 4 A.A.C. 11, Articles 11, 12, 14, 15, and 18***

In compliance with A.R.S. § 41-1056(A), the Arizona State Board of Dental Examiners (Board) has reviewed most of the rules in A.A.C. Title 4, Chapter 1, Articles 11, 12, 14, 15, and 18 and submits the enclosed report to the Council for approval.

The Board did not review R4-11-1406 with the intent that the rule expires because HB2071 (2024) repealed the authorizing statute for that rule.

The Board certifies that it is in compliance with A.R.S. § 41-1091. The Board contact person for this report is Ryan Edmonson, Executive Director, who may be reached at 602.542.4493.

Sincerely,

Ryan Edmonson
Executive Director
Arizona State Board of Dental Examiners

Enclosure

The Americans with Disabilities Act: Persons with disabilities may request reasonable accommodations, such as sign language interpreters. Requests should be made as early as possible to allow time to arrange the accommodation. This document is available in alternative format upon request.

**Arizona State Board of Dental Examiners**

4 A.A.C. 11, Articles 11, 12, 14, 15, and 18

April 2025

**TABLE OF CONTENTS**

## INTRODUCTION

The Arizona Board of Dental Examiners protects the health, safety and welfare of the citizens of Arizona by regulating the practice of dentistry.

The rules in 4 A.A.C. 11, Article 11, establish the permissible advertising activities of a dentist, dental hygienist, or denturist and the permissible advertising activities of a dentist who advertises as a recognized specialist. The rules in 4 A.A.C. 11, Article 12, establish a continuing dental education requirement for licensees, certificate holders, and restricted permit holders, address documentation, compliance, renewal, and exception issues regarding the continuing education requirements for licensure, establish the number of continuing education hours by topics that are required for dentists and dental consultants, establish the number of continuing education hours by topics that are required for dental hygienist licensure, establish the number of continuing education hours by topics that are required for denturist certification, establish the number of continuing education hours by topics that are required for a dental restricted permit holder, establish the number of continuing education hours by topics that are required for a dental hygiene restricted permit holder, establish the number of continuing education hours by topics that are required for a retired licensee or certificate holder, and establish the types of continuing education courses recognized by the Board. The rules in 4 A.A.C. 11, Article 14, establish the requirements of a prescription order for dispensing by a dentist, the specific labeling and dispensing requirements for dispensing by a dentist, the storage and packaging requirements for

dispensing by a dentist, the recordkeeping requirements for dispensing by a dentist, the reporting requirements for a theft or loss of controlled substances and the possible disciplinary actions for violations of Article 14, and the registration and renewal requirements for a dentist who dispenses drugs and devices for profit. The rules in 4 A.A.C. 11, Article 15, establish that a complainant or regulated party against whom a complaint is filed shall not engage in ex-parte communication with the decision maker in the matter, the qualifications for the Board's complaint investigators, the Board's complaint review procedures, and the requirements for postponing an investigative or formal interview. The rules in 4 A.A.C. 11, Article 18, establish the requirements for business entity registration and the requirements for business entity display of registration.

## INFORMATION THAT IS IDENTICAL FOR ALL RULES

1. **Effectiveness in Achieving Objectives**

   All the rules reviewed are effective in achieving their stated objectives.

2. **Written Criticisms of the Rules Received in the Past Five Years**

   The agency has not received any written criticisms of the rules in the past five years.

3. **Authorization of the Rules by Existing Statutes**

   The agency's general rulemaking authority is found in A.R.S. §§ 32-1201(21)(C), (t), and (u), and 32-1207(A) (1) and (B) (3); with specific authority found in A.R.S. §§ 32-1213(B)(4) and (M), 32-1263.02, and 32-1298(C), (E), and (F).

4. **Consistency with Statutes and Other Rules Made by the Agency**

   The rules reviewed are consistent with the statutes for the agency, namely A.R.S. Title 32, Chapter 18. In addition, the rules are consistent both internally and with relation to the agency's other rules, with the exception of R4-11-1102, whose consistency is addressed individually below.

4a. **Enforcement**

   The rules are enforced as written without incident.

5. **Clarity, Conciseness, and Understandability of the Rules**

   The agency has analyzed the rules and has found the rules to be clear, concise, and understandable.

6. **Economic, Small Business, and Consumer Impact Comparison**

   The economic impact has not differed from that projected when the rules were amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005; at 19 A.A.R. 334, effective

April 6, 2013; at 28 A.A.R. 1898, effective September 12, 2022; at 29 A.A.R. 1330, effective July 10, 2023; and at 29 A.A.R. 3793, effective January 29, 2024. The main costs are born by the agency and include staff time to process new and renewal applications.

As of October 1, 2024, the Board active licensees include, 5,658 dentists, 5,405 dental hygienists, 415 business entities, eight denturists and two dental therapists compared to 5,181 dentists, 4,834 dental hygienists, 371 business entities, 12 denturists and zero dental therapists licensed on October 1, 2019, as reported during the Board's last 5-year rule review of Articles 11, 12, 14, 15, and 18 in 2015. Our analysis indicates that establishing standards of practice is beneficial to society. Our statutes and rules exist to protect the public health. These administrative mandates become the standard of practice within the profession. Relying on a single standard promotes consistency of service and improvement of outcomes as well as negating the confusion that comes from either too many or nonexistent standards. Therefore, we estimate the economic impact of the reviewed rules is minimal.

7. **Analysis Submitted by Another Person Regarding the Rules' Impact on this State's Business Competitiveness as Compared to the Competitiveness of Businesses in Other States**

No analysis was submitted to the agency.

9. **Probable Benefits Outweigh Probable Costs / Rules Impose Least Burden on Regulated Persons**

The rules impose the least burden and probable costs to regulated persons, which are outweighed by the probable benefits of the rules.

10. **Stringency Compared with Corresponding Federal Law**

These rules do not have corresponding federal law, with the exception of R4-11-1405 and R4-11-1406. Those rules correspond with federal law, 21 CFR 1300. The agency found that the rules reviewed are not more stringent than the corresponding federal law.

## INDIVIDUAL ANALYSIS

### R4-11-1101 Advertising

Objective

The rule establishes the permissible advertising activities of a dentist, dental hygienist, or denturist to prevent false or misleading advertising.

3. Authorization of the Rules by Existing Statute

The agency's general and specific rulemaking authority is found in A.R.S. §§ 32-1207(A)(1) and 32-1201 (21)(t).

8. Completion of the Previous Five-Year –Review Report Process

The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule was adopted before July 29, 2010.

12. Proposed Course of Action

The rule requires no action.

**R4-11-1102 Advertising as a Recognized Specialist**

Objective

The rule establishes the permissible advertising activities of a dentist who advertises as a recognized specialist.

3. Authorization of the Rules by Existing Statute

The agency's general and specific rulemaking authority is found in A.R.S. §§ 32-1207 (A) (1) and 32-1201(21)(t).

4. Consistency

The rule could be more consistent with A.R.S. § 32-1276 et seq. by including Dental Therapists in subsection (D).

8. Completion of the Previous Five-Year-Review Report Process

The last five-year-review report was completed and indicated that the rule could be updated to account for dental therapists pursuant to A.R.S. § 32-1276 et seq. The Board completed several rulemakings that took precedence over this change due to safety concerns, including drafting significant changes to the Board's anesthesia and sedation rules.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule was adopted before July 29, 2010.

12 Proposed Course of Action

The rule needs to be amended to account for Dental Therapists pursuant to A.R.S. §§ 32-1276 et seq. and the Board anticipates completing a rulemaking by December 2025.

**R4-11-1201 Continuing Dental Education**

Objective

The rule establishes a continuing dental education requirement for licensees, certificate holders, and restricted permit holders.

3. Authorization of the Rules by Existing Statute

The agency's general and specific rulemaking authority is found in A.R.S. §§ 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule was adopted before July 29, 2010.

12 Proposed Course of Action
The rule requires no course of action.

**R4-11-1202 Continuing Education Compliance and Renewal Requirements**

Objective
The rule addresses documentation, compliance, renewal, and exception issues regarding the continuing education requirements for licensure. The rule is necessary for license renewal.

3. Authorization of the Rules by Existing Statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process
The last five-year rule review report was completed and indicated the rule needed to be amended to require a licensee to provide documentation of continuing education within 30 days of notice of audit. The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
Although the rule was last amended in 2022, the rule complies with the exception in subsection (A)(2) of A.R.S. § 41-1037, because the rule issues a specific license or permit specified in A.R.S. Title 32 Chapter 11, Article 2.

12. Proposed Course of Action
The rule requires no course of action.

**R4-11-1203 Dentists and Dental Consultants**

Objective
The rule establishes the number of continuing education hours by topics that are required for dentists and dental consultants.

3. Authorization of the Rules by Existing Statute
The agency's general and specific rulemaking authority is found in A.R.S. § 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process
The last five-year rule review report was completed and indicated the rule needs to be updated to specifically include opioid education. The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no course of action.

**R4-11-1204 Dental Hygienists**

Objective
The rule establishes the number of continuing education hours by topics that are required for dental hygienist licensure.

3. Authorization of the Rules by Existing Statute
The agency's general and specific rulemaking authority is found in A.R.S. § 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process
The last five-year rule review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no course of action.

**R4-11-1205 Denturists**

Objective
The rule establishes the number of continuing education hours by topics that are required for denturist certification.

3. Authorization of the Rules by Existing Statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process
The last five-year rule review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no course of action.

**R4-11-1206 Restricted Permit Holders – Dental**

Objective
The rule establishes the number of continuing education hours by topics that are required for a dental restricted permit holder.

3. Authorization of the Rules by Existing Statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process
The last five-year rule review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no course of action.

**R4-11-1207 Restricted Permit Holders – Dental Hygiene**

Objective
The rule establishes the number of continuing education hours by topics that are required for a dental hygiene restricted permit holder.

3. Authorization of the Rules by Existing Statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process

The last five-year rule review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action

The rule requires no course of action.

**R4-11-1208 Retired Licensees or Certificate Holders**

Objective

The rule establishes the number of continuing education hours by topics that are required for a retired licensee or certificate holder.

3. Authorization of the Rules by Existing Statute

The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process

The last five-year-review report was completed and indicated the rule needs to be updated to include the license renewal requirements for Dental Therapists. The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule was adopted before July 29, 2010.

12 Proposed Course of Action

The rule requires no course of action.

**R4-11-1209 Types of Courses**

Objective

The rule establishes the types of continuing education courses recognized by the Board.

3. Authorization of the Rules by Existing Statute

The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and (B)(3).

8. Completion of the Previous Five-Year-Review Report Process

The last five-year rule review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action

The rule requires no course of action.

**R4-11-1401 Prescribing**

Objective

The rule establishes the requirements of a prescription order for dispensing by a dentist.

3. Authorization of the Rules by Existing Statute

The agency's general and specific rulemaking authority is found in A.R.S. 32-1201(21)(C) and (u), 32-1207, and 32-1298(C ) and (F).

8. Completion of the Previous Five-Year –Review Report Process

The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule was adopted before July 29, 2010.

12. Proposed Course of Action

The rule requires no action.

**R4-11-1402 Labeling and Dispensing**

Objective

The rule establishes the specific labeling and dispensing requirements for dispensing by a dentist.

3. Authorization of the rules by existing statute

The agency's general and specific rulemaking authority is found in A.R.S. 32-1201(21)(C) and (u), 32-1207, and 32-1298(E).

8. Completion of the Previous Five-Year –Review Report Process

The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.

The rule was adopted before July 29, 2010.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1403 Storage and Packaging**

Objective
The rule establishes the storage and packaging requirements for dispensing by a dentist.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1201(21)(C) and (u), 32-1207, and 32-1298(E).

8. Completion of the Previous Five-Year –Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule was adopted before July 29, 2010.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1404 Recordkeeping**

Objective
The rule establishes the recordkeeping requirements for dispensing by a dentist.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1201(21)(C) and (u), 32-1207, and 32-1298(E ).

8. Completion of the Previous Five-Year –Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule was adopted before July 29, 2010.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1405 Compliance**

Objective
The rule establishes the reporting requirements for a theft or loss of controlled substances and the possible disciplinary actions for violations of Article 14.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1201(21)(C) and (u), 32-1207, and 32-1298(E).

8. Completion of the Previous Five-Year –Review Report Process
The last five-year-review report was completed and proposed the rule be amended to be consistent with 21 CFR 1301.76(b). The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule was adopted before July 29, 2010.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1501 Ex-parte Communication**

Objective
The rule establishes that a complainant or regulated party against whom a complaint is filed shall not engage in ex-parte communication with the decision maker in the matter.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and 32-1263.02.

8. Completion of the Previous Five-Year-Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1502 Complaint Investigator Qualifications**

Objective

The rule establishes the qualifications for the Board's complaint investigators.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and 32-1263.02.

8. Completion of the Previous Five-Year-Review Report Process
The last five-year-review report was completed and indicated the rule needs to be amended to account for Dental Therapists pursuant to A.R.S. §§ 32-1276 et seq. The rule was amended by final rulemaking at 29 A.A.R. 1330, effective July 10, 2023.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1503 Initial Complaint Review**

Objective
The rule establishes the Board's complaint review procedures. The rule is necessary for completion of the complaint process.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and 32-1263.02.

8. Completion of the Previous Five-Year-Review Report Process
The last five-year-review report was completed and indicated the rule needed to be updated to remove the requirement for certified mail and allow the Board to send notice of complaints by email in order to provide multiple and more timely methods of notice. The rule needed to be updated to include dental therapists. The rule needed to be updated to allow the Board to disclose the identity of the licensee who is subject to a complaint to a dental consultant performing a clinical examination in order to ensure there is no conflict of interest. This rule needed to be updated to allow the Board to take emergency action against a licensee in order to protect public health and safety consistent with A.R.S. §§ 32-1201.01 and 32-1263. The rule was amended by final rulemaking at 29 A.A.R. 3793, effective January 29, 2024.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1504 Postponement of Investigative or Informal Interview**

Objective
The rule establishes the requirements for postponing an investigative or formal interview and provides a necessary part of the complaint process.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1) and 32-1263.02.

8. Completion of the Previous Five-Year-Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule does not require issuance of a regulatory permit, license, or agency authorization.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1801 Application**

Objective
The rule establishes the requirements for business entity registration, as required by statute.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1), 32-1213(B)(4), and 32-1213(M).

8. Completion of the Previous Five-Year –Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule was adopted before July 29, 2010.

12. Proposed Course of Action
The rule requires no action.

**R4-11-1802 Display of Registration**

Objective
The rule establishes the requirements for business entity display of registration, as required by statute.

3. Authorization of the rules by existing statute
The agency's general and specific rulemaking authority is found in A.R.S. 32-1207(A)(1), 32-1213(B)(4) and 32-1213(M)

8. Completion of the Previous Five-Year –Review Report Process
The last five-year-review report was completed and did not identify any needed course of action.

11. For Rules Adopted After July 29, 2010 that Require Issuance of a Regulatory Permit, License, or Agency Authorization, Whether the Rule Complies with the General Permit Requirement in A.R.S. § 41-1037.
The rule was adopted before July 29, 2010.

12. Proposed Course of Action
The rule requires no action.

# ARIZONA STATE BOARD OF DENTAL EXAMINERS

2025 Five-Year Review, Title 4, Chapter 11

**Articles 11, 12, 14, 15, and 18**

| Rule No. | Title | Last Revision | Eff. | Enf. | C | CCU | PB/ LB | ARS Authority | EIS Comp. | PCA |
|---|---|---|---|---|---|---|---|---|---|---|
| R4-11-1101 | Advertising | 04/02/2005 | Y | Y | Y | Y | Y | 32-1207(A)(1) and 32-1201(21)(t) | No Change | None. |
| R4-11-1102 | Advertising as a Recognized Specialist | 04/02/2005 | Y | Y | N | Y | Y | 32-1207(A)(1) and 32-1201(21)(t) | No Change | The Board completed several rulemakings that took precedence due to safety concerns, including drafting significant changes to the Board's anesthesia and sedation rules. The rule still needs to be updated to account for dental therapists in subsection (D) pursuant to A.R.S. § 32-1276 et seq. |
| R4-11-1201 | Continuing Dental Education | 04/02/2005 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | None. |
| R4-11-1202 | Continuing Education Compliance and Renewal Requirements | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022, to require a licensee to provide documentation of continuing education within 35 days of notice of audit. No other course of action is proposed. |
| R4-11-1203 | Dentists and Dental Consultants | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022, to specifically include opioid education in order to be consistent with A.R.S. § 32-3248.02. No other course of action is proposed. |
| R4-11-1204 | Dental Hygienists | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | None. |
| R4-11-1205 | Denturists | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | None. |
| R4-11-1206 | Restricted Permit Holders - Dental | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | None. |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| R4-11-1207 | Restricted Permit Holders - Dental Hygiene | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | None. |
| R4-11-1208 | Retired Licensees or Certificate Holders | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change. | The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022, to include the license renewal requirements for dental therapists under A.R.S. § 32-1276.02. No other course of action is proposed. |
| R4-11-1209 | Types of Courses | 09/12/2022 | Y | Y | Y | Y | Y | 32-1207(A)(1) and (B)(3) | No Change | None. |
| R4-11-1401 | Prescribing | 04/02/2005 | Y | Y | Y | Y | Y | 32-1201(21)(c) and (u), 32-1207, and 32-1298(C) and (F) | No Change. | None. |
| R4-11-1402 | Labeling and Dispensing | 04/02/2005 | Y | Y | Y | Y | Y | 32-1201(21)(c) and (u), 32-1207, and 32-1298((E) | No Change. | None. |
| R4-11-1403 | Storage and Packaging | 04/02/2005 | Y | Y | Y | Y | Y | 32-1201(21)(c) and (u), 32-1207, and 32-1298((E) | No Change. | None. |
| R4-11-1404 | Recordkeeping | 04/02/2005 | Y | Y | Y | Y | Y | 32-1201(21)(c) and (u), 32-1207, and 32-1298((E) | No Change. | None. |
| R4-11-1405 | Compliance | 9/12/2022 | Y | Y | Y | Y | Y | 32-1201(21)(c) and (u), 32-1207, and 32-1298((E) | No Change. | The rule was amended by final rulemaking at 28 A.A.R. 1898, effective September 12, 2022, to change seven days to immediately in order to be consistent with 21 CFR 1301.76(b). No other course of action is proposed. |
| R4-11-1501 | Ex-parte Communication | 4/6/2013 | Y | Y | Y | Y | Y | 32-1207(A)(1) | No Change | None. |
| R4-11-1502 | Complaint Investigator Qualifications | 7/10/2023 | Y | Y | Y | Y | Y | 32-1207(A)(1) | No Change | The rule was amended by final rulemaking at 29 A.A.R. 1330, effective July 10, 2023, to account for dental therapists pursuant to A.R.S. § 32-1276 et seq. No other course of action is proposed. |
| R4-11-1503 | Initial Complaint Review | 1/29/2024 | Y | Y | Y | Y | Y | 32-1207(A)(1) | No Change | The rule was amended by final rulemaking at 29 A.A.R. 3793, effective |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | January 29, 2024, to remove the requirement for certified mail and allow the Board to send notice of complaints by email in order to provide multiple and more timely methods of notice; to include dental therapists; to allow the Board to disclose the identity of the licensee who is subject to a complaint to a dental consultant performing a clinical examination in order to ensure there is no conflict of interest; to allow the Board to take emergency action against a licensee in order to protect public health and safety consistent with A.R.S. §§ 32-1201.01 and 32-1263. No other course of action is proposed. |
| R4-11-1504 | Postponement of Investigative or Informal Interview | 4/6/2013 | Y | Y | Y | Y | Y | 32-1207(A)(1) | No Change | None. |
| R4-11-1801 | Application | 04/02/2005 | Y | Y | Y | Y | Y | 32-1207(A)(1), 32-1213(B)(4), and 32-1213(M) | No Change. | None. |
| R4-11-1802 | Display of Registration | 04/02/2005 | Y | Y | Y | Y | Y | 32-1207(A)(1), 32-1213(B)(4), and 32-1213(M) | No Change. | None. |

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# TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 11. STATE BOARD OF DENTAL EXAMINERS

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of October 1, 2023 through December 31, 2023



**Questions about these rules? Contact:**

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Address: 1740 W. Adams St., Suite 2470
Phoenix, AZ 85007
Website: https://dentalboard.az.gov
Name: Ryan Edmonson, Executive Director
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Email: ryan.edmonson@dentalboard.az.gov

**The release of this Chapter in Supp. 23-4 replaces Supp. 23-2, 1-37 pages.**
Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

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### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. *"'Rule' means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency."*

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The "R" stands for "rule" with a sequential numbering and lettering outline separated into subsections.

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First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

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### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature's website, www.azleg.gov. An agency's authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State's website, www.azsos.gov under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor's notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*


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# TITLE 4. PROFESSIONS AND OCCUPATIONS

# CHAPTER 11. STATE BOARD OF DENTAL EXAMINERS

Authority: A.R.S. §§ 32-1201 et seq.

**Supp. 23-4**

## CHAPTER TABLE OF CONTENTS

***Editor's Note: All former rules renumbered, new Article 11 added (Supp. 81-4).***

### ARTICLE 1. DEFINITIONS

*Article 1, consisting of Section R4-11-101, adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 1, consisting of Sections R4-11-101 through R4-11-103, renumbered to Article 2, Sections R4-11-201 through R4-11-203; Sections R4-11-104 and R4-11-105 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



### ARTICLE 2. LICENSURE BY CREDENTIAL

*New Article 2, consisting of Sections R4-11-201 through R4-11-205, made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3).*

*Article 2, consisting of Sections R4-11-201 through R4-11-203, expired under A.R.S. § 41-1056(E), effective April 30, 2001 (Supp. 01-2).*

*Article 2, consisting of Sections R4-11-201 through R4-11-203, renumbered from Article 1, Sections R4-11-101 through R4-11-103 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 2, consisting of Sections R4-11-201 and R4-11-203, renumbered to Article 3, Sections R4-11-301 and R4-11-302; Sections R4-11-202 and R4-11-204 through R4-11-216 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



### ARTICLE 3. EXAMINATIONS, LICENSING QUALIFICATIONS, APPLICATION AND RENEWAL, TIME-FRAMES

*Article 3, consisting of Sections R4-11-301 and R4-11-302, renumbered from Article 2, Sections R4-11-201 and R4-11-203 and amended; new Sections R4-11-303 through R4-11-305 adopted, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 3, consisting of Sections R4-11-301 through R4-11-304, repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



### ARTICLE 4. FEES

*Article 4, consisting of Sections R4-11-401 through R4-11-407, renumbered from Article 9, Sections R4-11-901 through R4-11-906 and R4-11-909, amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 4, consisting of Sections R4-11-401 through R4-11-403 and R4-11-408, renumbered to Article 6, Sections R4-11-601 through R4-11-603, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

## ARTICLE 5. DENTISTS

*Article 5, consisting of Section R4-11-501, renumbered from Article 11, Section R4-11-1102, amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 5, consisting of Section R4-11-502 and R4-11-504, renumbered to Article 7, Sections R4-11-701 and R4-11-702; Sections R4-11-501 and R4-11-503 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 6. DENTAL HYGIENISTS

*Article 6, consisting of Sections R4-11-601 through R4-11-603, renumbered from Article 4, Sections R4-11-402, R4-11-403, and R4-11-408 and amended; Sections R4-11-604 through R4-11-608 adopted, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 6, consisting of Sections R4-11-602 and R4-11-603, renumbered to Article 10, Sections R4-11-1001 and R4-11-1002, and Section R4-11-601 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 7. DENTAL ASSISTANTS

*Article 7, consisting of Sections R4-11-701 and R4-11-702, renumbered from Article 5, Sections R4-11-502 and R4-11-504, and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 7, consisting of Section R4-11-701, renumbered to Article 5, Section R4-11-502, and Sections R4-11-702 through R4-11-710 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 8. DENTURISTS

*Article 8, consisting of Sections R4-11-801 and R4-11-802, renumbered from Article 12, Sections R4-11-1201 and R4-11-1202, and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 8, consisting of Sections R4-11-802 through R4-11-806, renumbered to Article 13, Sections R4-11-1301 through R4-11-1305, and Section R4-11-801 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 9. RESTRICTED PERMITS

*Article 9, consisting of Sections R4-11-901 through R4-11-905, renumbered from Article 10, Sections R4-11-1001 through R4-11-1005 and amended; Section R4-11-906 adopted, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 9, consisting of Sections R4-11-901 through R4-11-906 and R4-11-909, renumbered to Article 4, Sections R4-11-401 through R4-11-407, and Sections R4-11-907 and R4-11-908 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 10. DENTAL TECHNICIANS

*Article 10, consisting of Sections R4-11-1001 and R4-11-1002, renumbered from Article 6, Section R4-11-602 and R4-11-603, amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 10, consisting of Sections R4-11-1001 through R4-11-1005, renumbered to Article 9, Sections R4-11-901 through R4-11-905, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

## ARTICLE 11. ADVERTISING

*Article 11, consisting of Section R4-11-1101, adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 11, consisting of Section R4-11-1102, renumbered to Article 5, Section R4-11-501, and Section R4-11-1104 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 12. CONTINUING DENTAL EDUCATION AND RENEWAL REQUIREMENTS

*Article 12, consisting of Sections R4-11-1201 through R4-11-1207, renumbered from Article 14, Sections R4-11-1402 through R4-11-1408 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 12, consisting of Sections R4-11-1201 and R4-11-1202, renumbered to Article 8, Sections R4-11-801 and R4-11-802, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 13. GENERAL ANESTHESIA AND SEDATION

*Article 13, consisting of Sections R4-11-1301 through R4-11-1305, adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 14. DISPENSING DRUGS AND DEVICES

*Article 14, consisting of Sections R4-11-1401 through R4-11-1406, made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).*

*Article 14 consisting of Sections R4-11-1401 through R4-11-1406, repealed by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).*

*Article 14, consisting of Sections R4-11-1401 through R4-11-1406, adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 14, consisting of Sections R4-11-1402 through R4-11-1408, renumbered to Article 12, Sections R4-11-1201 through R4-11-1207 and Sections R4-11-1401 and R4-11-1409 repealed, by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*

*Article 14, consisting of R4-11-1401 through R4-11-1409, adopted effective July 21, 1995 (Supp. 95-3).*



## ARTICLE 15. COMPLAINTS, INVESTIGATIONS, DISCIPLINARY ACTION

*Article 15, consisting of Sections R4-11-1501 through R4-11-1504, adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 16. DENTAL THERAPISTS

*Article 16, consisting of Sections R4-11-1601 through R4-11-1604, made by final rulemaking at 29 A.A.R. 1330 (June 30, 2023), effective July 10, 2023 (Supp. 23-2).*

*Article 16, consisting of Section R4-11-1601 expired under A.R.S. § 41-1056(E) at 14 A.A.R. 3183, effective April 30, 2008 (Supp. 08-3).*

*Article 16, consisting of Section R4-11-1601 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 17. REHEARING OR REVIEW

*Article 17, consisting of Section R4-11-1701, renumbered from Article 7, Section R4-11-701, and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).*



## ARTICLE 18. BUSINESS ENTITIES

*Article 18, consisting of Sections R4-11-1801 and R4-11-1802, made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).*

## ARTICLE 1. DEFINITIONS

**R4-11-101. Definitions**

The following definitions, and definitions in A.R.S. § 32-1201, apply to this Chapter:

"Analgesia" means a state of decreased sensibility to pain produced by using nitrous oxide and oxygen with or without Local Anesthesia.

"Business Entity" means a business organization that offers to the public professional services regulated by the Board and is established under the laws of any state or foreign country, including a sole practitioner, partnership, limited liability partnership, corporation, and limited liability company, unless specifically exempted by A.R.S. § 32-1213(J).

"Calculus" means a hard, mineralized deposit attached to the teeth.

"Charitable Dental Clinic or Organization" means a non-profit organization meeting the requirements of 26 U.S.C. 501(c)(3) and providing dental, dental therapy, or dental hygiene services.

"Clinical evaluation" means a dental examination of a patient named in a complaint regarding the patient's dental condition as it exists at the time the examination is performed.

"Controlled substance" has the meaning prescribed in A.R.S. § 36-2501(A)(3).

"Credit hour" means one clock hour of participation in a Recognized Continuing Dental Education program.

"Deep sedation" is a Drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. The patient may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is maintained.

"Dentist of record" means a dentist who examines, diagnoses, and formulates treatment plans for a patient and may provide treatment to the patient.

"Direct supervision" means, for purposes of Article 7 only, that a licensed dentist is present in the office and available to provide immediate treatment or care to a patient and observe a dental assistant's work.

"Disabled" means a dentist, dental therapist, dental hygienist, or denturist has totally withdrawn from the active practice of dentistry, dental therapy, dental hygiene, or denturism due to a permanent medical disability and based on a physician's order.

"Documentation of attendance" means documents that contain the following information:

Name of sponsoring entity;
Course title;
Number of Credit Hours;
Name of speaker; and
Date, time, and location of the course.

"Drug" means:

Articles recognized, or for which standards or specifications are prescribed, in the official compendium;

Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in the human body;

Articles other than food intended to affect the structure of any function of the human body; or

Articles intended for use as a component of any articles specified in this definition but does not include devices or components, parts, or accessories of devices.

"Emerging scientific technology" means any technology used in the treatment of oral disease that is not currently generally accepted or taught in a recognized dental, dental therapy, or dental hygiene school and use of the technology poses material risks.

"Epithelial attachment" means the layer of cells that extends apically from the depth of the gingival sulcus along the tooth, forming an organic attachment.

"Ex-parte communication" means a written or oral communication between a decision maker, fact finder, or Board member and one party to the proceeding, in the absence of other parties.

"General anesthesia" is a Drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. The patient often requires assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or Drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"General supervision" means, for purposes of Article 7 only, a licensed dentist is available for consultation, whether or not the dentist is in the office, regarding procedures or treatment that the dentist authorizes and for which the dentist remains responsible.

"Homebound patient" means a person who is unable to receive dental care in a dental office as a result of a medically diagnosed disabling physical or mental condition.

"Irreversible procedure" means a single treatment, or a step in a series of treatments, that causes change in the affected hard or soft tissues and is permanent or may require reconstructive or corrective procedures to correct the changes.

"Licensee" means a dentist, dental therapist, dental hygienist, dental consultant, retired licensee, or person who holds a restricted permit under A.R.S. §§ 32-1237 or 32-1292.

"Local anesthesia" is the elimination of sensations, such as pain, in one part of the body by the injection of an anesthetic Drug.

"Minimal sedation" is a minimally depressed level of consciousness that retains a patient's ability to independently and continuously maintain an airway and respond appropriately to light tactile stimulation, not limited to reflex withdrawal from a painful stimulus, or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected. In accord with this particular definition, the Drugs or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely.

"Mobile dental permit holder" means a Licensee or denturist who holds a mobile permit under R4-11-1301, R4-11-1302, or R4-11-1303.

"Moderate sedation" is Drug-induced depression of consciousness during which a patient responds purposefully to verbal commands either alone or accompanied by light tactile stimulation, not limited to reflex withdrawal from a painful stimulus. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is maintained. The Drugs or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of a Drug before the effects of previous dosing can be fully recognized may result in a greater alteration of the state of consciousness than intended by the permit holder.

"Nitrous oxide analgesia" means nitrous oxide used as an inhalation analgesic.

"Official compendium" means the latest revision of the United States Pharmacopeia and the National Formulary and any current supplement.

"Oral sedation" is the enteral administration of a Drug or non-Drug substance or combination inhalation and enterally administered Drug or non-Drug substance in a dental office or dental clinic to achieve Minimal Sedation or Moderate Sedation.

"Parenteral sedation" is a minimally depressed level of consciousness that allows the patient to retain the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and is induced by a pharmacological or non-pharmacological method or a combination of both methods of administration in which the Drug bypasses the gastrointestinal tract.

"Periodontal pocket" means a pathologic fissure bordered on one side by the tooth and on the opposite side by crevicular epithelium and limited in its depth by the Epithelial Attachment.

"Plaque" means a film-like sticky substance composed of mucoidal secretions containing bacteria and toxic products, dead tissue cells, and debris.

"Polishing" means a procedure limited to the removal of Plaque and extrinsic stain from exposed natural and restored tooth surfaces that utilizes an appropriate rotary instrument with rubber cup or brush and Polishing agent. A Licensee or dental assistant shall not represent that this procedure alone constitutes an oral Prophylaxis.

"Prescription-only device" means:

Any device that is restricted by the federal act, as defined in A.R.S. § 32-1901, to use only under the supervision of a medical practitioner; or

Any device required by the federal act, as defined in A.R.S. § 32-1901, to bear on its label the legend "Rx Only."

"Prescription-only Drug" does not include a Controlled Substance but does include:

Any Drug that, because of its toxicity or other potentiality for harmful effect, the method of its use, or the collateral measures necessary to its use, is not generally recognized among experts, qualified by scientific training and experience to evaluate its safety and efficacy, as safe for use except by or under the supervision of a medical practitioner;

Any Drug that is limited by an approved new Drug application under the federal act or A.R.S. § 32-1962 to use under the supervision of a medical practitioner;

Every potentially harmful Drug, the labeling of which does not bear or contain full and adequate directions for use by the consumer; or

Any Drug required by the federal act to bear on its label the legend "RX Only."

"President's designee" means the Board's executive director, an investigator, or a Board member acting on behalf of the Board president.

"Preventative and therapeutic agents" means substances that affect the hard or soft oral tissues to aid in preventing or treating oral disease.

"Prophylaxis" means a Scaling and Polishing procedure performed on patients with healthy tissues to remove coronal Plaque, Calculus, and stains.

"Recognized continuing dental education" means a program whose content directly relates to the art and science of oral health and treatment, provided by a recognized dental school, recognized dental therapy school, recognized dental hygiene school, or recognized denturist school, or sponsored by a national or state dental, dental therapy, dental hygiene, or denturist association, American Dental Association Continuing Education Recognition Program or Academy of General Dentistry, Program Approval for Continuing Education approved provider, dental, dental therapy, dental hygiene, or denturist Study Club, governmental agency, commercial dental supplier, non-profit organization, accredited hospital, or programs or courses approved by other state, district, or territorial dental licensing boards.

"Restricted permit holder" means a dentist who meets the requirements of A.R.S. § 32-1237, or a dental hygienist who meets the requirements of A.R.S. § 32-1292 and is issued a restricted permit by the Board.

"Retired" means a dentist, dental therapist, dental hygienist, or denturist is at least 65 years old and has totally withdrawn from the active practice of dentistry, dental therapy, dental hygiene, or denturism.

"Root planing" means a definitive treatment procedure designed to remove cementum or surface dentin that is rough, impregnated with Calculus, or contaminated with toxins or microorganisms.

"Scaling" means use of instruments on the crown and root surfaces of the teeth to remove Plaque, Calculus, and stains from these surfaces.

"Section 1301 permit" means a permit to administer General Anesthesia and Deep Sedation, employ or work with a physician anesthesiologist, or employ or work with a Certified Registered Nurse Anesthetist under Article 13.

"Section 1302 permit" means a permit to administer Parenteral Sedation, employ or work with a physician anesthesiologist, or employ or work with a Certified Registered Nurse Anesthetist under Article 13.

"Section 1303 permit" means a permit to administer Oral Sedation, employ or work with a physician anesthesiologist, or employ or work with a Certified Registered Nurse Anesthetist under Article 13.

"Section 1304 permit" means a permit to employ or work with a physician anesthesiologist, or employ or work with a Certified Registered Nurse Anesthetist under Article 13.

"Study club" means a group of at least five Arizona licensed dentists, dental therapists, dental hygienists, or denturists who provide written course materials or a written outline for a continuing education presentation that meets the requirements of Article 12.

"Treatment records" means all documentation related directly or indirectly to the dental treatment of a patient.

**Historical Note**

Adopted effective May 12, 1977 (Supp. 77-3). Former Section R4-11-02 renumbered as Section R4-11-102 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-101 renumbered to R4-11-201, new Section R4-11-101 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 13 A.A.R. 962, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 19 A.A.R. 334 and at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-102. Renumbered**

**Historical Note**

Adopted effective May 12, 1977 (Supp. 77-3). Former Section R4-11-02 renumbered as Section R4-11-102 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-102 renumbered to R4-11-202 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-103. Renumbered**

**Historical Note**

Adopted effective May 12, 1977 (Supp. 77-3). Former Section R4-11-03 renumbered as Section R4-11-103 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-103 renumbered to R4-11-203 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-104. Repealed**

**Historical Note**

Adopted effective May 12, 1977 (Supp. 77-3). Former Section R4-11-04 renumbered as Section R4-11-104 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-104 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-105. Repealed**

**Historical Note**

Adopted effective May 12, 1977 (Supp. 77-3). Former Section R4-11-05 renumbered as Section R4-11-105 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-105 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

## ARTICLE 2. LICENSURE BY CREDENTIAL

*New Article 2, consisting of Sections R4-11-201 through R4-11-205, made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3).*

**R4-11-201. Clinical Examination; Requirements**

**A.** If an applicant is applying under A.R.S. §§ 32-1240, 32-1276.07, or 32-1292.01, the Board shall ensure that the applicant has passed the clinical examination of A.R.S. §§ 32-1233(2) for dentists, or 32-1276.01(B)(3)(a) for dental therapists, or 32-1285(2) for dental hygienists, notwithstanding each respective statute's timing stipulation. Satisfactory completion of the clinical examination may be demonstrated by certified documentation, sent directly from another state, United States territory, District of Columbia or a testing agency that meets the requirements of A.R.S. §§ 32-1233(2) for dentists, or 32-1276.01(B)(3)(a) for dental therapists, or 32-1285(2) for dental hygienists, notwithstanding each respective statute's timing stipulation, that confirms successful completion of the clinical examination or multiple examinations administered by the state, United States territory, District of Columbia or testing agency. The certified documentation shall contain the name of the applicant, date of examination or examinations and proof of a passing score.

**B.** An applicant shall meet the licensure requirements in R4-11-301 and R4-11-303.

**Historical Note**

Former Rule 2a; Amended effective November 20, 1979 (Supp. 79-6). Amended effective November 28, 1980 (Supp. 80-6). Former Section R4-11-11 renumbered as Section R4-11-201 and amended effective July 29, 1981 (Supp. 81-4). Former Section R4-11-201 renumbered to R4-11-301, new Section R4-11-201 renumbered from R4-11-101 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E), effective April 30, 2001 (Supp. 01-2). New Section made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-202. Dental Licensure by Credential; Application**

**A.** A dentist applying under A.R.S. § 32-1240 shall comply with all other applicable requirements in A.R.S. Title 32, Chapter 11 and this Article.

**B.** A dentist applying under A.R.S. § 32-1240 shall:

1. Have a current dental license in another state, territory or district of the United States;
2. Submit a written affidavit affirming that the dentist has practiced dentistry for a minimum of 5000 hours during the five years immediately before applying for licensure by credential. For purposes of this subsection, dental practice includes experience as a dental educator at a dental program accredited by the Commission on Dental Accreditation or another post-secondary dental education program accrediting agency recognized by the U.S. Department of Education, or employment as a dentist in a public health setting;
3. Submit a written affidavit affirming that the applicant has complied with the continuing dental education requirement of the state in which the applicant is currently licensed;

4. Provide evidence regarding the clinical examination by complying with R4-11-201(A); and
5. Pass the Arizona jurisprudence examination with a minimum score of 75%.

**C.** For any application submitted under A.R.S. § 32-1240, the Board may request additional clarifying evidence required under R4-11-201(A).

**D.** An applicant for dental licensure by credential shall pay the fee prescribed in A.R.S. § 32-1240, except the fee is reduced by 50% for applicants who will be employed or working under contract in:
1. Underserved areas, such as declared or eligible Health Professional Shortage Areas; or
2. Other facilities caring for underserved populations as recognized by the Arizona Department of Health Services and approved by the Board.

**E.** An applicant for dental licensure by credential who works in areas or facilities described in subsection (D) shall:
1. Commit to a three-year, exclusive service period,
2. File a copy of a contract or employment verification statement with the Board, and
3. As a Licensee, submit an annual contract or employment verification statement to the Board by December 31 of each year.

**F.** A Licensee's failure to comply with the requirements in subsection (E) is considered unprofessional conduct and may result in disciplinary action based on the circumstances of the case.

**Historical Note**

Former Rule 2b; Former Section R4-11-12 renumbered as Section R4-11-202 and amended effective July 29, 1981 (Supp. 81-4). Former Section R4-11-202 repealed, new Section R4-11-202 renumbered from R4-11-102 and the heading amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Labeling changes made to reflect current style requirements (Supp. 99-1). Section expired under A.R.S. § 41-1056(E), effective April 30, 2001 (Supp. 01-2). New Section made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-203. Dental Hygienist Licensure by Credential; Application**

**A.** A dental hygienist applying under A.R.S. § 32-1292.01 shall comply with all other applicable requirements in A.R.S. Title 32, Chapter 11 and this Article.

**B.** A dental hygienist applying under A.R.S. § 32-1292.01 shall:
1. Have a current dental hygienist license in another state, territory, or district of the United States;
2. Submit a written affidavit affirming that the applicant has practiced as a dental hygienist for a minimum of 1000 hours during the two years immediately before applying for licensure by credential. For purposes of this subsection, dental hygienist practice includes experience as a dental hygienist educator at a dental program accredited by the Commission on Dental Accreditation or another post-secondary dental education program accrediting agency recognized by the U.S. Department of Education, or employment as a dental hygienist in a public health setting;
3. Submit a written affidavit affirming that the applicant has complied with the continuing dental hygienist education requirement of the state in which the applicant is currently licensed;
4. Provide evidence regarding the clinical examination by complying with R4-11-201(A); and
5. Pass the Arizona jurisprudence examination with a minimum score of 75%.

**C.** For any application submitted under A.R.S. § 32-1292.01, the Board may request additional clarifying evidence as required under R4-11-201(A).

**D.** An applicant for dental hygienist licensure by credential shall pay the fee prescribed in A.R.S. § 32-1292.01, except the fee is reduced by 50% for applicants who will be employed or working under contract in:
1. Underserved areas such as declared or eligible Health Professional Shortage Areas; or
2. Other facilities caring for underserved populations, as recognized by the Arizona Department of Health Services and approved by the Board.

**E.** An applicant for dental hygienist licensure by credential who works in areas or facilities described in subsection (D) shall:
1. Commit to a three-year exclusive service period,
2. File a copy of a contract or employment verification statement with the Board, and
3. As a Licensee, submit an annual contract or employment verification statement to the Board by December 31 of each year.

**F.** A Licensee's failure to comply with the requirements in R4-11-203(E) is considered unprofessional conduct and may result in disciplinary action based on the circumstances of the case.

**Historical Note**

Former Rule 2c; Former Section R4-11-13 repealed, new Section R4-11-13 adopted effective November 20, 1979 (Supp. 79-6). Amended effective October 30, 1980 (Supp. 80-5). Former Section R4-11-13 renumbered as Section R4-11-203 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-203 renumbered to R4-11-302, new Section R4-11-203 renumbered from R4-11-103 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E), effective April 30, 2001 (Supp. 01-2). New Section made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-204. Dental Assistant Radiography Certification by Credential**

Eligibility. To be eligible for dental assistant radiography certification by credential, an applicant shall have a current certificate or other form of approval for taking dental radiographs, issued by a professional licensing agency in another state, United States territory or the District of Columbia that required successful completion of a written dental radiography examination.

**Historical Note**

Former Rule 2d; Former Section R4-11-14 repealed, new Section R4-11-14 adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-14 renumbered as Section R4-11-204, repealed, and new Section R4-11-204 adopted effective July 29, 1981 (Supp. 81-4). Former

Section R4-11-204 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). New Section made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1).

**R4-11-205. Application for Dental Assistant Radiography Certification by Credential**

**A.** An applicant for dental assistant radiography certification by credential shall provide to the Board a completed application, on a form furnished by the Board that contains the following information:
1. A sworn statement of the applicant's eligibility, and
2. A letter from the issuing institution that verifies compliance with R4-11-204.

**B.** Based upon review of information provided under subsection (A), the Board or its designee shall request that an applicant for dental assistant radiography certification by credential provide a copy of a certified document that indicates the reason for a name change if the applicant's documentation contains different names.

**Historical Note**

Former Rule 2e; Former Section R4-11-15 renumbered as Section R4-11-205 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-205 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). New Section made by final rulemaking at 9 A.A.R. 4126, effective November 8, 2003 (Supp. 03-3).

**R4-11-206. Dental Therapist Licensure by Credential; Application**

**A.** A dental therapist applying under A.R.S. § 32-1276.07 shall comply with all other applicable requirements in A.R.S. Title 32, Chapter 11 and this Article.

**B.** A dental therapist applying under A.R.S. § 32-1276.07 shall:
1. Have a current dental therapy license in another state, territory or district of the United States with substantially the same scope of practice as defined in A.R.S. § 32-1276.03;
2. Submit a written affidavit affirming that the applicant has practiced as a dental therapist for a minimum of 3000 hours during the five years immediately before applying for licensure by credential. For purposes of this subsection, dental therapy practice includes experience as a dental therapy educator at a dental program accredited by the Commission on Dental Accreditation or another post-secondary dental education program accrediting agency recognized by the U.S. Department of Education, or employment as a dental therapist in a public health setting;
3. Submit a written affidavit affirming that the applicant has complied with the continuing dental therapy education requirement of the state in which the applicant is currently licensed;
4. Provide evidence showing that five years or more before applying for licensure under this Section, the applicant completed the clinical examination by complying with R4-11-201(A);
5. Submit official transcripts to the Board directly from a recognized dental therapy school as defined by A.R.S. § 32-1201(21) or an approved third party showing a degree was conferred to the applicant; and
6. Not be required to obtain an Arizona dental hygienist license, if the dental therapist submits one of the following:
   a. Certified documentation of a current or past dental hygiene license sent directly from the applicable state, United States territory, District of Columbia to the Board; or
   b. Official transcripts sent to the Board directly from a recognized dental hygiene school as defined by A.R.S. § 32-1201(19) or an approved third party showing a degree was conferred to the applicant; or
   c. A written affidavit from a recognized dental therapy school as defined in A.R.S. § 32-1201(21) affirming that all dental hygiene procedures defined in A.R.S. § 32-1281 were part of the education the applicant received.

**C.** For any application submitted under A.R.S. § 32-1276.07, the Board may request additional clarifying evidence required under R4-11-201(A).

**D.** If an applicant meets all the requirements set forth in this Section except that their current dental therapy license is from a state, territory, or district of the United States that does not include one or more of the following procedures in its legally defined scope, then the applicant must provide evidence of competency before being granted a dental therapy license by credential:
1. Fabricating soft occlusal guards;
2. Administering Nitrous Oxide Analgesia;
3. Performing nonsurgical extractions of periodontally diseased permanent teeth that exhibit plus or grade three mobility and that are not impacted, fractured, unerupted or in need of sectioning for removal;
4. Suturing; or
5. Placing space maintainers.

**E.** The Board will accept the any of following as evidence of competency in the aforementioned procedures:
1. A certificate or credential in the procedure or procedures issued by a state licensing jurisdiction; or
2. A signed affidavit from a recognized dental therapy school, recognized dental hygiene school, or recognized dental school, affirming that the applicant successfully completed academic coursework that included both theory and supervised clinical practice in the procedure or procedures.

**F.** Subject to A.R.S. § 32-1276.04, an applicant for licensure under this Section shall pay the fee prescribed in A.R.S. § 32-1276.07, except the fee is reduced by 50% for applicants who will be employed or working under contract in:
1. Underserved areas, such as declared or eligible Health Professional Shortage Areas; or
2. Other facilities caring for underserved populations as recognized by the Arizona Department of Health Services and approved by the Board.

**G.** An applicant for dental therapist licensure by credential who works in areas or facilities described in subsection (F) shall:
1. Commit to a three-year, exclusive service period,
2. File a copy of a contract or employment verification statement with the Board, and
3. As a Licensee, submit an annual contract or employment verification statement to the Board by December 31 of each year.

**H.** A Licensee's failure to comply with the requirements in subsection (G) is considered unprofessional conduct and may

result in disciplinary action based on the circumstances of the case.

**Historical Note**

Former Rule 2f; Amended as an emergency effective July 7, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-4). Former emergency adoption now adopted and amended effective September 7, 1979 (Supp. 79-5). Former Section R4-11-16 renumbered as Section R4-11-206 and amended effective July 29, 1981 (Supp. 81-4). Former Section R4-11-206 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). New Section made by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-207. Repealed**

**Historical Note**

Former Rule 2g; Former Section R4-11-17 renumbered as Section R4-11-207, repealed, and new Section R4-11-207 adopted effective July 29, 1981 (Supp. 81-4). Former Section R4-11-207 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-208. Repealed**

**Historical Note**

Former Section R4-11-20 repealed, new Section R4-11-20 adopted effective May 12, 1977 (Supp. 77-3). Amended effective October 30, 1980 (Supp. 80-5). Former Section R4-11-20 renumbered as Section R4-11-208 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-208 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-209. Repealed**

**Historical Note**

Adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-19 renumbered as R4-11-209 and repealed. Former Section R4-11-21 renumbered as Section R4-11-209 and amended effective July 29, 1981 (Supp. 81-4). Former Section R4-11-209 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-210. Repealed**

**Historical Note**

Adopted effective March 23, 1976 (Supp. 76-2). Amended effective June 7, 1978 (Supp. 78-3). Former Section R4-11-22 renumbered as Section R4-11-210 and amended effective July 29, 1981 (Supp. 81-4). Former Section R4-11-210 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-211. Repealed**

**Historical Note**

Adopted effective August 26, 1977 (Supp. 77-4). Former Section R4-11-23 renumbered as Section R4-11-211 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-211 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-212. Repealed**

**Historical Note**

Adopted effective March 28, 1978 (Supp. 78-2). Former Section R4-11-24 renumbered as Section R4-11-212 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-212 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-213. Repealed**

**Historical Note**

Adopted as an emergency effective July 7, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-4). Former emergency adoption now adopted effective September 7, 1979 (Supp. 79-5). Former Section R4-11-25 renumbered as Section R4-11-213, repealed, and new Section R4-11-213 adopted effective July 29, 1981 (Supp. 81-4). Former Section R4-11-213 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-214. Repealed**

**Historical Note**

Former Rule 2h; Amended effective March 23, 1976 (Supp. 76-2). Former Section R4-11-18 renumbered as Section R4-11-214 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-214 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-215. Repealed**

**Historical Note**

Adopted effective June 16, 1982 (Supp. 82-3). Former Section R4-11-215 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-216. Repealed**

**Historical Note**

Adopted effective June 16, 1982 (Supp. 82-3). Former Section R4-11-216 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

## ARTICLE 3. EXAMINATIONS, LICENSING QUALIFICATIONS, APPLICATION AND RENEWAL, TIMEFRAMES

**R4-11-301. Application**

**A.** An applicant for licensure or certification shall provide the following information and documentation:

1. A sworn statement of the applicant's qualifications for the license or certificate on a form provided by the Board;
2. A photograph of the applicant that is no more than 6 months old;
3. An official, sealed transcript sent directly to the Board from either:
   a. The applicant's dental, dental therapy, dental hygiene, or denturist school, or
   b. A verified third-party transcript provider.
4. Except for a dental consultant license applicant, a dental, dental therapy, and dental hygiene license applicant shall provide proof of successfully completing a clinical examination by submitting:
   a. If applying for dental licensure by examination, a copy of the certificate or scorecard sent to the Board directly from a clinical examination administered by a state or testing agency that meets the requirements of A.R.S. § 32-1233(2), indicating that the applicant passed a state or regional testing agency examination that meets the requirements of A.R.S. § 32-

1233(2) within the five years immediately before the date the application is filed with the Board;

b. If applying for dental therapy licensure by examination, a copy of the certificate or scorecard sent to the Board directly from a clinical examination administered by a state, United States territory, District of Columbia or testing agency that meets the requirements of A.R.S. § 32-1276.01(B)(3)(a). The certificate or scorecard must indicate that the applicant passed the examination within the five years immediately before the date the application is filed with the Board. The application must also include the applicant's Arizona dental hygiene license number;

c. If applying for dental hygiene licensure by examination, a copy of the certificate or scorecard sent to the Board directly from a clinical examination administered by a state, United States territory, District of Columbia or testing agency that meets the requirements of A.R.S. § 32-1285(2). The certificate or scorecard must indicate that the applicant passed the examination within the five years immediately before the date the application is filed with the Board;

5. Except for a dental consultant license applicant as provided in A.R.S. § 32-1234(A)(7), dental and dental hygiene license applicants must have an official scorecard sent directly from the National Board examination to the Board;
6. A copy showing the expiration date of the applicant's current cardiopulmonary resuscitation healthcare provider level certificate from the American Red Cross, the American Heart Association, or another certifying agency that follows the same procedures, standards, and techniques for cardiopulmonary resuscitation training and certification as the American Red Cross or American Heart Association;
7. A license or certification verification from any other jurisdiction in which an applicant is licensed or certified, sent directly from that jurisdiction to the Board. If the license verification cannot be sent directly to the Board from the other jurisdiction, the applicant must submit a written affidavit affirming that the license verification submitted was issued by the other jurisdiction;
8. If an applicant has been licensed or certified in another jurisdiction, a copy of the self-inquiry from the National Practitioner Data Bank that is no more than 30 calendar days old;
9. If the applicant is in the military or employed by the United States government, a letter sent to the Board directly from the applicant's commanding officer or supervisor verifying the applicant is licensed or certified by the military or United States government; and
10. The jurisprudence examination fee paid by a method authorized by law.

**B.** The Board may request that an applicant provide:

1. An official copy of the applicant's dental, dental therapy, dental hygiene, or denturist school diploma from the issuing institution;
2. A copy of a certified document that indicates the reason for a name change if the applicant's application contains different names;
3. Written verification of the applicant's work history; and
4. A copy of a high school diploma or equivalent certificate.

**C.** An applicant shall pass the Arizona jurisprudence examination with a minimum score of 75%.

**Historical Note**

Former Rule 3A; Former Section R4-11-29 repealed, new Section R4-11-29 adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-29 renumbered as Section R4-11-301 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-301 repealed, new Section R4-11-301 renumbered from R4-11-201 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-302. Repealed**

**Historical Note**

Former Rule 3B; Former Section R4-11-30 repealed, new Section R4-11-30 adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-30 renumbered as Section R4-11-302 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-302 repealed, new Section R4-11-302 renumbered from R4-11-203 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1).

**R4-11-303. Application Processing Procedures: Issuance, Denial, and Renewal of Dental Licenses, Dental Therapy Licenses, Restricted Permits, Dental Hygiene Licenses, Dental Consultant Licenses, Denturist Certificates, Drug or Device Dispensing Registrations, Business Entity Registration and Mobile Dental Facility and Portable Dental Unit Permits**

**A.** The Board office shall complete an administrative completeness review within 30 calendar days of the date of receipt of an application for a license, certificate, permit, or registration.

1. Within 30 calendar days of receiving an initial or renewal application for a dental license, restricted permit, dental therapy license, dental hygiene license, dental consultant license, denturist certificate, Business Entity registration, mobile dental facility or portable dental unit permit, the Board office shall notify the applicant, in writing, whether the application package is complete or incomplete.
2. If the application package is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 30 calendar day time-frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
3. If the Board office does not provide the applicant with notice regarding administrative completeness, the application package shall be deemed complete 30 calendar days after receipt by the Board office.

**B.** An applicant with an incomplete application package shall submit all missing information within 60 calendar days of service of the notice of incompleteness.

**C.** Upon receipt of all missing information, the Board office shall notify the applicant, in writing, within 30 calendar days, that

the application package is complete. If an applicant fails to submit a complete application package within the time allowed in subsection (B), the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a license, certificate, permit, or registration shall apply again as required in R4-11-301.

**D.** The Board shall not approve or deny an application until the applicant has fully complied with the requirements of A.A.C. Title 4, Chapter 11, Article 3.

**E.** The Board shall complete a substantive review of the applicant's qualifications in no more than 90 calendar days from the date on which the administrative completeness review of an application package is complete.

1. If the Board finds an applicant to be eligible for a license, certificate, permit, or registration and grants the license, certificate, permit, or registration, the Board office shall notify the applicant in writing.
2. If the Board finds an applicant to be ineligible for a license, certificate, permit, or registration, the Board office shall issue a written notice of denial to the applicant that includes:
   a. Each reason for the denial, with citations to the statutes or rules on which the denial is based;
   b. The applicant's right to request a hearing on the denial, including the number of days the applicant has to file the request;
   c. The applicant's right to request an informal settlement conference under A.R.S. § 41-1092.06; and
   d. The name and telephone number of an agency contact person who can answer questions regarding the application process.
3. If the Board finds deficiencies during the substantive review of an application package, the Board office may issue a comprehensive written request to the applicant for additional documentation. An additional supplemental written request for information may be issued upon mutual agreement between the Board or Board office and the applicant.
4. The 90-day time-frame for a substantive review of an applicant's qualifications is suspended from the date of a written request for additional documentation until the date that all documentation is received. The applicant shall submit the additional documentation before the next regularly scheduled Board meeting.
5. If the applicant and the Board office mutually agree in writing, the 90-day substantive review time-frame may be extended once for no more than 28 days.

**F.** The following time-frames apply for an initial or renewal application governed by this Section:

1. Administrative completeness review time-frame: 30 calendar days.
2. Substantive review time-frame: 90 calendar days.
3. Overall time-frame: 120 calendar days.

**G.** An applicant whose license is denied has a right to a hearing, an opportunity for rehearing, and, if the denial is upheld, may seek judicial review pursuant to A.R.S. Title 41, Chapter 6, Article 10, and A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

Former Rule 3C; Former Section R4-11-31 renumbered as Section R4-11-303 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-303 repealed, new Section R4-11-303 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-304. Application Processing Procedures: Issuance and Denial of Dental Assistant Certificates Radiography Certification by Credential**

**A.** Within 30 calendar days of receiving an application from an applicant for a dental assistant radiography certification by credential, the Board or its designee shall notify the applicant, in writing, that the application package is complete or incomplete. If the package is incomplete, the notice shall specify what information is missing.

**B.** An applicant with an incomplete application package shall supply the missing information within 60 calendar days from the date of the notice. If the applicant fails to do so, an applicant shall begin the application process anew.

**C.** Upon receipt of all missing information, within 10 calendar days, the Board or its designee shall notify the applicant, in writing, that the application is complete.

**D.** The Board or its designee shall not process an application until the applicant has fully complied with the requirements of this Article.

**E.** The Board or its designee shall notify an applicant, in writing, whether the certificate is granted or denied, no later than 90 calendar days after the date of the notice advising the applicant that the package is complete.

**F.** The notice of denial shall inform the applicant of the following:

1. The reason for the denial, with a citation to the statute or rule which requires the applicant to pass the examination;
2. The applicant's right to request a hearing on the denial, including the number of days the applicant has to file the request;
3. The applicant's right to request an informal settlement conference under A.R.S. § 41-1092.06; and
4. The name and telephone number of an agency contact person or a designee who can answer questions regarding the application process.

**G.** The following time-frames apply for certificate applications governed by this Section:

1. Administrative completeness review time-frame: 24 calendar days.
2. Substantive review time-frame: 90 calendar days.
3. Overall time-frame: 114 calendar days.

**H.** An applicant whose certificate is denied has a right to a hearing, an opportunity for rehearing, and, if the denial is upheld, may seek judicial review pursuant to A.R.S. Title 41, Chapter 6, Article 10, and A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

Former Rule 3D; Former Section R4-11-32 renumbered as Section R4-11-304 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-304 repealed, new Section R4-11-304 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-305. Application Processing Procedures: Issuance, Denial, and Renewal of General Anesthesia and Deep Sedation**

**Permits, Parenteral Sedation Permits, Oral Sedation Permits, and Permit to Employ a Physician Anesthesiologist or Certified Registered Nurse Anesthetist**

**A.** The Board office shall complete an administrative completeness review within 24 days from the date of the receipt of an application for a permit.
1. Within 30 calendar days of receiving an initial or renewal application for a General Anesthesia and Deep Sedation permit, parenteral sedation permit, Oral Sedation permit or permit to employ a physician anesthesiologist or Certified Registered Nurse Anesthetist the Board office shall notify the applicant, in writing, whether the application package is complete or incomplete.
2. If the application package is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 24-day time-frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
3. If the Board office does not provide the applicant with notice regarding administrative completeness, the application package shall be deemed complete 24 days after receipt by the Board office.

**B.** An applicant with an incomplete application package shall submit all missing information within 60 calendar days of service of the notice of incompleteness.

**C.** Upon receipt of all missing information, the Board office shall notify the applicant, in writing, within 10 calendar days, that the application package is complete. If an applicant fails to submit a complete application package within the time allowed in subsection (B), the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a permit shall apply again as required in A.A.C. Title 4, Chapter 11, Article 13.

**D.** The Board shall not approve or deny an application until the applicant has fully complied with the requirements of this Section and A.A.C. Title 4, Chapter 11, Article 13.

**E.** The Board shall complete a substantive review of the applicant's qualifications in no more than 120 calendar days from the date on which the administrative completeness review of an application package is complete.
1. If the Board finds an applicant to be eligible for a permit and grants the permit, the Board office shall notify the applicant in writing.
2. If the Board finds an applicant to be ineligible for a permit, the Board office shall issue a written notice of denial to the applicant that includes:
   a. Each reason for the denial, with citations to the statutes or rules on which the denial is based;
   b. The applicant's right to request a hearing on the denial, including the number of days the applicant has to file the request;
   c. The applicant's right to request an informal settlement conference under A.R.S. § 41-1092.06; and
   d. The name and telephone number of an agency contact person who can answer questions regarding the application process.
3. If the Board finds deficiencies during the substantive review of an application package, the Board office shall issue a comprehensive written request to the applicant for additional documentation.
4. The 120-day time-frame for a substantive review of an applicant's qualifications is suspended from the date of a written request for additional documentation until the date that all documentation is received.
5. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time-frame may be extended once for no more than 36 days.

**F.** The following time-frames apply for an initial or renewal application governed by this Section:
1. Administrative completeness review time-frame: 24 calendar days.
2. Substantive review time-frame: 120 calendar days.
3. Overall time-frame: 144 calendar days.

**Historical Note**
New Section R4-11-305 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 22 A.A.R. 371, effective April 3, 2016 (Supp. 16-1). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

## ARTICLE 4. FEES

**R4-11-401. Retired or Disabled Licensure Renewal Fee**

As expressly authorized under A.R.S. § 32-1207(B)(3)(c), the licensure renewal fee for a Retired Licensee or Disabled Licensee is $15 and shall be paid by a method authorized by law.

**Historical Note**
Adopted effective December 6, 1974 (Supp. 75-1). Amended effective March 23, 1976 (Supp. 76-2). Former Section R4-11-42 renumbered as Section R4-11-401 and repealed effective July 29, 1981 (Supp. 81-4). Adopted effective February 16, 1995 (Supp. 95-1). Former Section R4-11-401 repealed, new Section R4-11-401 renumbered from R4-11-901 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 22 A.A.R. 3697, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-402. Business Entity Fees**

As expressly authorized under A.R.S. § 32-1213, the Board establishes and shall collect the following fees from a Business Entity offering dental services paid by credit card on the Board's website or by money order or cashier's check:
1. Initial triennial registration, $300 per location;
2. Renewal of triennial registration, $300 per location; and
3. Late triennial registration renewal, $100 per location in addition to the fee under subsection (2).

**Historical Note**
Adopted effective December 6, 1974 (Supp. 75-1). amended effective March 23, 1976 (Supp. 76-2). Former Section R4-11-43 renumbered as Section R4-11-402, repealed, and new Section R4-11-402 adopted effective July 29, 1981 (Supp. 81-4). Amended effective February 16, 1995 (Supp. 95-1). Former Section R4-11-402 renumbered to R4-11-601, new Section R4-11-402 renumbered

from R4-11-902 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (05-1). Amended by final rulemaking at 22 A.A.R. 3697, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-403. Licensing Fees**

**A.** As expressly authorized under A.R.S. §§ 32-1236, 32-1276.02, 32-1287, 32-1297.06, and 32-1299.23, the Board establishes and shall collect up to the following licensing fees paid by a method authorized by law:

1. Dentist triennial renewal fee: $650;
2. Dentist prorated initial license fee: $110;
3. Dental therapist triennial renewal fee: $375;
4. Dental therapist prorated initial license fee: $80;
5. Dental hygienist triennial renewal fee: $325;
6. Dental hygienist prorated initial license fee: $55;
7. Denturist triennial renewal fee: $300;
8. Denturist prorated initial license fee: $46; and
9. Mobile dental facility permit initial license or annual renewal fee: $200.

**B.** The following license-related fees are established in or expressly authorized by statute. The Board shall collect the following fees paid by a method authorized by law:

1. Jurisprudence examination fee:
   a. Dentists: $300;
   b. Dental therapists: $200;
   c. Dental hygienists: $100; and
   d. Denturists: $250.
2. Licensure by credential fee:
   a. Dentists: $2,000; and
   b. Dental therapists: $1,500;
   c. Dental hygienists: $1,000.
3. Penalty to reinstate an expired license or certificate: $100 for a dentist, mobile dental facility permit, dental therapist, dental hygienist, or denturist in addition to renewal fee specified under subsection (A).
4. Penalty for a dentist, mobile dental facility permit, dental therapist, dental hygienist, or denturist who fails to notify Board of a change of mailing address:
   a. Failure after 10 days: $50; and
   b. Failure after 30 days: $100.

**Historical Note**

Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-44 renumbered as Section R4-11-403 and repealed effective July 29, 1981 (Supp. 81-4). Adopted effective February 16, 1995 (Supp. 95-1). Former Section R4-11-403 renumbered to R4-11-602, new Section R4-11-403 renumbered from R4-11-903 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1). Section repealed by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (05-1). New Section made by final rulemaking at 22 A.A.R. 3697, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2). Amended by final rulemaking at 29 A.A.R. 3791 (December 15, 2023), effective January 29, 2024 (Supp. 23-4).

**R4-11-404. Repealed**

**Historical Note**

Adopted effective December 6, 1974 (Supp. 75-1_. Former Section R4-11-45 renumbered as Section R4-11-404 without change effective July 29, 1981 (Supp. 81-4). Repealed effective February 16, 1995 (Supp. 95-1). New Section R4-11-404 renumbered from R4-11-904 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1). Section repealed by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (05-1).

**R4-11-405. Charges for Board Services**

The Board shall charge the following fees for the services provided paid by credit card on the Board's website or by money order or cashier's check:

1. Duplicate license: $25;
2. Duplicate certificate: $25;
3. License verification: $25;
4. Copy of audio recording: $10;
5. Photocopies (per page): $.25;
6. Mailing lists of Licensees in digital format: $100

**Historical Note**

Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-46 repealed, new Section R4-11-46 adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-46 renumbered as Section R4-11-405 without change effective July 29, 1981 (Supp. 81-4). Repealed effective February 16, 1995 (Supp. 95-1). New Section R4-11-405 renumbered from R4-11-905 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1). Amended by final rulemaking at 22 A.A.R. 3697, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-406. Anesthesia and Sedation Permit Fees**

**A.** As expressly authorized under A.R.S. § 32-1207, the Board establishes and shall collect the following fees:

1. Section 1301 permit fee: $300 plus $25 for each additional location;
2. Section 1302 permit fee: $300 plus $25 for each additional location;
3. Section 1303 permit fee: $300 plus $25 for each additional location; and
4. Section 1304 permit fee: $300 plus $25 for each additional location.

**B.** Upon successful completion of an initial onsite evaluation and upon receipt of the required permit fee, the Board shall issue a separate Section 1301, 1302, 1303, or 1304 permit to a dentist for each location requested by the dentist. A permit expires on December 31 of every fifth year.

**C.** Permit renewal fees:

1. Section 1301 permit renewal fee: $300 plus $25 for each additional location;
2. Section 1302 permit renewal fee: $300 plus $25 for each additional location;
3. Section 1303 permit renewal fee: $300 plus $25 for each additional location; and

4. Section 1304 permit renewal fee: $300 plus $25 for each additional location.

**Historical Note**
Adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-47 renumbered as Section R4-11-406 without change effective July 29, 1981 (Supp. 81-4). Repealed effective February 16, 1995 (Supp. 95-1). New Section R4-11-406 renumbered from R4-11-906 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section R4-11-406 renumbered from R4-11-407 and amended by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1). Amended by final rulemaking at 9 A.A.R. 4130, effective November 8, 2003 (Supp. 03-3). Amended by final rulemaking at 22 A.A.R. 3697, effective February 6, 2017 (Supp. 16-4).

**R4-11-407. Renumbered**

**Historical Note**
Adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-48 renumbered as Section R4-11-407 without change effective July 29, 1981 (Supp. 81-4). Repealed effective February 16, 1995 (Supp. 95-1). New Section R4-11-407 renumbered from R4-11-909 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section R4-11-407 renumbered to R4-11-406 by final rulemaking at 6 A.A.R. 748, effective February 2, 2000 (Supp. 00-1).

**R4-11-408. Repealed**

**Historical Note**
Adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-49 renumbered as Section R4-11-408 without change effective July 29, 1981 (Supp. 81-4). Repealed effective February 16, 1995 (Supp. 95-1).

**R4-11-409. Repealed**

**Historical Note**
Adopted effective September 12, 1985 (Supp. 85-5). Repealed effective July 21, 1995 (Supp. 95-3).

## ARTICLE 5. DENTISTS

**R4-11-501. Dentist of Record**

**A.** A dentist of record shall ensure that each patient record has the treatment records for a patient treated in any dental office, clinic, hospital dental clinic, or charitable organization that offers dental services, and the full name of a dentist who is responsible for all of the patient's treatment.

**B.** A dentist of record shall obtain a patient's consent to change the treatment plan before changing the treatment plan that the patient originally agreed to, including any additional costs the patient may incur because of the change.

**C.** When a dentist who is a dentist of record decides to leave the practice of dentistry or a particular place of practice in which the dentist is the dentist of record, the dentist shall ensure before leaving the practice that a new dentist of record is entered on each patient record.

**D.** A dentist of record is responsible for the care given to a patient while the dentist was the dentist of record even after being replaced as the dentist of record by another dentist.

**E.** A dentist of record shall:

1. Remain responsible for the care of a patient during the course of treatment; and
2. Be available to the patient through the dentist's office, an emergency number, an answering service, or a substituting dentist.

**F.** A dentist's failure to comply with subsection (E) constitutes patient abandonment, and the Board may impose discipline under A.R.S. Title 32, Chapter 11, Article 3.

**Historical Note**
Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-62 renumbered as Section R4-11-501 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-501 repealed, new Section R4-11-501 renumbered from R4-11-1102 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-502. Affiliated Practice**

**A.** A dentist in a private for profit setting shall not enter into more than 15 affiliated practice relationships under A.R.S. § 32-1289 at one time.

**B.** There is no limit to the number of affiliated practice relationships a dentist may enter into when working in a government, public health, or non-profit organization under Section 501(C)(3) of the Internal Revenue Code.

**C.** Each affiliated practice dentist shall be available telephonically or electronically during the business hours of the affiliated practice dental hygienist to provide an appropriate level of contact, communication, and consultation.

**D.** The affiliated practice agreement shall include a provision for a substitute dentist in addition to the requirements of A.R.S. § 32-1289(E), to cover an extenuating circumstance that renders the affiliated practice dentist unavailable for contact, communication, or consultation with the affiliated practice dental hygienist.

**Historical Note**
Adopted effective December 6, 1974 (Supp. 75-1). Amended effective March 23, 1976 (Supp. 76-2). Former Section R4-11-63 renumbered as Section R4-11-502 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-502 renumbered to R4-11-701 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). New Section made by final rulemaking at 13 A.A.R. 962, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 29 A.A.R. 3793 (December 15, 2023), effective January 29, 2024 (Supp. 23-4).

**R4-11-503. Repealed**

**Historical Note**
Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-64 repealed, new Section R4-11-64 adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-64 renumbered as Section R4-11-503 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-503 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-504. Renumbered**

**Historical Note**
Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-65 repealed, new Section R4-11-65 adopted effective May 23, 1976 (Supp. 76-2). Former Section R4-11-65 renumbered as Section R4-11-504, repealed, and new Section R4-11-504 adopted effective

July 29, 1981 (Supp. 81-4). Former Section R4-11-504 renumbered to R4-11-702 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-505. Repealed**

**Historical Note**

Adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-66 renumbered as Section R4-11-505 and repealed effective July 29, 1981 (Supp. 81-4).

**R4-11-506. Repealed**

**Historical Note**

Adopted effective March 23, 1976 (Supp. 76-2). Former Section R4-11-67 renumbered as Section R4-11-506 and repealed effective July 29, 1981 (Supp. 81-4).

## ARTICLE 6. DENTAL HYGIENISTS

**R4-11-601. Duties and Qualifications**

**A.** A dental hygienist may apply Preventative and Therapeutic Agents under the general supervision of a licensed dentist.

**B.** A dental hygienist may perform a procedure not specifically authorized by A.R.S. § 32-1281 when all of the following conditions are satisfied:

1. The procedure is recommended or prescribed by the supervising dentist;
2. The dental hygienist has received instruction, training, or education to perform the procedure in a safe manner; and
3. The procedure is performed under the general supervision of a licensed dentist.

**C.** A dental hygienist shall not perform an Irreversible Procedure.

**D.** To qualify to use Emerging Scientific Technology as authorized by A.R.S. § 32-1281(C)(2), a dental hygienist shall successfully complete a course of study that meets the following criteria:

1. Is a course offered by a recognized dental school as defined in A.R.S. § 32-1201, a recognized dental hygiene school as defined in A.R.S. § 32-1201, or sponsored by a national or state dental or dental hygiene association or government agency;
2. Includes didactic instruction with a written examination;
3. Includes hands-on clinical instruction; and
4. Is technology that is scientifically based and supported by studies published in peer reviewed dental journals.

**Historical Note**

Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-82 renumbered as Section R4-11-601 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-601 repealed, new Section R4-11-601 renumbered from R4-11-402 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 13 A.A.R. 962, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-602. Care of Homebound Patients**

Dental hygienists treating homebound patients shall provide only treatment prescribed by the dentist of record in the diagnosis and treatment plan. The diagnosis and treatment plan shall be based on examination data obtained not more than 12 months before the treatment is administered.

**Historical Note**

Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-83 renumbered as Section R4-11-602 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-602 renumbered to R4-11-1001, new Section R4-11-602 renumbered from R4-11-403 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-603. Limitation on Number Supervised**

A dentist shall not supervise more than three dental hygienists at a time.

**Historical Note**

Adopted effective December 6, 1974 (Supp. 75-1). Former Section R4-11-84 renumbered as Section R4-11-603 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-603 renumbered to R4-11-1002, new Section R4-11-603 renumbered from R4-11-408 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-604. Selection Committee and Process**

**A.** The Board shall appoint a selection committee to screen candidates for the dental hygiene committee. The selection committee consists of three members. The Board shall appoint at least two members who are dental hygienists and one member who is a current Board member. The Board shall fill any vacancy for the unexpired portion of the term.

**B.** Each selection committee member's term is one year.

**C.** By majority vote, the selection committee shall nominate each candidate for the dental hygiene committee and transmit a list of names to the Board for approval, including at least one alternate.

**Historical Note**

New Section R4-11-604 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-605. Dental Hygiene Committee**

**A.** The Board shall appoint seven members to the dental hygiene committee as follows:

1. One dentist appointed at the annual December Board meeting, currently serving as a Board member, for a one year term;
2. One dental hygienist appointed at the annual December Board meeting, currently serving as a Board member and possessing the qualifications required in Article 6, for a one-year term;
3. Four dental hygienists that possess the qualifications required in Article 6; and
4. One lay person.

**B.** Except for members appointed as prescribed in subsections (A)(1) and (2), the Board shall appoint dental hygiene committee members for staggered terms of three years, beginning January 1, 1999, and limit each member to two consecutive terms. The Board shall fill any vacancy for the unexpired portion of the term.

**C.** The dental hygiene committee shall annually elect a chairperson at the first meeting convened during the calendar year.

**Historical Note**

New Section R4-11-605 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-606. Candidate Qualifications and Submissions**

**A.** A dental hygienist who seeks membership on the dental hygiene committee shall possess a license in good standing, issued by the Board.

**B.** A dental hygienist who is not a Board member and qualifies under subsection (A) shall submit a letter of intent and resume to the Board.

**C.** The selection committee shall consider all of the following criteria when nominating a candidate for the dental hygiene committee:
1. Geographic representation,
2. Experience in postsecondary curriculum analysis and course development,
3. Public health experience, and
4. Dental hygiene clinical experience.

**Historical Note**
New Section R4-11-606 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-607. Duties of the Dental Hygiene Committee**

**A.** The committee shall advise the Board on all matters relating to the regulation of dental hygienists.

**B.** In performing the duty in subsection (A), the committee may:
1. Act as a liaison for the Board, promoting communication and providing a forum for discussion of dental hygiene regulatory issues;
2. Review applications, syllabi, and related materials and make recommendations to the Board regarding certification of courses in Local Anesthesia, Nitrous Oxide Analgesia, and suture placement under Article 6 and other procedures which may require certification under Article 6;
3. Review documentation submitted by dental hygienists to determine compliance with the continuing education requirement for license renewal under Article 12 and make recommendations to the Board regarding compliance;
4. Make recommendations to the Board concerning statute and rule development which affect dental hygienists' education, licensure, regulation, or practice;
5. Provide advice to the Board on standards and scope of practice which affect dental hygiene practice;
6. Provide ad hoc committees to the Board upon request;
7. Request that the Board consider recommendations of the committee at the next regularly scheduled Board meeting; and
8. Make recommendations to the Board for approval of dental hygiene consultants.

**C.** Committee members who are licensed dentists or dental hygienists may serve as dental hygiene examiners or Board consultants.

**D.** The committee shall meet at least two times per calendar year. The chairperson or the president of the Board, or their respective designees, may call a meeting of the committee.

**E.** The Board may assign additional duties to the committee.

**Historical Note**
New Section R4-11-607 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).
Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-608. Dental Hygiene Consultants**

After submission of a current curriculum vitae or resume and approval by the Board, dental hygiene consultants may:
1. Act as dental hygiene examiners for the clinical portion of the dental hygiene examination;
2. Act as dental hygiene examiners for the Local Anesthesia portion of the dental hygiene examination;
3. Participate in Board-related procedures, including Clinical Evaluations, investigation of complaints concerning infection control, insurance fraud, or the practice of supervised personnel, and any other procedures not directly related to evaluating a dentist's quality of care; and
4. Participate in onsite office evaluations for infection control, as part of a team.

**Historical Note**
New Section R4-11-608 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).
Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-609. Affiliated Practice**

**A.** To perform dental hygiene services under an affiliated practice relationship pursuant to A.R.S. § 32-1289.01, a dental hygienist shall:
1. Provide evidence to the Board of successfully completing a total of 12 hours of Recognized Continuing Dental Education that consists of the following subject areas:
   a. A minimum of four hours in medical emergencies; and
   b. A minimum of eight hours in at least two of the following areas:
      i. Pediatric or other special health care needs,
      ii. Preventative dentistry, or
      iii. Public health community-based dentistry, and
2. Hold a current certificate in basic cardiopulmonary resuscitation.

**B.** A dental hygienist shall complete the required continuing dental education before entering an affiliated practice relationship. The dental hygienist shall complete the continuing dental education in subsection (A) before renewing the dental hygienist's license. The dental hygienist may take the continuing dental education online but shall not exceed the allowable hours indicated in R4-11-1209(B)(1).

**C.** To comply with A.R.S. § 32-1287(B) and this Section, a dental hygienist shall submit a completed affidavit on a form supplied by the Board office. Board staff shall review the affidavit to determine compliance with all requirements.

**D.** Each affiliated practice dentist shall be available telephonically or electronically during the business hours of the affiliated practice dental hygienist to provide an appropriate level of contact, communication, and consultation.

**E.** The affiliated practice agreement shall include a provision for a substitute dentist, to cover an extenuating circumstance that renders the affiliated practice dentist unavailable for contact, communication, and consultation with the affiliated practice dental hygienist.

**Historical Note**
New Section made by final rulemaking at 13 A.A.R. 962, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

## ARTICLE 7. DENTAL ASSISTANTS

**R4-11-701. Procedures and Functions Performed by a Dental Assistant under Supervision**

**A.** A dental assistant may perform the following procedures and functions under the Direct Supervision of a licensed dentist or a licensed dental therapist:

1. Place dental material into a patient's mouth in response to a licensed dentist's or licensed dental therapist's instruction;
2. Cleanse the supragingival surface of the tooth in preparation for:
   a. The placement of bands, crowns, and restorations;
   b. Dental dam application;
   c. Acid etch procedures; and
   d. Removal of dressings and packs;
3. Remove excess cement from inlays, crowns, bridges, and orthodontic appliances with hand instruments;
4. Remove temporary cement, interim restorations, and periodontal dressings with hand instruments;
5. Remove sutures;
6. Place and remove dental dams and matrix bands;
7. Fabricate and place interim restorations with temporary cement;
8. Apply sealants;
9. Apply topical fluorides;
10. Take final digital impressions for any activating orthodontic appliance, fixed, or removable prosthesis;
11. Prepare a patient for Nitrous Oxide Analgesia administration upon the direct instruction and presence of a dentist or licensed dental therapist; or
12. Observe a patient during Nitrous Oxide Analgesia as instructed by the dentist or licensed dental therapist.

**B.** A dental assistant may perform the following procedures and functions under the general supervision of a licensed dentist or a licensed dental therapist:

1. Train or instruct patients in oral hygiene techniques, preventive procedures, dietary counseling for caries and Plaque control, and provide pre-and post-operative instructions relative to specific office treatment;
2. Collect and record information pertaining to extraoral conditions; and
3. Collect and record information pertaining to existing intraoral conditions.

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-100 renumbered as Section R4-11-701 and amended effective July 29, 1981 (Supp. 81-4). Former Section R4-11-701 renumbered to R4-11-1701, new Section R4-11-701 renumbered from R4-11-502 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-702. Limitations on Procedures or Functions Performed by a Dental Assistant under Supervision**

A dental assistant shall not perform the following procedures or functions:

1. A procedure which by law only licensed dentists, licensed dental therapists, licensed dental hygienists, or certified denturists can perform;
2. Intraoral carvings of dental restorations or prostheses;
3. Final jaw registrations;
4. Taking final impressions, other than digital impressions, for any activating orthodontic appliance, fixed or removable prosthesis;
5. Activating orthodontic appliances; or
6. An Irreversible Procedure.

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-101 renumbered as Section R4-11-702 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-702 repealed, new Section R4-11-702 renumbered from R4-11-504 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-703. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-102 renumbered as Section R4-11-703 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-703 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-704. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-103 renumbered as Section R4-11-704 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-704 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-705. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-104 renumbered as Section R4-11-705 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-705 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-706. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-105 renumbered as Section R4-11-706 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-706 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-707. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-106 renumbered as Section R4-11-707 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-707 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-708. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-107 renumbered as Section R4-11-708 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-708 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-709. Repealed**

**Historical Note**

Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-108 renumbered as Section R4-11-709 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-709 repealed by final rulemaking at 5

A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-710. Repealed**

**Historical Note**
Adopted effective April 27, 1977 (Supp. 77-2). Former Section R4-11-109 renumbered as Section R4-11-710 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-710 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

## ARTICLE 8. DENTURISTS

**R4-11-801. Expired**

**Historical Note**
Adopted effective March 28, 1978 (Supp. 78-2). Former Section R4-11-120 renumbered as Section R4-11-801 without change effective July 29, 1981 (Supp. 81-4). Section R4-11-801 repealed, new Section filed April 4, 1986, adopted effective January 1, 1988 (Supp. 86-2). Amended effective May 17, 1995 (Supp. 95-2). Former Section R4-11-801 repealed, new Section R4-11-801 renumbered from R4-11-1201 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 2575, effective August 25, 2017 (Supp. 17-3).

**R4-11-802. Expired**

**Historical Note**
Adopted effective March 28, 1978 (Supp. 78-2). Former Section R4-11-121 renumbered as Section R4-11-802 without change effective July 29, 1981 (Supp. 81-4). Section R4-11-802 repealed, new Section filed April 4, 1986, adopted effective January 1, 1988 (Supp. 86-2). Amended effective May 17, 1995 (Supp. 95-2). Former Section R4-11-802 renumbered to R4-11-1301, new Section R4-11-802 renumbered from R4-11-1202 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 2575, effective August 25, 2017 (Supp. 17-3).

**R4-11-803. Renumbered**

**Historical Note**
Adopted effective March 28, 1978 (Supp. 78-2). Former Section R4-11-122 renumbered as Section R4-11-803 without change effective July 29, 1981 (Supp. 81-4). Section R4-11-803 repealed, new Section filed April 4, 1986, adopted effective January 1, 1988 (Supp. 86-2). Amended effective May 17, 1995 (Supp. 95-2). Former Section R4-11-803 renumbered to R4-11-1302 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-804. Renumbered**

**Historical Note**
Adopted effective March 28, 1978 (Supp. 78-2). Former Section R4-11-123 renumbered as Section R4-11-804 without change effective July 29, 1981 (Supp. 81-4). Section R4-11-804 repealed, new Section filed April 4, 1986, adopted effective January 1, 1988 (Supp. 86-2). Former Section R4-11-804 renumbered to R4-11-1303 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-805. Renumbered**

**Historical Note**
Adopted as filed April 4, 1986, adopted effective January 1, 1988 (Supp. 86-2). Amended effective May 17, 1995 (Supp. 95-2). Former Section R4-11-805 renumbered to R4-11-1304 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-806. Renumbered**

**Historical Note**
Adopted effective May 17, 1995 (Supp. 95-2). Former Section R4-11-806 renumbered to R4-11-1305 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

## ARTICLE 9. RESTRICTED PERMITS

**R4-11-901. Application for Restricted Permit**

**A.** An applicant for a restricted permit shall provide the following information and documentation on a form provided by the Board:
1. A sworn statement of the applicant's qualifications for a restricted permit;
2. A photograph of the applicant that is no more than six months old;
3. A letter from any other jurisdiction in which an applicant is licensed or certified verifying that the applicant is licensed or certified in that jurisdiction, sent directly from that jurisdiction to the Board;
4. If the applicant is in the military or employed by the United States government, a letter from the applicant's commanding officer or supervisor verifying the applicant is licensed or certified by the military or United States government;
5. A copy of the applicant's current cardiopulmonary resuscitation certification that meets the requirements of R4-11-301(A)(6); and
6. A copy of the applicant's pending contract with a Charitable Dental Clinic or Organization offering dental or dental hygiene services.

**B.** The Board may request that an applicant provide a copy of a certified document that indicates the reason for a name change if the applicant's application contains different names.

**Historical Note**
Adopted effective September 7, 1979 (Supp. 79-5). Former Section R4-11-130 renumbered as Section R4-11-901, repealed, and new Section R4-11-901 adopted effective July 29, 1981 (Supp. 81-4). Amended effective April 4, 1986 (Supp. 86-2). Emergency amendment adopted effective June 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Adopted effective July 13, 1992 (Supp. 92-3). Former Section R4-11-901 renumbered to R4-11-401, new Section R4-11-901 renumbered from R4-11-1001 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 28 A.A.R. 1885 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-902. Issuance of a Restricted Permit**

Before issuing a restricted permit under A.R.S. §§ 32-1237 through 32-1239 or 32-1292, the Board shall investigate the statutory qualifications of the charitable dental clinic or organization. The Board shall not recognize a dental clinic or organization under A.R.S. §§ 32-1237 through 32-1239 or 32-1292 as a charitable dental clinic or organization permitted to employ dentists or dental hygienists not licensed in Arizona who hold restricted permits unless the Board makes the following findings of fact:

1. That the entity is a dental clinic or organization offering professional dental or dental hygiene services in a manner consistent with the public health;
2. That the dental clinic or organization offering dental or dental hygiene services is operated for charitable purposes only, offering dental or dental hygiene services either without compensation to the clinic or organization or with compensation at the minimum rate to provide only reimbursement for dental supplies and overhead costs;
3. That the persons performing dental or dental hygiene services for the dental clinic or organization do so without compensation; and
4. That the charitable dental clinic or organization operates in accordance with applicable provisions of law.

**Historical Note**

Adopted effective September 7, 1979 (Supp. 79-5). Former Section R4-11-131 renumbered as Section R4-11-902, repealed, and new Section R4-11-902 adopted effective July 29, 1981 (Supp. 81-4). Amended effective April 4, 1986 (Supp. 86-2). Emergency amendment adopted effective June 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Adopted effective July 13, 1992 (Supp. 92-3). Former Section R4-11-902 renumbered to R4-11-402, new Section R4-11-902 renumbered from R4-11-1002 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-903. Recognition of a Charitable Dental Clinic or Organization**

In order for the Board to make the findings required in R4-11-902, the charitable clinic or organization shall provide information to the Board, such as employment contracts with restricted permit holders, Articles and Bylaws, and financial records.

**Historical Note**

Adopted effective September 7, 1979 (Supp. 79-5). Former Section R4-11-132 renumbered as Section R4-11-903, repealed, and new Section R4-11-903 adopted effective July 29, 1981 (Supp. 81-4). Former Section R4-11-903 renumbered to R4-11-403, new Section R4-11-903 renumbered from R4-11-1003 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 29 A.A.R. 3793 (December 15, 2023), effective January 29, 2024 (Supp. 23-4).

**R4-11-904. Determination of Minimum Rate**

In determining whether professional services are provided at the minimum rate to provide reimbursement for dental supplies and overhead costs under A.R.S. §§ 32-1237(1) or 32-1292(A)(1), the Board shall obtain and review information relating to the actual cost of dental supplies to the dental clinic or organization, the actual overhead costs of the dental clinic or organization, the amount of charges for the dental or dental hygiene services offered, and any other information relevant to its inquiry.

**Historical Note**

Adopted effective September 7, 1979 (Supp. 79-5). Former Section R4-11-133 renumbered as Section R4-11-904 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-904 renumbered to R4-11-404, new Section R4-11-904 renumbered from R4-11-1004 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-905. Expired**

**Historical Note**

Adopted effective September 7, 1979 (Supp. 79-5). Former Section R4-11-134 renumbered as Section R4-11-905 without change effective July 29, 1981 (Supp. 81-4). Amended effective April 4, 1986 (Supp. 86-2). Former Section R4-11-905 renumbered to R4-11-405, new Section R4-11-905 renumbered from R4-11-1005 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 2575, effective August 25, 2017 (Supp. 17-3).

**R4-11-906. Expired**

**Historical Note**

Adopted effective July 29, 1981 (Supp. 81-4). Amended effective April 4, 1986 (Supp. 86-4). Emergency amendment adopted effective June 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Adopted effective July 13, 1992 (Supp. 92-3). Former Section R4-11-906 renumbered to R4-11-406, new Section R4-11-906 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 2575, effective August 25, 2017 (Supp. 17-3).

**R4-11-907. Repealed**

**Historical Note**

Adopted effective April 4, 1986 (Supp. 86-2). Former Section R4-11-907 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-908. Repealed**

**Historical Note**

Adopted effective April 4, 1986 (Supp. 86-2). Former Section R4-11-908 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-909. Renumbered**

**Historical Note**

Adopted effective May 17, 1995 (Supp. 95-2). Former Section R4-11-909 renumbered to R4-11-407 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

## ARTICLE 10. DENTAL TECHNICIANS

**R4-11-1001. Expired**

**Historical Note**
Adopted effective November 28, 1980 (Supp. 80-6). Former Section R4-11-140 renumbered as Section R4-11-1001 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-1001 renumbered to R4-11-901, new Section R4-11-1001 renumbered from R4-11-602 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 2575, effective August 25, 2017 (Supp. 17-3).

**R4-11-1002. Expired**

**Historical Note**
Adopted effective November 28, 1980 (Supp. 80-6). Former Section R4-11-141 renumbered as Section R4-11-1002 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-1002 renumbered to R4-11-902, new Section R4-11-1002 renumbered from R4-11-603 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 2575, effective August 25, 2017 (Supp. 17-3).

**R4-11-1003. Renumbered**

**Historical Note**
Adopted effective November 28, 1980 (Supp. 80-6). Former Section R4-11-142 renumbered as Section R4-11-1003 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-1003 renumbered to R4-11-903 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-1004. Renumbered**

**Historical Note**
Adopted effective November 28, 1980 (Supp. 80-6). Former Section R4-11-143 renumbered as Section R4-11-1004 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-1004 renumbered to R4-11-904 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-1005. Renumbered**

**Historical Note**
Adopted effective November 28, 1980 (Supp. 80-6). Former Section R4-11-144 renumbered as Section R4-11-1005 without change effective July 29, 1981 (Supp. 81-4). Former Section R4-11-1005 renumbered to R4-11-905 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-1006. Repealed**

**Historical Note**
Adopted effective September 12, 1985 (Supp. 85-5). Repealed effective July 21, 1995 (Supp. 95-3).

## ARTICLE 11. ADVERTISING

**R4-11-1101. Advertising**
A dentist may advertise specific dental services or certification in a non-specialty area only if the advertisement includes the phrase "Services provided by an Arizona licensed general dentist." A dental hygienist may advertise specific dental hygiene services only if the advertisement includes the phrase "Services provided by an Arizona licensed dental hygienist." A denturist may advertise specific denture services only if the advertisement includes the phrase "Services provided by an Arizona certified denturist."

**Historical Note**
Adopted effective July 29, 1981 (Supp. 81-4). Amended by repealing the former guideline on "Management of Craniomandibular Disorders" and adopting a new guideline effective June 16, 1982 (Supp. 82-3). Repealed effective November 20, 1992 (Supp. 92-4). Former Section R4-11-1101 repealed, new Section R4-11-1101 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-1102. Advertising as a Recognized Specialist**

**A.** A dentist may advertise as a specialist or use the terms "specialty" or "specialist" to describe professional services only if the dentist limits the dentist's practice exclusively to one or more specialty area that are:
1. Recognized by a board that certifies specialists for the area of specialty; and
2. Accredited by the Commission on Dental Accreditation of the American Dental Association.

**B.** The following specialty areas meet the requirements of subsection (A):
1. Endodontics,
2. Oral and maxillofacial surgery,
3. Orthodontics and dentofacial orthopedics,
4. Pediatric dentistry,
5. Periodontics,
6. Prosthodontics,
7. Dental Public Health,
8. Oral and Maxillofacial Pathology, and
9. Oral and Maxillofacial Radiology.

**C.** For purposes of this Article, a dentist who wishes to advertise as a specialist or a multiple-specialist in a recognized field under subsection (B) shall meet the criteria in one or more of the following categories:
1. Grandfathered: A dentist who declared a specialty area before December 31, 1964, according to requirements established by the American Dental Association, and has a practice limited to a dentistry area approved by the American Dental Association;
2. Educationally qualified: A dentist who has successfully completed an educational program of two or more years in a specialty area accredited by the Commission on Dental Accreditation of the American Dental Association, as specified by the Council on Dental Education of the American Dental Association;
3. Board eligible: A dentist who has met the guidelines of a specialty board that operates in accordance with the requirements established by the American Dental Association in a specialty area recognized by the Board, if the specialty board:
   a. Has established examination requirements and standards,
   b. Appraised an applicant's qualifications,
   c. Administered comprehensive examinations, and
   d. Upon completion issues a certificate to a dentist who has achieved diplomate status; or
4. Board certified: A dentist who has met the requirements of a specialty board referenced in subsection (C)(3), and who has received a certificate from the specialty board, indicating the dentist has achieved diplomate status.

**D.** A dentist, dental hygienist, or denturist whose advertising implies that services rendered in a dental office are of a specialty area other than those listed in subsection (B) and recognized by a specialty board that has been accredited by the Commission on Dental Accreditation of the American Dental Association violates this Article and A.R.S. § 32-1201(18)(u), and is subject to discipline under A.R.S. Title 32, Chapter 11.

**Historical Note**

Adopted effective July 29, 1981 (Supp. 81-4). Former Section R4-11-1102 renumbered to R4-11-501 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). New Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-1103. Reserved**

**R4-11-1104. Repealed**

**Historical Note**

Adopted effective November 25, 1985 (Supp. 85-6). Former Section R4-11-1104 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-1105. Repealed**

**Historical Note**

Adopted effective September 12, 1985 (Supp. 85-5). Repealed effective July 21, 1995 (Supp. 95-3).

## ARTICLE 12. CONTINUING DENTAL EDUCATION AND RENEWAL REQUIREMENTS

**R4-11-1201. Continuing Dental Education**

**A.** A licensee or certificate holder shall:
1. Satisfy a continuing dental education requirement that is designed to provide an understanding of current developments, skills, procedures, or treatment related to the licensee's or certificate holder's practice; and
2. Complete the recognized continuing dental education required by this Article each renewal period.

**B.** A licensee or certificate holder receiving an initial license or certificate shall complete the prescribed credit hours of recognized continuing dental education by the end of the first full renewal period.

**Historical Note**

Adopted effective May 21, 1982 (Supp. 82-3). Former Section R4-11-1201 renumbered to R4-11-801, new Section R4-11-1201 renumbered from R4-11-1402 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-1202. Continuing Dental Education Compliance and Renewal Requirements**

**A.** When applying for a renewal license, certificate, or restricted permit, a Licensee, denturist, or Restricted Permit Holder shall complete a renewal application provided by the Board.

**B.** Before receiving a renewal license or certificate, each Licensee or denturist shall possess a current form of one of the following:
1. A cardiopulmonary resuscitation healthcare provider level certificate from the American Red Cross, the American Heart Association, or another certifying agency;
2. Advanced cardiac life support course completion confirmation from the American Heart Association or another agency. The confirmation must indicate that the course was completed within two years immediately before submitting a renewal application; or
3. Pediatric advanced life support course completion confirmation from the American Heart Association or another agency. The confirmation must indicate that the course was completed within two years immediately before submitting a renewal application.

**C.** A Licensee or denturist shall include an affidavit affirming the Licensee's or denturist's completion of the prescribed Credit Hours of Recognized Continuing Dental Education with a renewal application. A Licensee or denturist shall include on the affidavit the Licensee's or denturist's name, license or certificate number, the number of hours completed in each category, and the total number of hours completed for activities defined in R4-11-1209(A)(4).

**D.** A Licensee or denturist shall submit a written request for an extension before the renewal deadline prescribed in A.R.S. §§ 32-1236, 32-1276.02, 32-1287, and 32-1297.06. If a Licensee or denturist fails to meet the Credit Hours requirement because of military service, dental or religious missionary activity, residence in a foreign country, or other extenuating circumstances as determined by the Board, the Board, upon written request, may grant an extension of time to complete the Recognized Continuing Dental Education Credit Hour requirement.

**E.** The Board shall:
1. Only accept Recognized Continuing Dental Education credits accrued during the prescribed period immediately before license or certificate renewal, and
2. Not allow Recognized Continuing Dental Education credit accrued in a renewal period in excess of the amount required in this Article to be carried forward to the next renewal period.

**F.** A Licensee or denturist shall maintain Documentation of Attendance for each program for which credit is claimed that verifies the Recognized Continuing Dental Education Credit Hours the Licensee or denturist participated in during the most recently completed renewal period.

**G.** Each year, the Board shall audit continuing dental education requirement compliance on a random basis or when information is obtained which indicates a Licensee or denturist may not be in compliance with this Article. A Licensee or denturist selected for audit shall provide the Board with Documentation of Attendance that shows compliance with the continuing dental education requirements within 35 calendar days from the date the Board issues notice of the audit by certified mail.

**H.** If a Licensee or denturist is found to not be in compliance with the continuing dental education requirements, the Board may take any disciplinary or non-disciplinary action authorized by A.R.S. Title 32, Chapter 11.

**Historical Note**

Adopted effective May 21, 1982 (Supp. 82-3). Former Section R4-11-1202 renumbered to R4-11-802, new Section R4-11-1202 renumbered from R4-11-1403 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 21 A.A.R. 921, effective August 3, 2015 (Supp. 15-2). Amended by final rulemaking at 28 A.A.R. 344 (February 4, 2022), effective March 14, 2022 (Supp. 22-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022

(Supp. 22-3).

**R4-11-1203. Dentists and Dental Consultants**

Dentists and dental consultants shall complete 63 hours of Recognized Continuing Dental Education in each renewal period as follows:

1. At least 36 Credit Hours in any one or more of the following areas: Dental and medical health, preventive services, dental diagnosis and treatment planning, dental recordkeeping, dental clinical procedures, managing medical emergencies, pain management, dental public health, and courses in corrective and restorative oral health and basic dental sciences, which may include current research, new concepts in dentistry, chemical dependency, tobacco cessation, and behavioral and biological sciences that are oriented to dentistry. A Licensee who holds a permit to administer General Anesthesia, Deep Sedation, Parenteral Sedation, or Oral Sedation who is required to obtain continuing education pursuant to Article 13 may apply those Credit Hours to the requirements of this Section;
2. No more than 15 Credit Hours in one or more of the following areas: Dental practice organization and management, patient management skills, and methods of health care delivery;
3. At least three Credit Hours in opioid education;
4. At least three Credit Hours in infectious diseases or infectious disease control;
5. At least three Credit Hours in cardiopulmonary resuscitation healthcare provider level, advanced cardiac life support or pediatric advanced life support. Coursework may be completed online if the course requires a physical demonstration of skills; and
6. At least three Credit Hours in ethics or Arizona dental jurisprudence.

**Historical Note**

Adopted effective September 12, 1985 (Supp. 85-5). Repealed effective July 21, 1995 (Supp. 95-3). New Section R4-11-1203 renumbered from R4-11-1404 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1204. Dental Hygienists**

**A.** A dental hygienist shall complete 45 Credit Hours of Recognized Continuing Dental Education in each renewal period as follows:

1. At least 25 Credit Hours in any one or more of the following areas: Dental and medical health, and dental hygiene services, periodontal disease, care of implants, maintenance of cosmetic restorations and sealants, radiology safety and techniques, managing medical emergencies, pain management, dental recordkeeping, dental public health, and new concepts in dental hygiene;
2. No more than 11 Credit Hours in one or more of the following areas: Dental hygiene practice organization and management, patient management skills, and methods of health care delivery;
3. At least three Credit Hours in one or more of the following areas: chemical dependency, tobacco cessation, ethics, risk management, or Arizona dental jurisprudence;
4. At least three Credit Hours in infectious diseases or infectious disease control; and
5. At least three Credit Hours in cardiopulmonary resuscitation healthcare provider level, advanced cardiac life support and pediatric advanced life support. Coursework may be completed online if the course re-quires a physical demonstration of skills.

**B.** A Licensee who performs dental hygiene services under an affiliated practice relationship who is required to obtain continuing education under R4-11-609 may apply those Credit Hours to the requirements of this Section.

**Historical Note**

New Section R4-11-1204 renumbered from R4-11-1405 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 13 A.A.R. 962, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1205. Denturists**

Denturists shall complete 27 Credit Hours of Recognized Continuing Dental Education in each renewal period as follows:

1. At least 15 Credit Hours in any one or more of the following areas: Medical and dental health, laboratory procedures, clinical procedures, dental recordkeeping, removable prosthetics, pain management, dental public health, and new technology in dentistry;
2. No more than three Credit Hours in one or more of the following areas: Denturist practice organization and management, patient management skills, and methods of health care delivery;
3. At least one Credit Hour in chemical dependency, which may include tobacco cessation;
4. At least two Credit Hours in infectious diseases or infectious disease control;
5. At least three Credit Hours in cardiopulmonary resuscitation healthcare provider level, advanced cardiac life support and pediatric advanced life support. Coursework may be completed online if the course re-quires a physical demonstration of skills; and
6. At least three Credit Hours in ethics or Arizona dental jurisprudence.

**Historical Note**

New Section R4-11-1205 renumbered from R4-11-1406 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1206. Restricted Permit Holders - Dental**

In addition to the requirements in R4-11-1202, a dental Restricted Permit Holder shall comply with the following requirements:

1. When applying for renewal under A.R.S. § 32-1238, the Restricted Permit Holder shall provide information to the Board that the Restricted Permit Holder has completed 15 Credit Hours of Recognized Continuing Dental Education yearly.

2. To determine whether to grant the renewal, the Board shall only consider Recognized Continuing Dental Education credits accrued during the 36 months immediately before the renewal deadline prescribed in A.R.S. § 32-1236.
3. A dental Restricted Permit Holder shall complete the 15 hours of Recognized Continuing Dental Education before renewal as follows:
   a. At least six Credit Hours in one or more of the subjects enumerated in R4-11-1203(1);
   b. No more than three Credit Hours in one or more of the subjects enumerated in R4-11-1203(2);
   c. At least one Credit Hour in the subjects enumerated in R4-11-1203(3);
   d. At least one Credit Hour in the subjects enumerated in R4-11-1203(4).
   e. At least three Credit Hours in the subjects enumerated in R4-11-1203(5); and
   f. At least one Credit Hour in the subjects enumerated in R4-11-1203(6).

**Historical Note**

New Section R4-11-1206 renumbered from R4-11-1407 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 344 (February 4, 2022), effective March 14, 2022 (Supp. 22-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1207. Restricted Permit Holders - Dental Hygiene**

In addition to the requirements in R4-11-1202, a dental hygiene Restricted Permit Holder shall comply with the following:

1. When applying for renewal under A.R.S. § 32-1292, the Restricted Permit Holder shall provide information to the Board that the Restricted Permit Holder has completed nine Credit Hours of Recognized Continuing Dental Education yearly.
2. To determine whether to grant renewal, the Board shall only consider Recognized Continuing Dental Education credits accrued during the 36 months immediately before the renewal deadline prescribed in A.R.S. § 32-1287.
3. A dental hygiene Restricted Permit Holder shall complete the nine hours of Recognized Continuing Dental Education before renewal as follows:
   a. At least three Credit Hours in one or more of the subjects enumerated in R4-11-1204(1);
   b. No more than three Credit Hours in one or more of the subjects enumerated in R4-11-1204(2);
   c. At least one Credit Hour in the subjects enumerated in R4-11-1204(3);
   d. At least two Credit Hours in the subjects enumerated in R4-11-1204(4) and
   e. At least three Credit Hours in the subjects enumerated in R4-11-1204(5).

**Historical Note**

New Section R4-11-1207 renumbered from R4-11-1408 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 344 (February 4, 2022), effective March 14, 2022 (Supp. 22-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1208. Retired Licensees or Retired Denturists**

A Retired Licensee or Retired denturist shall:

1. Except for the number of Credit Hours required, comply with the requirements in R4-11-1202; and
2. When applying for renewal under A.R.S. § 32-1236 for a dentist, A.R.S. § 32-1276.02 for a dental therapist, A.R.S. § 32-1287 for a dental hygienist, and A.R.S. § 32-1297.06 for a denturist, provide information to the Board that the Retired Licensee or Retired denturist has completed the following Credit Hours of Recognized Continuing Dental Education per renewal period:
   a. Dentist - 24 Credit Hours of which no less than three Credit Hours shall be for cardiopulmonary resuscitation-healthcare provider level;
   b. Dental therapist - 21 Credit Hours of which no less than three Credit Hours shall be for cardiopulmonary resuscitation- healthcare provider level;
   c. Dental hygienist - 18 Credit Hours of which no less than three Credit Hours shall be for cardiopulmonary resuscitation-healthcare provider level; and
   d. Denturist - six Credit Hours of which no less than three Credit Hours shall be for cardiopulmonary resuscitation-healthcare provider level.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1209. Types of Courses**

**A.** A Licensee or denturist shall obtain Recognized Continuing Dental Education from one or more of the following activities:

1. Seminars, symposiums, lectures, or programs designed to provide an understanding of current developments, skills, procedures, or treatment related to the practice of dentistry;
2. Seminars, symposiums, lectures, or programs designed to provide an understanding of current developments, skills, procedures, or treatment related to the practice of dentistry by means of audio-video technology in which the Licensee is provided all seminar, symposium, lecture or program materials and the technology permits attendees to fully participate; or
3. Curricula designed to prepare for specialty board certification as a specialist or recertification examinations or advanced training at an accredited institution as defined in A.R.S. Title 32, Chapter 11; and
4. Subject to the limitations in subsection (B), any of the following activities that provide an understanding of current developments, skills, procedures, or treatment related to the practice of dentistry:
   a. A correspondence course, video, internet or similar self-study course, if the course includes an examination and the Licensee or denturist passes the examination;
   b. Participation on the Board, in Board complaint investigations including Clinical Evaluations or anesthesia and sedation permit evaluations;

c. Participation in peer review of a national or state dental, dental therapy, dental hygiene, or denturist association or participation in quality of care or utilization review in a hospital, institution, or governmental agency;
d. Providing dental-related instruction to dental, dental therapy, dental hygiene, or denturist students, or allied health professionals in a recognized dental school, recognized dental therapy school, recognized dental hygiene school, or recognized denturist school or providing dental-related instruction sponsored by a national, state, or local dental, dental therapy, dental hygiene, or denturist association;
e. Publication or presentation of a dental paper, report, or book authored by the Licensee or denturist that provides information on current developments, skills, procedures, or treatment related to the practice of dentistry. A Licensee or denturist may claim Credit Hours:
i. Only once for materials presented;
ii. Only if the date of publication or original presentation was during the applicable renewal period; and
iii. One Credit Hour for each hour of preparation, writing, and presentation; or
f. Providing dental, dental therapy, dental hygiene, or denturist services in a Board-recognized Charitable Dental Clinic or Organization.

**B.** The following limitations apply to the total number of Credit Hours earned per renewal period in any combination of the activities listed in subsection (A)(4):
1. Dentists, no more than 21 hours;
2. Dental therapists, no more than 18 hours;
3. Dental hygienists, no more than 15 hours;
4. Denturists, no more than nine hours;
5. Retired or Restricted Permit Holder dentists, dental therapists, or dental hygienists, no more than two hours; and
6. Retired denturists, no more than two hours.

**Historical Note**
New Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 3873, effective January 5, 2014 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1210. Dental Therapists**
Dental therapists shall complete 54 hours of Recognized Continuing Dental Education in each renewal period as follows:
1. At least 31 Credit Hours in any one or more of the following areas: Dental and medical health, dental therapy services, dental therapy treatment planning, preventive services, dental diagnosis and treatment planning, dental recordkeeping, dental clinical procedures, managing medical emergencies, pain management, dental public health, periodontal disease, care of implants, maintenance of cosmetic restorations and sealants, radiology safety and techniques, and courses in corrective and restorative oral health and basic dental sciences, which may include current research, new concepts in dentistry, and behavioral and biological sciences that are oriented to dentistry;
2. No more than 14 Credit Hours in any one or more of the following areas: Dental practice organization and management, patient management skills, and methods of health care delivery;
3. At least three Credit Hours in infectious diseases or infectious disease control;
4. At least three Credit Hours in cardiopulmonary resuscitation healthcare provider level, advanced cardiac life support or pediatric advanced life support. Coursework may be completed online if the course requires a physical demonstration of skills; and
5. At least three Credit Hours in any one or more of the following areas: ethics, risk management, chemical dependency, tobacco cessation, or Arizona dental jurisprudence.

**Historical Note**
New Section made by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

## ARTICLE 13. GENERAL ANESTHESIA AND SEDATION

**R4-11-1301. General Anesthesia and Deep Sedation**

**A.** Before administering General Anesthesia, or Deep Sedation by any means, in a dental office or dental clinic, a dentist shall possess a Section 1301 Permit issued by the Board. The dentist may renew a Section 1301 Permit every five years by complying with R4-11-1307.

**B.** To obtain or renew a Section 1301 Permit, a dentist shall:
1. Submit a completed application on a form provided by the Board office that, in addition to the requirements of subsections (B)(2) and (3), and R4-11-1307, includes:
a. General information about the applicant such as:
i. Name;
ii. Home and office addresses and telephone numbers;
iii. Limitations of practice;
iv. Hospital affiliations;
v. Denial, curtailment, revocation, or suspension of hospital privileges;
vi. Denial of membership in, denial of renewal of membership in, or disciplinary action by a dental organization; and
vii. Denial of licensure by, denial of renewal of licensure by, or disciplinary action by a dental regulatory body; and
b. The dentist's dated and signed affidavit stating that the information provided is true, and that the dentist has read and complied with the Board's statutes and rules;
2. On forms provided by the Board, provide a dated and signed affidavit attesting that any office or dental clinic where the dentist will administer General Anesthesia or Deep Sedation:
a. Contains the following properly operating equipment and supplies during the provision of General Anesthesia and Deep Sedation:
i. Emergency Drugs;
ii. Electrocardiograph monitor;
iii. Pulse oximeter;
iv. Cardiac defibrillator or automated external defibrillator;
v. Positive pressure oxygen and supplemental oxygen;
vi. Suction equipment, including endotracheal, tonsillar, or pharyngeal and emergency backup medical suction device;

vii. Laryngoscope, multiple blades, backup batteries, and backup bulbs;
viii. Endotracheal tubes and appropriate connectors;
ix. Magill forceps;
x. Oropharyngeal and nasopharyngeal airways;
xi. Auxiliary lighting;
xii. Stethoscope; and
xiii. Blood pressure monitoring device; and

b. Maintains a staff of supervised personnel capable of handling procedures, complications, and emergency incidents. All personnel involved in administering and monitoring General Anesthesia or Deep Sedation shall hold a current course completion confirmation in cardiopulmonary resuscitation healthcare provider level;

3. Hold a valid license to practice dentistry in this state;
4. Maintain a current permit to prescribe and administer Controlled Substances in this state issued by the United States Drug Enforcement Administration; and
5. Provide confirmation of completing coursework within the two years prior to submitting the permit application in one or more of the following:
   a. Advanced cardiac life support from the American Heart Association or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association;
   b. Pediatric advanced life support in a practice treating pediatric patients; or
   c. A recognized continuing education course in advanced airway management.

**C.** Initial applicants shall meet one or more of the following conditions by submitting to the Board verification of meeting the condition directly from the issuing institution:
1. Complete, within the three years before submitting the permit application, a full credit load, as defined by the training program, during one calendar year of training, in anesthesiology or related academic subjects, beyond the undergraduate dental school level in a training program described in R4-11-1306(A), offered by a hospital accredited by the Joint Commission on Accreditation of Hospitals Organization, or sponsored by a university accredited by the American Dental Association Commission on Dental Accreditation;
2. Be, within the three years before submitting the permit application, a Diplomate of the American Board of Oral and Maxillofacial Surgeons or eligible for examination by the American Board of Oral and Maxillofacial surgeons, a Fellow of the American Association of Oral and Maxillofacial surgeons, a Fellow of the American Dental Society of Anesthesiology, a Diplomate of the National Dental Board of Anesthesiology, or a Diplomate of the American Dental Board of Anesthesiology; or
3. For an applicant who completed the requirements of subsections (C)(1) or (C)(2) more than three years before submitting the permit application, provide the following documentation:
   a. On a form provided by the Board, a written affidavit affirming that the applicant has administered General Anesthesia or Deep Sedation to a minimum of 25 patients within the year before submitting the permit application or 75 patients within the last five years before submitting the permit application;
   b. A copy of the General Anesthesia or Deep Sedation permit in effect in another state or certification of military training in General Anesthesia or Deep Sedation from the applicant's commanding officer; and
   c. On a form provided by the Board, a written affidavit affirming the completion of 30 clock hours of continuing education taken within the last five years as outlined in R4-11-1306(B)(1)(a) through (f).

**D.** After submitting the application and written evidence of compliance with requirements in subsection (B) and, if applicable, subsection (C) to the Board, the applicant shall schedule an onsite evaluation by the Board during which the applicant shall administer General Anesthesia or Deep Sedation. After the applicant completes the application requirements and successfully completes the onsite evaluation, a Section 1301 Permit shall be issued to the applicant.
1. The onsite evaluation team shall consist of:
   a. Two dentists who are Board members, or Board designees for initial applications; or
   b. One dentist who is a Board member or Board designee for renewal applications.
2. The onsite team shall evaluate the following:
   a. The availability of equipment and personnel as specified in subsection (B)(2);
   b. Proper administration of General Anesthesia or Deep Sedation to a patient by the applicant in the presence of the evaluation team;
   c. Successful responses by the applicant to oral examination questions from the evaluation team about patient management, medical emergencies, and emergency medications;
   d. Proper documentation of Controlled Substances, that includes a perpetual inventory log showing the receipt, administration, dispensing, and destruction of Controlled Substances;
   e. Proper recordkeeping as specified in subsection (E) by reviewing the records generated for the patient specified in subsection (D)(2)(b); and
   f. For renewal applicants, records supporting continued competency as specified in R4-11-1306.
3. The evaluation team shall recommend one of the following:
   a. Pass. Successful completion of the onsite evaluation;
   b. Conditional Approval for failing to have appropriate equipment, proper documentation of Controlled Substances, or proper recordkeeping. The applicant must submit proof of correcting the deficiencies before a permit is issued;
   c. Category 1 Evaluation Failure. The applicant must review the appropriate subject matter and schedule a subsequent evaluation by two Board Members or Board designees not less than 30 days from the failed evaluation. An example is failure to recognize and manage one emergency;
   d. Category 2 Evaluation Failure. The applicant must complete Board approved continuing education in subject matter within the scope of the onsite evaluation as identified by the evaluators and schedule a subsequent evaluation by two Board Members or Board designees not less than 60 days from the failed evaluation. An example is failure to recognize and manage more than one emergency; or
   e. Category 3 Evaluation Failure. The applicant must complete Board approved remedial continuing edu-

cation with the subject matter outlined in R4-11-1306 as identified by the evaluators and reapply not less than 90 days from the failed evaluation. An example is failure to recognize and manage an anesthetic urgency.

4. The onsite evaluation of an additional dental office or dental clinic in which General Anesthesia or Deep Sedation is administered by an existing Section 1301 Permit holder may be waived by the Board staff upon receipt in the Board office of an affidavit verifying compliance with subsection (D)(2)(a).
5. A Section 1301 mobile permit may be issued if a Section 1301 Permit holder travels to dental offices or dental clinics to provide anesthesia or Deep Sedation. The applicant must submit a completed affidavit verifying:
   a. That the equipment and supplies for the provision of anesthesia or Deep Sedation as required in subsection (B)(2)(a) either travel with the Section 1301 Permit holder or are in place and in appropriate condition at the dental office or dental clinic where anesthesia or Deep Sedation is provided, and
   b. Compliance with subsection (B)(2)(b).

**E.** A Section 1301 Permit holder shall keep an anesthesia or Deep Sedation record for each General Anesthesia and Deep Sedation procedure that includes the following entries:

1. Pre-operative and post-operative electrocardiograph documentation;
2. Pre-operative, intra-operative, and post-operative pulse oximeter documentation;
3. Pre-operative, intra-operative, and post-operative blood pressure and vital sign documentation;
4. A list of all medications given, with dosage and time intervals, and route and site of administration;
5. Type of catheter or portal with gauge;
6. Indicate nothing by mouth or time of last intake of food or water;
7. Consent form; and
8. Time of discharge and status, including name of escort.

**F.** The Section 1301 Permit holder, for intravenous access, shall use a new infusion set, including a new infusion line and new bag of fluid, for each patient.

**G.** The Section 1301 Permit holder shall utilize supplemental oxygen for patients receiving General Anesthesia or Deep Sedation for the duration of the procedure.

**H.** The Section 1301 Permit holder shall continuously supervise the patient from the initiation of anesthesia or Deep Sedation until termination of the anesthesia or Deep Sedation procedure and oxygenation, ventilation, and circulation are stable. The Section 1301 Permit holder shall not commence with the administration of a subsequent anesthetic case until the patient is in monitored recovery or meets the guidelines for discharge.

**I.** A Section 1301 Permit holder may employ the following health care professionals to provide anesthesia or sedation services and shall ensure that the health care professional continuously supervises the patient from the administration of anesthesia or sedation until termination of the anesthesia or sedation procedure and oxygenation, ventilation, and circulation are stable:

1. An allopathic or osteopathic physician currently licensed in Arizona by the Arizona Medical Board or the Arizona Board of Osteopathic Examiners who has successfully completed a residency program in anesthesiology approved by the American Council on Graduate Medical Education or the American Osteopathic Association or who is certified by either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology and is credentialed with anesthesia privileges through an Arizona licensed medical facility, or
2. A Certified Registered Nurse Anesthesiology currently licensed in Arizona who provides services under the Nurse Practice Act in A.R.S. Title 32, Chapter 15.

**J.** A Section 1301 Permit holder may also administer parenteral sedation without obtaining a Section 1302 Permit.

**Historical Note**

New Section R4-11-1301 renumbered from R4-11-802 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Amended by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1302. Parenteral Sedation**

**A.** Before administering parenteral sedation in a dental office or dental clinic, a dentist shall possess a Section 1302 Permit issued by the Board. The dentist may renew a Section 1302 Permit every five years by complying with R4-11-1307.

1. A Section 1301 Permit holder may also administer parenteral sedation.
2. A Section 1302 Permit holder shall not administer or employ any agents which have a narrow margin for maintaining consciousness including, but not limited to, ultrashort acting barbiturates, propofol, parenteral ketamine, or similarly acting Drugs, agents, or techniques, or any combination thereof that would likely render a patient deeply sedated, generally anesthetized or otherwise not meeting the conditions of Moderate Sedation.

**B.** To obtain or renew a Section 1302 Permit, the dentist shall:

1. Submit a completed application on a form provided by the Board office that, in addition to the requirements of subsections (B)(2) and (3) and R4-11-1307, includes:
   a. General information about the applicant such as:
      i. Name;
      ii. Home and office addresses and telephone numbers;
      iii. Limitations of practice;
      iv. Hospital affiliations;
      v. Denial, curtailment, revocation, or suspension of hospital privileges;
      vi. Denial of membership in, denial of renewal of membership in, or disciplinary action by a dental organization; and
      vii. Denial of licensure by, denial of renewal of licensure by, or disciplinary action by a dental regulatory body; and
   b. The dentist's dated and signed affidavit stating that the information provided is true, and that the dentist has read and complied with the Board's statutes and rules;
2. On forms provided by the Board, provide a dated and signed affidavit attesting that any dental office or dental clinic where the dentist will administer parenteral sedation by intravenous or intramuscular route:
   a. Contains the following properly operating equipment and supplies during the provision of parenteral sedation by the permit holder or General Anesthesia

or Deep Sedation by a physician anesthesiologist or Certified Registered Nurse Anesthetist:

i. Emergency Drugs;
ii. Positive pressure oxygen and supplemental oxygen;
iii. Stethoscope;
iv. Suction equipment, including tonsillar or pharyngeal and emergency backup medical suction device;
v. Oropharyngeal and nasopharyngeal airways;
vi. Pulse oximeter;
vii. Auxiliary lighting;
viii. Blood pressure monitoring device; and
ix. Cardiac defibrillator or automated external defibrillator; and

b. Maintains a staff of supervised personnel capable of handling procedures, complications, and emergency incidents, including at least one staff member who:

i. Holds a current course completion confirmation in cardiopulmonary resuscitation healthcare provider level;
ii. Is present during the parenteral sedation procedure; and
iii. After the procedure, monitors the patient until discharge;

3. Hold a valid license to practice dentistry in this state;
4. Maintain a current permit to prescribe and administer Controlled Substances in this state issued by the United States Drug Enforcement Administration;
5. Provide confirmation of completing coursework within the two years prior to submitting the permit application in one or more of the following:
   a. Advanced cardiac life support from the American Heart Association or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association;
   b. Pediatric advanced life support in a practice treating pediatric patients; or
   c. A recognized continuing education course in advanced airway management.

**C.** Initial applicants shall meet one of the following conditions by submitting to the Board verification of meeting the condition directly from the issuing institution:

1. Successfully complete Board-recognized undergraduate, graduate, or postgraduate education within the three years before submitting the permit application, that includes the following:
   a. Sixty didactic hours of basic parenteral sedation to include:
      i. Physical evaluation;
      ii. Management of medical emergencies;
      iii. The importance of and techniques for maintaining proper documentation; and
      iv. Monitoring and the use of monitoring equipment; and
   b. Hands-on administration of parenteral sedative medications to at least 20 patients in a manner consistent with this Section; or
2. An applicant who completed training in parenteral sedation more than three years before submitting the permit application shall provide the following documentation:
   a. On a form provided by the Board, a written affidavit affirming that the applicant has administered parenteral sedation to a minimum of 25 patients within the year or 75 patients within the last five years before submitting the permit application;
   b. A copy of the parenteral sedation permit in effect in another state or certification of military training in parenteral sedation from the applicant's commanding officer; and
   c. On a form provided by the Board, a written affidavit affirming the completion of 30 clock hours of continuing education taken within the last five years as outlined in R4-11-1306(B)(1)(b) through (f).

**D.** After submitting the application and written evidence of compliance with requirements outlined in subsection (B) and, if applicable, subsection (C) to the Board, the applicant shall schedule an onsite evaluation by the Board during which the applicant shall administer parenteral sedation. After the applicant completes the application requirements and successfully completes the onsite evaluation, the Board shall issue a Section 1302 Permit to the applicant.

1. The onsite evaluation team shall consist of:
   a. Two dentists who are Board members, or Board designees for initial applications, or
   b. One dentist who is a Board member or Board designee for renewal applications.
2. The onsite team shall evaluate the following:
   a. The availability of equipment and personnel as specified in subsection (B)(2);
   b. Proper administration of parenteral sedation to a patient by the applicant in the presence of the evaluation team;
   c. Successful responses by the applicant to oral examination questions from the evaluation team about patient management, medical emergencies, and emergency medications;
   d. Proper documentation of Controlled Substances, that includes a perpetual inventory log showing the receipt, administration, dispensing, and destruction of all Controlled Substances;
   e. Proper recordkeeping as specified in subsection (E) by reviewing the records generated for the patient receiving parenteral sedation as specified in subsection (D)(2)(b); and
   f. For renewal applicants, records supporting continued competency as specified in R4-11-1306.
3. The evaluation team shall recommend one of the following:
   a. Pass. Successful completion of the onsite evaluation;
   b. Conditional Approval for failing to have appropriate equipment, proper documentation of Controlled Substances, or proper recordkeeping. The applicant must submit proof of correcting the deficiencies before a permit is issued;
   c. Category 1 Evaluation Failure. The applicant must review the appropriate subject matter and schedule a subsequent evaluation by two Board Members or Board designees not less than 30 days from the failed evaluation. An example is failure to recognize and manage one emergency;
   d. Category 2 Evaluation Failure. The applicant must complete Board approved continuing education in subject matter within the scope of the onsite evaluation as identified by the evaluators and schedule a subsequent evaluation by two Board Members or Board designees not less than 60 days from the

failed evaluation. An example is failure to recognize and manage more than one emergency; or

e. Category 3 Evaluation Failure. The applicant must complete Board approved remedial continuing education with the subject matter outlined in R4-11-1306 as identified by the evaluators and reapply not less than 90 days from the failed evaluation. An example is failure to recognize and manage an anesthetic urgency.

4. The onsite evaluation of an additional dental office or dental clinic in which parenteral sedation is administered by an existing Section 1302 Permit holder may be waived by the Board staff upon receipt in the Board office of an affidavit verifying compliance with subsection (D)(2)(a).
5. A Section 1302 mobile permit may be issued if a Section 1302 Permit holder travels to dental offices or dental clinics to provide parenteral sedation. The applicant must submit a completed affidavit verifying:
   a. That the equipment and supplies for the provision of parenteral sedation as required in R4-11-1302(B)(2)(a) either travel with the Section 1302 Permit holder or are in place and in appropriate working condition at the dental office or dental clinic where parenteral sedation is provided, and
   b. Compliance with R4-11-1302(B)(2)(b).

**E.** A Section 1302 Permit holder shall keep a parenteral sedation record for each parenteral sedation procedure that:
1. Includes the following entries:
   a. Pre-operative, intra-operative, and post-operative pulse oximeter documentation;
   b. Pre-operative, intra-operative, and post-operative blood pressure and vital sign documentation;
   c. A list of all medications given, with dosage and time intervals and route and site of administration;
   d. Type of catheter or portal with gauge;
   e. Indicate nothing by mouth or time of last intake of food or water;
   f. Consent form; and
   g. Time of discharge and status, including name of escort; and
2. May include pre-operative and post-operative electrocardiograph report.

**F.** The Section 1302 Permit holder shall establish intravenous access on each patient receiving parenteral sedation utilizing a new infusion set, including a new infusion line and new bag of fluid.

**G.** The Section 1302 Permit holder shall utilize supplemental oxygen for patients receiving parenteral sedation for the duration of the procedure.

**H.** The Section 1302 Permit holder shall continuously supervise the patient from the initiation of parenteral sedation until termination of the parenteral sedation procedure and oxygenation, ventilation and circulation are stable. The Section 1302 Permit holder shall not commence with the administration of a subsequent anesthetic case until the patient is in monitored recovery or meets the guidelines for discharge.

**I.** A Section 1302 Permit holder may employ a health care professional as specified in R4-11-1301(I).

**Historical Note**

New Section R4-11-1302 renumbered from R4-11-803 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Amended by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1303. Oral Sedation**

**A.** Before administering Oral Sedation in a dental office or dental clinic, a dentist shall possess a Section 1303 Permit issued by the Board. The dentist may renew a Section 1303 Permit every five years by complying with R4-11-1307.
1. A Section 1301 Permit holder or Section 1302 Permit holder may also administer Oral Sedation without obtaining a Section 1303 Permit.
2. The administration of a single Drug for Minimal Sedation does not require a Section 1303 Permit if:
   a. The administered dose is within the Food and Drug Administration's maximum recommended dose as printed in the Food and Drug Administration's approved labeling for unmonitored home use;
      i. Incremental multiple doses of the Drug may be administered until the desired effect is reached, but does not exceed the maximum recommended dose; and
      ii. During Minimal Sedation, a single supplemental dose may be administered. The supplemental dose may not exceed one-half of the initial dose and the total aggregate dose may not exceed one and one-half times the Food and Drug Administration's maximum recommended dose on the date of treatment; and
   b. Nitrous oxide/oxygen may be administered in addition to the oral Drug as long as the combination does not exceed Minimal Sedation.

**B.** To obtain or renew a Section 1303 Permit, a dentist shall:
1. Submit a completed application on a form provided by the Board office that, in addition to the requirements of subsections (B)(2) and (3) and R4-11-1307, includes:
   a. General information about the applicant such as:
      i. Name;
      ii. Home and office addresses and telephone numbers;
      iii. Limitations of practice;
      iv. Hospital affiliations;
      v. Denial, curtailment, revocation, or suspension of hospital privileges;
      vi. Denial of membership in, denial of renewal of membership in, or disciplinary action by a dental organization; and
      vii. Denial of licensure by, denial of renewal of licensure by, or disciplinary action by a dental regulatory body; and
   b. The dentist's dated and signed affidavit stating that the information provided is true, and that the dentist has read and complied with the Board's statutes and rules;
2. On forms provided by the Board, provide a dated and signed affidavit attesting that any dental office or dental clinic where the dentist will administer Oral Sedation:
   a. Contains the following properly operating equipment and supplies during the provision of sedation:
      i. Emergency Drugs;
      ii. Cardiac defibrillator or automated external defibrillator;
      iii. Positive pressure oxygen and supplemental oxygen;
      iv. Stethoscope;

v. Suction equipment, including tonsillar or pharyngeal and emergency backup medical suction device;
vi. Pulse oximeter;
vii. Blood pressure monitoring device; and
viii. Auxiliary lighting; and

b. Maintains a staff of supervised personnel capable of handling procedures, complications, and emergency incidents, including at least one staff member who:
i. Holds a current certificate in cardiopulmonary resuscitation healthcare provider level;
ii. Is present during the Oral Sedation procedure; and
iii. After the procedure, monitors the patient until discharge;

3. Hold a valid license to practice dentistry in this state;
4. Maintain a current permit to prescribe and administer Controlled Substances in this state issued by the United States Drug Enforcement Administration;
5. Provide confirmation of completing coursework within the two years prior to submitting the permit application in one or more of the following:
a. Cardiopulmonary resuscitation healthcare provider level from the American Heart Association, American Red Cross, or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association or American Red Cross;
b. Pediatric advanced life support in a practice treating pediatric patients; or
c. A recognized continuing education course in advanced airway management.

**C.** Initial applicants shall meet one of the following by submitting to the Board verification of meeting the condition directly from the issuing institution:
1. Complete a Board-recognized post-doctoral residency program that includes documented training in Oral Sedation within the last three years before submitting the permit application; or
2. Complete a Board recognized post-doctoral residency program that includes documented training in Oral Sedation more than three years before submitting the permit application shall provide the following documentation:
a. On a form provided by the Board, a written affidavit affirming that the applicant has administered Oral Sedation to a minimum of 25 patients within the year or 75 patients within the last five years before submitting the permit application;
b. A copy of the Oral Sedation permit in effect in another state or certification of military training in Oral Sedation from the applicant's commanding officer; and
c. On a form provided by the Board, a written affidavit affirming the completion of 30 hours of continuing education taken within the last five years as outlined in R4-11-1306(C)(1)(a) through (f); or
3. Provide proof of participation in 30 clock hours of Board-recognized undergraduate, graduate, or post-graduate education in Oral Sedation within the three years before submitting the permit application that includes:
a. Training in basic Oral Sedation,
b. Pharmacology,
c. Physical evaluation,
d. Management of medical emergencies,
e. The importance of and techniques for maintaining proper documentation, and
f. Monitoring and the use of monitoring equipment.

**D.** After submitting the application and written evidence of compliance with requirements in subsection (B) and, if applicable, subsection (C) to the Board, the applicant shall schedule an onsite evaluation by the Board. After the applicant completes the application requirements and successfully completes the onsite evaluation, the Board shall issue a Section 1303 Permit to the applicant.
1. The onsite evaluation team shall consist of:
a. For initial applications, two dentists who are Board members, or Board designees.
b. For renewal applications, one dentist who is a Board member, or Board designee.
2. The onsite team shall evaluate the following:
a. The availability of equipment and personnel as specified in subsection (B)(2);
b. Successful responses by the applicant to oral examination questions from the evaluation team about patient management, medical emergencies, and emergency medications;
c. Proper documentation of Controlled Substances, that includes a perpetual inventory log showing the receipt, administration, dispensing, and destruction of Controlled Substances;
d. Proper recordkeeping as specified in subsection (E) by reviewing the forms that document the Oral Sedation record; and
e. For renewal applicants, records supporting continued competency as specified in R4-11-1306.
3. The evaluation team shall recommend one of the following:
a. Pass. Successful completion of the onsite evaluation;
b. Conditional Approval for failing to have appropriate equipment, proper documentation of Controlled Substance, or proper recordkeeping. The applicant must submit proof of correcting the deficiencies before permit will be issued;
c. Category 1 Evaluation Failure. The applicant must review the appropriate subject matter and schedule a subsequent evaluation by two Board Members or Board designees not less than 30 days from the failed evaluation. An example is failure to recognize and manage one emergency; or
d. Category 2 Evaluation Failure. The applicant must complete Board approved continuing education in subject matter within the scope of the onsite evaluation as identified by the evaluators and schedule a subsequent evaluation by two Board Members or Board designees not less than 60 days from the failed evaluation. An example is failure to recognize and manage more than one emergency.
4. The onsite evaluation of an additional dental office or dental clinic in which Oral Sedation is administered by a Section 1303 Permit holder may be waived by the Board staff upon receipt in the Board office of an affidavit verifying compliance with subsection (D)(2)(a).
5. A Section 1303 mobile permit may be issued if the Section 1303 Permit holder travels to dental offices or dental clinics to provide Oral Sedation. The applicant must submit a completed affidavit verifying:

a. That the equipment and supplies for the provision of Oral Sedation as required in R4-11-1303(B)(2)(a) either travel with the Section 1303 Permit holder or are in place and in appropriate condition at the dental office or dental clinic where Oral Sedation is provided, and
b. Compliance with R4-11-1303(B)(2)(b).

**E.** A Section 1303 Permit holder shall keep an Oral Sedation record for each Oral Sedation procedure that:
1. Includes the following entries:
a. Pre-operative, intra-operative, and post-operative, pulse oximeter oxygen saturation and pulse rate documentation;
b. Pre-operative and post-operative blood pressure;
c. Documented reasons for not taking vital signs if a patient's behavior or emotional state prevents monitoring personnel from taking vital signs;
d. List of all medications given, including dosage and time intervals;
e. Patient's weight;
f. Consent form;
g. Special notes, such as, nothing by mouth or last intake of food or water; and
h. Time of discharge and status, including name of escort; and
2. May include the following entries:
a. Pre-operative and post-operative electrocardiograph report; and
b. Intra-operative blood pressures.

**F.** The Section 1303 Permit holder shall utilize supplemental oxygen for patients receiving Oral Sedation for the duration of the procedure.

**G.** The Section 1303 Permit holder shall ensure the continuous supervision of the patient from the administration of Oral Sedation until oxygenation, ventilation and circulation are stable and the patient is appropriately responsive for discharge from the dental office or dental clinic.

**H.** A Section 1303 Permit holder may employ a health care professional to provide anesthesia services, if all of the following conditions are met:
1. The physician anesthesiologist or Certified Registered Nurse Anesthetist meets the requirements as specified in R4-11-1301(I);
2. The Section 1303 Permit holder has completed coursework within the two years prior to submitting the permit application in one or more of the following:
a. Advanced cardiac life support from the American Heart Association or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association;
b. Pediatric advanced life support in a practice treating pediatric patients;
c. A recognized continuing education course in advanced airway management;
3. The Section 1303 Permit holder ensures that:
a. The dental office or clinic contains the equipment and supplies listed in R4-11-1304(B)(2)(a) during the provision of anesthesia or sedation by the physician anesthesiologist or Certified Registered Nurse Anesthetist;
b. The anesthesia or sedation record contains all the entries listed in R4-11-1304(D);
c. For intravenous access, the physician anesthesiologist or Certified Registered Nurse Anesthetist uses a new infusion set, including a new infusion line and new bag of fluid for each patient; and
d. The patient is continuously supervised from the administration of anesthesia or sedation until the termination of the anesthesia or sedation procedure and oxygenation, ventilation and circulation are stable. The Section 1303 Permit holder shall not commence with a subsequent procedure or treatment until the patient is in monitored recovery or meets the guidelines for discharge.

**Historical Note**

New Section R4-11-1303 renumbered from R4-11-805 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Former Section R4-11-1303 renumbered to R4-11-1304; new Section R4-11-1303 made by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Amended by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1304. Permit to Employ or Work with a Physician Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA)**

**A.** This Section does not apply to a Section 1301 permit holder or a Section 1302 permit holder practicing under the provisions of R4-11-1302(I) or a Section 1303 permit holder practicing under the provisions of R4-11-1303(H). A dentist may utilize a physician anesthesiologist or certified registered nurse anesthetist (CRNA) for anesthesia or sedation services while the dentist provides treatment in the dentist's office or dental clinic after obtaining a Section 1304 permit issued by the Board.
1. The physician anesthesiologist or CRNA meets the requirements as specified in R4-11-1301(I).
2. The dentist permit holder shall provide all dental treatment and ensure that the physician anesthesiologist or CRNA remains on the dental office or dental clinic premises until any patient receiving anesthesia or sedation services is discharged.
3. A dentist may renew a Section 1304 permit every five years by complying with R4-11-1307.

**B.** To obtain or renew a Section 1304 permit, a dentist shall:
1. Submit a completed application on a form provided by the Board office that, in addition to the requirements of subsections (B)(2) and (3) and R4-11-1307 includes:
a. General information about the applicant such as:
i. Name;
ii. Home and office addresses and telephone numbers;
iii. Limitations of practice;
iv. Hospital affiliations;
v. Denial, curtailment, revocation, or suspension of hospital privileges;
vi. Denial of membership in, denial of renewal of membership in, or disciplinary action by a dental organization; and
vii. Denial of licensure by, denial of renewal of licensure by, or disciplinary action by a dental regulatory body; and
b. The dentist's dated and signed affidavit stating that the information provided is true, and that the dentist

has read and complied with the Board's statutes and rules;

2. On forms provided by the Board, provide a dated and signed affidavit attesting that any dental office or dental clinic where the dentist provides treatment during administration of general anesthesia or sedation by a physician anesthesiologist or CRNA:
   a. Contains the following properly operating equipment and supplies during the provision of general anesthesia and sedation:
      i. Emergency drugs;
      ii. Electrocardiograph monitor;
      iii. Pulse oximeter;
      iv. Cardiac defibrillator or automated external defibrillator (AED);
      v. Positive pressure oxygen and supplemental continuous flow oxygen;
      vi. Suction equipment, including endotrachael, tonsillar or pharyngeal and emergency backup medical suction device;
      vii. Laryngoscope, multiple blades, backup batteries and backup bulbs;
      viii. Endotracheal tubes and appropriate connectors;
      ix. Magill forceps;
      x. Oropharyngeal and nasopharyngeal airways;
      xi. Auxiliary lighting;
      xii. Stethoscope; and
      xiii. Blood pressure monitoring device; and
   b. Maintains a staff of supervised personnel capable of handling procedures, complications, and emergency incidents. All personnel involved in administering and monitoring general anesthesia or sedation shall hold a current course completion confirmation in cardiopulmonary resuscitation (CPR) Health Care Provider level;
3. Hold a valid license to practice dentistry in this state; and
4. Provide confirmation of completing coursework within the last two years prior to submitting the permit application in one or more of the following:
   a. Advanced cardiac life support (ACLS) from the American Heart Association or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association;
   b. Pediatric advanced life support (PALS) in a practice treating pediatric patients; or
   c. A recognized continuing education course in advanced airway management.

**C.** After submitting the application and written evidence of compliance with requirements in subsection (B) to the Board, the applicant shall schedule an onsite evaluation by the Board. After the applicant completes the application requirements and successfully completes the onsite evaluation, the Board shall issue the applicant a Section 1304 permit.
1. The onsite evaluation team shall consist of one dentist who is a Board member, or Board designee.
2. The onsite team shall evaluate the following:
   a. The availability of equipment and personnel as specified in subsection (B)(2);
   b. Proper documentation of controlled substances, that includes a perpetual inventory log showing the receipt, administration, dispensing, and destruction of controlled substances; and
   c. Proper recordkeeping as specified in subsection (E) by reviewing previous anesthesia or sedation records.
3. The evaluation team shall recommend one of the following:
   a. Pass. Successful completion of the onsite evaluation; or
   b. Conditional approval for failing to have appropriate equipment, proper documentation of controlled substances, or proper recordkeeping. The applicant must submit proof of correcting the deficiencies before a permit is issued.
4. The evaluation of an additional dental office or dental clinic in which a Section 1304 permit holder provides treatment during the administration general anesthesia or sedation by a physician anesthesiologist or CRNA may be waived by the Board staff upon receipt in the Board office of an affidavit verifying compliance with subsection (B)(2).

**D.** A Section 1304 permit holder shall keep an anesthesia or sedation record for each general anesthesia and sedation procedure that includes the following entries:
1. Pre-operative and post-operative electrocardiograph documentation;
2. Pre-operative, intra-operative, and post-operative, pulse oximeter documentation;
3. Pre-operative, intra-operative, and post-operative blood pressure and vital sign documentation; and
4. A list of all medications given, with dosage and time intervals and route and site of administration;
5. Type of catheter or portal with gauge;
6. Indicate nothing by mouth or time of last intake of food or water;
7. Consent form; and
8. Time of discharge and status, including name of escort.

**E.** For intravenous access, a Section 1304 permit holder shall ensure that the physician anesthesiologist or CRNA uses a new infusion set, including a new infusion line and new bag of fluid for each patient.

**F.** A Section 1304 permit holder shall ensure that the physician anesthesiologist or CRNA utilizes supplemental continuous flow oxygen for patients receiving general anesthesia or sedation for the duration of the procedure.

**G.** The Section 1304 permit holder shall continuously supervise the patient from the administration of anesthesia or sedation until termination of the anesthesia or sedation procedure and oxygenation, ventilation and circulation are stable. The Section 1304 permit holder shall not commence with a subsequent procedure or treatment until the patient is in monitored recovery or meets the guidelines for discharge.

**Historical Note**

New Section R4-11-1304 renumbered from R4-11-805 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Former Section R4-11-1304 renumbered to R4-11-1305; new Section R4-11-1304 renumbered from R4-11-1303 and amended by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Section repealed; new Section made by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1).

**R4-11-1305. Reports of Adverse Occurrences**

If a death, or incident requiring emergency medical response, occurs in a dental office or dental clinic during the administration of

or recovery from general anesthesia, deep sedation, moderate sedation, or minimal sedation, the permit holder and the treating dentist involved shall submit a complete report of the incident to the Board within 10 days after the occurrence.

**Historical Note**

New Section R4-11-1305 renumbered from R4-11-806 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Former Section R4-11-1305 renumbered to R4-11-1306; new Section R4-11-1305 renumbered from R4-11-1304 and amended by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Section repealed; new Section made by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1).

**R4-11-1306. Education; Continued Competency**

**A.** To obtain a Section 1301, permit by satisfying the education requirement of R4-11-1301(B)(6), a dentist shall successfully complete an advanced graduate or post-graduate education program in pain control.
1. The program shall include instruction in the following subject areas:
   a. Anatomy and physiology of the human body and its response to the various pharmacologic agents used in pain control;
   b. Physiological and psychological risks for the use of various modalities of pain control;
   c. Psychological and physiological need for various forms of pain control and the potential response to pain control procedures;
   d. Techniques of local anesthesia, sedation, and general anesthesia, and psychological management and behavior modification, as they relate to pain control in dentistry; and
   e. Handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway, and cardiopulmonary resuscitation.
2. The program shall consist of didactic and clinical training. The didactic component of the program shall:
   a. Be the same for all dentists, whether general practitioners or specialists; and
   b. Include each subject area listed in subsection (A)(1).
3. The program shall provide at least one calendar year of training as prescribed in R4-11-1301(B)(6)(a).

**B.** To maintain a Section 1301 or 1302 permit under R4-11-1301 or R4-11-1302 a permit holder shall:
1. Participate in 30 clock hours of continuing education every five years in one or more of the following areas:
   a. General anesthesia,
   b. Parenteral sedation,
   c. Physical evaluation,
   d. Medical emergencies,
   e. Monitoring and use of monitoring equipment, or
   f. Pharmacology of drugs and non-drug substances used in general anesthesia or parenteral sedation; and
2. Provide confirmation of completing coursework within the two years prior to submitting the renewal application from one or more of the following:
   a. Advanced cardiac life support (ACLS) from the American Heart Association or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association;
   b. Pediatric advanced life support (PALS) in a practice treating pediatric patients; or
   c. A recognized continuing education course in advanced airway management;
3. Complete at least 10 general anesthesia, deep sedation or parenteral sedation cases a calendar year; and
4. Apply a maximum of six hours from subsection (B)(2) toward the continuing education requirements for subsection (B)(1).

**C.** To maintain a Section 1303 permit issued under R4-11-1303, a permit holder shall:
1. Participate in 30 clock hours of continuing education every five years in one or more of the following areas:
   a. Oral sedation,
   b. Physical evaluation,
   c. Medical emergencies,
   d. Monitoring and use of monitoring equipment, or
   e. Pharmacology of oral sedation drugs and non-drug substances; and
2. Provide confirmation of completing coursework within the two years prior to submitting the renewal application from one or more of the following:
   a. Cardiopulmonary resuscitation (CPR) Health Care Provider level from the American Heart Association, American Red Cross or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association or American Red Cross;
   b. Advanced cardiac life support (ACLS) from the American Heart Association or another agency that follows the same procedures, standards, and techniques for training as the American Heart Association;
   c. Pediatric advanced life support (PALS);
   d. A recognized continuing education course in advanced airway management; and
3. Complete at least 10 oral sedation cases a calendar year.

**Historical Note**

Section R4-11-1306 renumbered from R4-11-1305 and amended by final rulemaking at 9 A.A.R. 1054, effective May 6, 2003 (Supp. 03-1). Amended by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1).

**R4-11-1307. Renewal of Permit**

**A.** To renew a Section 1301, 1302, or 1303 permit, the permit holder shall:
1. Provide written documentation of compliance with the applicable continuing education requirements in R4-11-1306;
2. Provide written documentation of compliance with the continued competency requirements in R4-11-1306;
3. Before December 31 of the year the permit expires, submit a completed application on a form provided by the Board office as described in R4-11-1301, R4-11-1302, or R4-11-1303; and
4. Not less than 90 days before the expiration of a permit holder's current permit, arrange for an onsite evaluation as described in R4-11-1301, R4-11-1302, or R4-11-1303.

**B.** To renew a Section 1304 permit, the permit holder shall:
1. Before December 31 of the year the permit expires, submit a completed application on a form provided by the Board office as described in R4-11-1304; and

2. Not less than 90 days before the expiration of a permit holder's current permit, arrange for an onsite evaluation as described in R4-11-1304.

**C.** After the permit holder successfully completes the evaluation and submits the required affidavits, the Board shall renew a Section 1301, 1302, 1303, 1304 permit, as applicable.

**D.** The Board may stagger due dates for renewal applications.

**Historical Note**

Made by final rulemaking at 19 A.A.R. 341, effective April 6, 2013 (Supp. 13-1).

## ARTICLE 14. DISPENSING DRUGS AND DEVICES

### R4-11-1401. Prescribing

**A.** In addition to the requirements of A.R.S. § 32-1298(C), a dentist shall ensure that a prescription order contains the following information:

1. Date of issuance;
2. Name and address of the patient to whom the prescription is issued;
3. Name, strength, dosage form, and quantity of the drug or name and quantity of the device prescribed;
4. Name and address of the dentist prescribing the drug; and
5. Drug Enforcement Administration registration number of the dentist, if prescribing a controlled substance.

**B.** Before dispensing a drug or device, a dentist shall present to the patient a written prescription for the drug or device being dispensed that includes on the prescription the following statement in bold type: "This prescription may be filled by the prescribing dentist or by a pharmacy of your choice."

**Historical Note**

Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1401 repealed, new Section R4-11-1401 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

### R4-11-1402. Labeling and Dispensing

**A.** A dentist shall include the following information on the label of all drugs and devices dispensed:

1. The dentist's name, address, and telephone number;
2. The serial number;
3. The date the drug or device is dispensed;
4. The patient's name;
5. Name, strength, and quantity of drug or name and quantity of device dispensed;
6. The name of the drug or device manufacturer or distributor;
7. Directions for use and cautionary statement necessary for safe and effective use of the drug or device; and
8. If a controlled substance is prescribed, the cautionary statement "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."

**B.** Before delivery to the patient, the dentist shall prepare and package the drug or device to ensure compliance with the prescription and personally inform the patient of the name of the drug or device, directions for its use, precautions, and storage requirements.

**C.** A dentist shall purchase all dispensed drugs and devices from a manufacturer, distributor, or pharmacy that is properly licensed in this state or one of the other 49 states, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States of America.

**D.** When dispensing a prescription drug or device from a prescription order, a dentist shall perform the following professional practices:

1. Verify the legality and pharmaceutical feasibility of dispensing a drug based upon:
   a. A patient's allergies,
   b. Incompatibilities with a patient's currently-taken medications,
   c. A patient's use of unusual quantities of dangerous drugs or narcotics, and
   d. The frequency of refills;
2. Verify that the dosage is within proper limits;
3. Interpret the prescription order;
4. Prepare, package, and label, or assume responsibility for preparing, packaging, and labeling, the drug or device dispensed under each prescription order;
5. Check the label to verify that the label precisely communicates the prescriber's directions and hand-initial each label;
6. Record, or assume responsibility for recording, the serial number and date dispensed on the front of the original prescription order; and
7. Record on the original prescription order the name or initials of the dentist who dispensed the order.

**Historical Note**

Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1402 renumbered to R4-11-1201, new Section R4-11-1402 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

### R4-11-1403. Storage and Packaging

A dentist shall:

1. Keep all prescription-only drugs and devices in a secured area and control access to the secured area by written procedure. The dentist shall make the written procedure available to the Board or its authorized agents on demand for inspection or copying;
2. Keep all controlled substances secured in a locked cabinet or room, control access to the cabinet or room by written procedure, and maintain an ongoing inventory of the contents. The dentist shall make the written procedure available to the Board or its authorized agents on demand for inspection or copying;
3. Maintain drug storage areas so that the temperature in the drug storage areas does not exceed 85º F;
4. Not dispense a drug or device that has expired or is improperly labeled;
5. Not redispense a drug or device that has been returned;
6. Dispense a drug or device:
   a. In a prepackaged container or light-resistant container with a consumer safety cap, unless the patient or patient's representative requests a non-safety cap; and
   b. With a label that is mechanically or electronically printed;
7. Destroy an outdated, deteriorated, or defective controlled substance according to Drug Enforcement Administration regulations or by using a reverse distributor. A list of reverse distributors may be obtained from the Drug Enforcement Administration; and
8. Destroy an outdated, deteriorated, or defective non-controlled substance drug or device by returning it to the sup-

plier or by using a reverse distributor. A list of reverse distributors may be obtained from the Drug Enforcement Administration.

**Historical Note**
Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1403 renumbered to R4-11-1202, new Section R4-11-1403 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-1404. Recordkeeping**

**A.** A dentist shall:
1. Chronologically date and sequentially number prescription orders in the order that the drugs or devices are originally dispensed;
2. Sequentially file orders separately from patient records, as follows:
   a. File Schedule II drug orders separately from all other prescription orders;
   b. File Schedule III, IV, and V drug orders separately from all other prescription orders; and
   c. File all other prescription orders separately from orders specified in subsections (A)(2)(a) and (b);
3. Record the name of the manufacturer or distributor of the drug or device dispensed on each prescription order and label;
4. Record the name or initials of the dentist dispensing the drug or device on each prescription order and label; and
5. Record the date the drug or device is dispensed on each prescription order and label.

**B.** A dentist shall record in the patient's dental record the name, dosage form, and strength of the drug or device dispensed, the quantity or volume dispensed, the date the drug or device is dispensed, and the dental therapeutic reasons for dispensing the drug or device.

**C.** A dentist shall maintain:
1. Purchase records of all drugs and devices for three years from the date purchased; and
2. Dispensing records of all drugs and devices for three years from the date dispensed.

**D.** A dentist who dispenses controlled substances:
1. Shall inventory Schedule II, III, IV, and V controlled substances as prescribed by A.R.S. § 36-2523;
2. Shall perform a controlled substance inventory on March 1 annually, if directed by the Board, and at the opening or closing of a dental practice;
3. Shall maintain the inventory for three years from the inventory date;
4. May use one inventory book for all controlled substances;
5. When conducting an inventory of Schedule II controlled substances, shall take an exact count;
6. When conducting an inventory of Schedule III, IV, and V controlled substances, shall take an exact count or may take an estimated count if the stock container contains fewer than 1001 units.

**E.** A dentist shall maintain invoices for drugs and devices dispensed for three years from the date of the invoices, filed as follows:
1. File Schedule II controlled substance invoices separately from records that are not Schedule II controlled substance invoices;
2. File Schedule III, IV, and V controlled substance invoices separately from records that are not Schedule III, IV, and V controlled substance invoices; and
3. File all non-controlled substance invoices separately from the invoices referenced in subsections (E)(1) and (2).

**F.** A dentist shall file Drug Enforcement Administration order form (DEA Form 222) for a controlled substance sequentially and separately from every other record.

**Historical Note**
Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1404 renumbered to R4-11-1203, new Section R4-11-1404 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-1405. Compliance**

**A.** A dentist who determines that there has been a theft or loss of Drugs or Controlled Substances from the dentist's office shall immediately notify a local law enforcement agency and the Board and provide written notice of the theft or loss in the following manner:
1. For non-Controlled Substance Drug theft or loss, provide the law enforcement agency and the Board with a written report explaining the theft or loss; or
2. For Controlled Substance theft or loss, complete a Drug Enforcement Administration's 106 form; and
3. Provide copies of the Drug Enforcement Administration's 106 form to the Drug Enforcement Administration and the Board within one day of the discovery.

**B.** A dentist who dispenses Drugs or devices in a manner inconsistent with this Article is subject to discipline under A.R.S. Title 32, Chapter 11, Article 3.

**Historical Note**
Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1405 renumbered to R4-11-1204, new Section R4-11-1405 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 28 A.A.R. 1898 (August 5, 2022), effective September 12, 2022 (Supp. 22-3).

**R4-11-1406. Dispensing for Profit Registration and Renewal**

**A.** A dentist who is currently licensed to practice dentistry in Arizona may dispense controlled substances, prescription-only drugs, and prescription-only devices for profit only after providing the Board the following information:
1. A completed registration form that includes the following information:
   a. The dentist's name and dental license number;
   b. A list of the types of drugs and devices to be dispensed for profit, including controlled substances; and
   c. Locations where the dentist desires to dispense the drugs and devices for profit; and
2. A copy of the dentist's current Drug Enforcement Administration Certificate of Registration for each dispensing location from which the dentist desires to dispense the drugs and devices for profit.

**B.** The Board shall issue a numbered certificate indicating the dentist is registered with the Board to dispense drugs and devices for profit.

**C.** A dentist shall renew a registration to dispense drugs and devices for profit by complying with the requirements in subsection (A) before the dentist's license renewal date. When a dentist has made timely and complete application for the renewal of a registration, the dentist may continue to dispense until the Board approves or denies the application. Failure to renew a registration shall result in immediate loss of dispensing for profit privileges.

**Historical Note**

Adopted effective July 21, 1995; inadvertently not published with Supp. 95-3 (Supp. 95-4). Former Section R4-11-1406 renumbered to R4-11-1205, new Section R4-11-1406 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

**R4-11-1407. Renumbered**

**Historical Note**

Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1407 renumbered to R4-11-1206 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-1408. Renumbered**

**Historical Note**

Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1408 renumbered to R4-11-1207 by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

**R4-11-1409. Repealed**

**Historical Note**

Adopted effective July 21, 1995 (Supp. 95-3). Former Section R4-11-1409 repealed by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1).

## ARTICLE 15. COMPLAINTS, INVESTIGATIONS, DISCIPLINARY ACTION

**R4-11-1501. Ex-parte Communication**

A complainant, licensee, certificate holder, business entity or mobile dental permit holder against whom a complaint is filed, shall not engage in ex-parte communication by means of a written or oral communication between a decision maker, fact finder, or Board member and only one party to the proceeding.

**Historical Note**

New Section R4-11-1501 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 334, effective April 6, 2013 (Supp. 13-1).

**R4-11-1502. Dental Consultant Qualifications**

A dentist, dental therapist, dental hygienist, or denturist approved as a Board dental consultant shall:

1. Possess a valid license or certificate to practice in Arizona;
2. Have practiced at least five years in Arizona; and
3. Not have been disciplined by the Board within the past five years.

**Historical Note**

New Section R4-11-1502 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 19 A.A.R. 334, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-1503. Initial Complaint Review**

**A.** The Board's procedures for complaint notification are:

1. The Board shall notify the Licensee, denturist, Business Entity or Mobile Dental Permit Holder by certified U.S. Mail when the following occurs:
   a. A formal interview is scheduled, and
   b. A subpoena, notice, or order is issued.
2. The Board shall notify the Licensee, denturist, Business Entity, or Mobile Dental Permit Holder by U.S. mail or email when the following occurs:
   a. The complaint is tabled, and
   b. The Board grants a postponement or continuance.
3. Board shall provide the Licensee, denturist, Business Entity, or Mobile Dental Permit Holder with a copy of the complaint.
4. If a complaint alleges a violation of the state or federal criminal code, the Board shall refer the complaint to the proper law enforcement agency.

**B.** The Board's procedures for complaints referred to Clinical Evaluation are:

1. Except as provided in subsection (B)(1)(a), the President's Designee shall appoint one or more dental consultants to perform a Clinical Evaluation. If there is more than one dental consultant, the dental consultants do not need to be present at the same time.
   a. If the complaint involves a dental hygienist, denturist, dental therapist, or dentist who is a recognized specialist in one of the areas listed in R4-11-1102(B), the President's Designee shall appoint a dental consultant from that area of practice or specialty.
   b. The Board shall disclose the identity of the Licensee, denturist, Business Entity, or Mobile Dental Permit Holder to a dental consultant performing a Clinical Evaluation before the Board receives the dental consultant's report.
2. The dental consultant shall prepare and submit a Clinical Evaluation report. The President's Designee shall provide a copy of the Clinical Evaluation report to the Licensee or denturist. The Licensee or denturist may submit a written response to the Clinical Evaluation report.

**C.** Notwithstanding any other provision, the Board may take immediate action consistent with A.R.S. §§ 32-1201.01 or 32-1263 in order to protect public health and safety.

**Historical Note**

New Section R4-11-1503 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 334, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2). Amended by final rulemaking at 29 A.A.R. 3793 (December 15, 2023), effective January 29, 2024 (Supp. 23-4).

**R4-11-1504. Postponement of Interview**

**A.** The licensee, certificate holder, business entity, or mobile dental permit holder may request a postponement of a formal interview. The Board or its designee shall grant a postponement until the next regularly scheduled Board meeting if the

licensee, certificate holder, business entity, or mobile dental permit holder makes a postponement request and the request:
1. Is made in writing,
2. States the reason for the postponement, and
3. Is received by the Board within 15 calendar days after the date the respondent received the formal interview request.

**B.** Within 48 hours of receipt of a request for postponement of a formal interview, the Board or its designee shall:
1. Review and either deny or approve the request for postponement; and
2. Notify in writing the complainant and licensee, certificate holder, business entity, or mobile dental permit holder of the decision to either deny or approve the request for postponement.

**Historical Note**
New Section R4-11-1504 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 3669, effective April 30, 2003 (Supp. 03-3). New Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 334, effective April 6, 2013 (Supp. 13-1).

## ARTICLE 16. DENTAL THERAPISTS

**R4-11-1601. Duties and Qualifications**

**A.** A dental therapist may perform a procedure not specifically authorized by A.R.S. § 32-1276.03 when all of the following conditions are satisfied:
1. The procedure is recommended or prescribed by the supervising dentist;
2. The dental therapist has received training by a recognized dental school, recognized dental therapy school, recognized dental hygiene school, or recognized denturist school, as defined under A.R.S. § 32-1201, to perform the procedure in a safe manner; and
3. The procedure is performed under the Direct Supervision of, or according to, a written collaborative practice agreement with a licensed dentist.

**B.** A dental therapist may administer Nitrous Oxide Analgesia as authorized by A.R.S. § 32-1276.03(B)(12) if the dental therapist submits proof directly from an issuing institution of completing courses in the administration of Nitrous Oxide Analgesia offered by a recognized dental school, recognized dental therapy school, or recognized dental hygiene school, as defined under A.R.S. § 32-1201, that include both theory and supervised clinical practice in the procedures.

**C.** A dental therapist may perform suturing and suture removal as authorized by A.R.S. § 32-1276.03(B)(21) if the dental therapist submits proof directly from an issuing institution of completing courses in suturing and suture removal offered by a recognized dental school, recognized dental therapy school, or recognized dental hygiene school, as defined under A.R.S. § 32-1201, that include both theory and supervised clinical practice in the procedures.

**D.** A dental therapist may perform an Irreversible Procedure only if it is specifically authorized by A.R.S. § 32-1276.03 or meets the conditions of R4-11-1601(A).

**Historical Note**
New Section R4-11-1601 adopted by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E) at 14 A.A.R. 3183, effective April 30, 2008. New Section made by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-1602. Limitation on Number Supervised**

A dentist shall not provide direct supervision for more than three dental therapists while the dental therapists are providing services or performing procedures under A.R.S. § 32-1276.03 or R4-11-1601.

**Historical Note**
New Section made by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-1603. Dental Therapy Consultants**

After submission of a current curriculum vitae or resume and approval by the Board, dental therapy consultants may:
1. Participate in Board-related procedures, including a Clinical Evaluation, investigation of complaints concerning infection control, insurance fraud, or the practice of supervised personnel, and any other procedures not directly related to evaluating a dentist's or denturist's quality of care; and
2. Participate in onsite office evaluations for infection control, as part of a team.

**Historical Note**
New Section made by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

**R4-11-1604. Written Collaborative Practice Agreements; Collaborative Practice Relationships**

**A.** A dental therapist shall submit a signed affidavit to the Board affirming that:
1. The Collaborative Practice Agreement complies with all the requirements listed in A.R.S. § 32-1276.04.
2. The dental therapist is and will be continuously certified in basic life support, including healthcare provider level cardiopulmonary resuscitation and training in automated external defibrillator.
3. The dental therapist is in compliance with the continuing dental education requirements of this state.

**B.** Each dentist who enters into a Collaborative Practice Agreement shall be available telephonically or electronically during the business hours of the dental therapist to provide an appropriate level of contact, communication, and consultation.

**C.** A Collaborative Practice Agreement shall include a provision for a substitute dentist, to cover an extenuating circumstance that renders the affiliated practice dentist unavailable for contact, communication, and consultation with the dental therapist.

**D.** A Collaborative Practice Agreement shall include a signed and dated statement from the dentist providing Direct Supervision, verifying the dental therapist's completion of 1000 hours of dental therapy clinical practice according to A.R.S. § 32-1276.04(B).

**E.** A Collaborative Practice Agreement shall be between one dentist and one dental therapist.

**Historical Note**
New Section made by final rulemaking at 29 A.A.R. 1330 (June 9, 2023), effective July 10, 2023 (Supp. 23-2).

## ARTICLE 17. REHEARING OR REVIEW

**R4-11-1701. Procedure**

**A.** Except as provided in subsection (F), a licensee, certificate holder, or business entity who is aggrieved by an order issued by the Board may file a written motion for rehearing or review

with the Board, pursuant to A.R.S. Title 41, Chapter 6, Article 10, specifying the grounds for rehearing or review.

**B.** A licensee, certificate holder, or business entity filing a motion for rehearing or review under this rule may amend the motion at any time before it is ruled upon by the Board. The opposing party may file a response within 15 days after the date the motion for rehearing or review is filed. The Board may require that the parties file supplemental memoranda explaining the issues raised in the motion, and may permit oral argument.

**C.** The Board may grant a rehearing or review of the order for any of the following causes materially affecting a licensee, certificate holder, or business entity's rights:

1. Irregularity in the proceedings of the Board or any order or abuse of discretion, which deprived a licensee, certificate holder, or business entity of a fair hearing;
2. Misconduct of the Board, its personnel, the administrative law judge, or the prevailing party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Excessive or insufficient penalties;
5. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceeding;
6. That the findings of fact or decision is arbitrary, capricious, or an abuse of discretion;
7. That the findings of fact of decision is not justified by the evidence or is contrary to law; or
8. Newly discovered, material evidence which could not, with reasonable diligence, have been discovered and produced at the original hearing.

**D.** The Board may affirm or modify the order or grant a rehearing or review to all or part of the issues for any of the reasons in subsection (C). The Board, within the time for filing a motion for rehearing or review, may grant a rehearing or review on its own initiative for any reason for which it might have granted relief on motion of a party. An order granting a rehearing or review shall specify the grounds on which rehearing or review is granted, and any rehearing or review shall cover only those matters specified.

**E.** When a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after such service, serve opposing affidavits.

**F.** If the Board makes specific findings that the immediate effectiveness of the order is necessary for the preservation of public health and safety and that a rehearing or review is impracticable, unnecessary, or contrary to the public interest, the order may be issued as a final order without an opportunity for a rehearing or review. If an order is issued as a final order without an opportunity or rehearing or review, the aggrieved party shall make an application for judicial review of the order within the time limits permitted for application for judicial review of the Board's final order.

**G.** The Board shall rule on the motion for rehearing or review within 15 days after the response has been filed, or at the Board's next meeting after the motion is received, whichever is later.

**Historical Note**

New Section R4-11-1701 renumbered from R4-11-701 and amended by final rulemaking at 5 A.A.R. 580, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 21 A.A.R. 2971, effective January 2, 2016 (Supp. 15-4).

## ARTICLE 18. BUSINESS ENTITIES

### R4-11-1801. Application

Before offering dental services, a business entity required to be registered under A.R.S. § 32-1213 shall apply for registration on an application form supplied by the Board. In addition to the requirements of A.R.S. § 32-1213(B) and the fee under R4-11-402, the registration application shall include a sworn statement from the applicant that:

1. The information provided by the business entity is true and correct, and
2. No information is omitted from the application.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

### R4-11-1802. Display of Registration

**A.** A business entity shall ensure that the receipt for the current registration period is:

1. Conspicuously displayed in the dental practice in a manner that is always readily observable by patients and visitors, and
2. Exhibited to members of the Board or to duly authorized agents of the Board on request.

**B.** A business entity's receipt for the licensure period immediately preceding shall be kept on display until replaced by the receipt for the current period.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 793, effective April 2, 2005 (Supp. 05-1).

# 32-1207. Powers and duties; executive director; immunity; fees; definitions

A. The board shall:

1. Adopt rules that are not inconsistent with this chapter for regulating its own conduct, for holding examinations and for regulating the practice of dentists and supervised personnel and registered business entities, provided that:

(a) Regulation of supervised personnel is based on the degree of education and training of the supervised personnel, the state of scientific technology available and the necessary degree of supervision of the supervised personnel by dentists.

(b) Except as provided pursuant to sections 32-1276.03 and 32-1281, only licensed dentists may perform diagnosis and treatment planning, prescribe medication and perform surgical procedures on hard and soft tissues.

(c) Only a licensed dentist, a dental therapist either under the direct supervision of a dentist or pursuant to a written collaborative practice agreement or a dental hygienist in consultation with a dentist may perform examinations, oral health assessments and treatment sequencing for dental hygiene procedures.

2. Adopt a seal.

3. Maintain a record that is available to the board at all times of its acts and proceedings, including the issuance, denial, renewal, suspension or revocation of licenses and the disposition of complaints. The existence of a pending complaint or investigation shall not be disclosed to the public. Records of complaints shall be available to the public, except only as follows:

(a) If the board dismisses or terminates a complaint, the record of the complaint shall not be available to the public.

(b) If the board has issued a nondisciplinary letter of concern, the record of the complaint shall be available to the public only for a period of five years after the date the board issued the letter of concern.

(c) If the board has required additional nondisciplinary continuing education pursuant to section 32-1263.01 but has not taken further action, the record of the complaint shall be available to the public only for a period of five years after the licensee satisfies this requirement.

(d) If the board has assessed a nondisciplinary civil penalty pursuant to section 32-1208 but has not taken further action, the record of the complaint shall be available to the public only for a period of five years after the licensee satisfies this requirement.

4. Establish a uniform and reasonable standard of minimum educational requirements consistent with the accreditation standards of the American dental association commission on dental accreditation to be observed by dental schools, dental therapy schools and dental hygiene schools in order to be classified as recognized dental schools, dental therapy schools or dental hygiene schools.

5. Establish a uniform and reasonable standard of minimum educational requirements that are consistent with the accreditation standards of the United States department of education or the council on higher education accreditation and that must be observed by denture technology schools in order to be classified as recognized denture technology schools.

6. Determine the reputability and classification of dental schools, dental therapy schools, dental hygiene schools and denture technology schools in accordance with their compliance with the standard set forth in paragraph 4 or 5 of this subsection, whichever is applicable.

7. Issue licenses to persons who the board determines are eligible for licensure pursuant to this chapter.

8. Determine the eligibility of applicants for restricted permits and issue restricted permits to those found eligible.

9. Pursuant to section 32-1263.02, investigate charges of misconduct on the part of licensees and persons to whom restricted permits have been issued.

10. Issue a letter of concern, which is not a disciplinary action but refers to practices that may lead to a violation and to disciplinary action.

11. Issue decrees of censure, fix periods and terms of probation, suspend or revoke licenses, certificates and restricted permits, as the facts may warrant, and reinstate licenses, certificates and restricted permits in proper cases.

12. Collect and disburse monies.

13. Perform all other duties that are necessary to enforce this chapter and that are not specifically or by necessary implication delegated to another person.

14. Establish criteria for the renewal of permits issued pursuant to board rules relating to general anesthesia and sedation.

B. The board may:

1. Sue and be sued.

2. Issue subpoenas, including subpoenas to the custodian of patient records, compel attendance of witnesses, administer oaths and take testimony concerning all matters within the board's jurisdiction. If a person refuses to obey a subpoena issued by the board, the refusal shall be certified to the superior court and proceedings shall be instituted for contempt of court.

3. Adopt rules:

(a) Prescribing requirements for continuing education for renewal of all licenses issued pursuant to this chapter.

(b) Prescribing educational and experience prerequisites for administering intravenous or intramuscular drugs for the purpose of sedation or for using general anesthetics in conjunction with a dental treatment procedure.

(c) Prescribing requirements for obtaining licenses for retired licensees or licensees who have a disability, including the triennial license renewal fee.

4. Hire consultants to assist the board in the performance of its duties and employ persons to provide investigative, professional and clerical assistance as the board deems necessary.

5. Contract with other state or federal agencies as required to carry out the purposes of this chapter.

6. If determined by the board, order physical, psychological, psychiatric and competency evaluations of licensed dentists, dental therapists and dental hygienists, certified denturists and applicants for licensure and certification at the expense of those individuals.

7. Establish an investigation committee consisting of not more than eleven licensees who are in good standing, who are appointed by the board and who serve at the pleasure of the board to investigate any complaint submitted to the board, initiated by the board or delegated by the board to the investigation committee pursuant to this chapter.

C. The executive director or the executive director's designee may:

1. Issue and renew licenses, certificates and permits to applicants who meet the requirements of this chapter.

2. Initiate an investigation if evidence appears to demonstrate that a dentist, dental therapist, dental hygienist, denturist or restricted permit holder may be engaged in unprofessional conduct or may be unable to safely practice dentistry.

3. Initiate an investigation if evidence appears to demonstrate that a business entity may be engaged in unethical conduct.

4. Subject to board approval, enter into a consent agreement with a dentist, dental therapist, denturist, dental hygienist or restricted permit holder if there is evidence of unprofessional conduct.

5. Subject to board approval, enter into a consent agreement with a business entity if there is evidence of unethical conduct.

6. Refer cases to the board for a formal interview.

7. If delegated by the board, enter into a stipulation agreement with a person under the board's jurisdiction for the treatment, rehabilitation and monitoring of chemical substance abuse or misuse.

D. Members of the board are personally immune from liability with respect to all acts done and actions taken in good faith and within the scope of their authority.

E. The board by rule shall require that a licensee obtain a permit for applying general anesthesia and sedation, shall establish and collect a fee of not more than $300 to cover administrative costs connected with issuing the permit and shall conduct inspections to ensure compliance.

F. The board by rule may establish and collect fees for license verification, board meeting agendas and minutes, published lists and mailing labels.

G. This section does not prohibit the board from conducting its authorized duties in a public meeting.

H. For the purposes of this section:

1. "Good standing" means that a person holds an unrestricted and unencumbered license that has not been suspended or revoked pursuant to this chapter.

2. "Record of complaint" means the document reflecting the final disposition of a complaint or investigation.

# 32-1213. Business entities; registration; renewal; civil penalty; exceptions

A. A business entity may not offer dental services pursuant to this chapter unless:

1. The business entity is registered with the board pursuant to this section.

2. The services are conducted by a licensee pursuant to this chapter.

B. The business entity must file a registration application on a form provided by the board. The application must include:

1. A description of the business entity's services offered to the public.

2. The name of any dentist who is authorized to provide and who is responsible for providing the dental services offered at each office.

3. The names and addresses of the officers and directors of the business entity.

4. The name of the business entity's custodian of records.

5. A registration fee prescribed by the board in rule.

C. A business entity must file a separate registration application and pay a fee for each branch office in this state.

D. A registration expires three years after the date the board issues the registration. A business entity that wishes to renew a registration must submit an application for renewal as prescribed by the board on a triennial basis on a form provided by the board before the expiration date. A business entity that fails to renew the registration before the expiration date is subject to a late fee as prescribed by the board by rule. The board may stagger the dates for renewal applications.

E. The business entity must notify the board in writing within thirty days after any change:

1. In the business entity's name, address or telephone number.

2. In the officers or directors of the business entity.

3. In the name of any dentist who is authorized to provide and who is responsible for providing the dental services in any facility.

4. The name of the business entity's custodian of records who will accept subpoenas and respond to patient records requests.

F. The business entity shall establish a written protocol for the secure storage, transfer and access of the dental records of the business entity's patients. This protocol must include, at a minimum, procedures for:

1. Notifying patients of the future locations of their records if the business entity terminates or sells the practice.

2. Disposing of unclaimed dental records.

3. The timely response to requests by patients for copies of their records.

G. The business entity must notify the board within thirty days after the dissolution of any registered business entity or the closing or relocation of any facility and must disclose to the board the business entity's procedure by which its patients may obtain their records.

H. The board may do any of the following pursuant to its disciplinary procedures if a business entity violates the board's statutes or rules:

1. Refuse to issue a registration.

2. Suspend or revoke a registration.

3. Impose a civil penalty of not more than $2,000 for each violation.

4. Enter a decree of censure.

5. Issue an order prescribing a period and terms of probation that are best adapted to protect the public welfare and that may include a requirement for restitution to a patient for a violation of this chapter or rules adopted pursuant to this chapter.

6. Issue a letter of concern if a business entity's actions may cause the board to take disciplinary action.

I. The board shall deposit, pursuant to sections 35-146 and 35-147, civil penalties collected pursuant to this section in the state general fund.

J. This section does not apply to:

1. A sole proprietorship or partnership that consists exclusively of dentists who are licensed pursuant to this chapter.

2. Any of the following entities licensed under title 20:

(a) A service corporation.

(b) An insurer authorized to transact disability insurance.

(c) A prepaid dental plan organization that does not provide directly for prepaid dental services.

(d) A health care services organization that does not provide directly for dental services.

3. A professional corporation or professional limited liability company, the shares of which are exclusively owned by dentists who are licensed pursuant to this chapter and that is formed to engage in the practice of dentistry pursuant to title 10, chapter 20 or title 29 relating to professional limited liability companies.

4. A facility regulated by the federal government or a state, district or territory of the United States.

5. An administrator or executor of the estate of a deceased dentist or a person who is legally authorized to act for a dentist who has been adjudicated to be mentally incompetent for not more than one year after the date the board receives notice of the dentist's death or incapacitation pursuant to section 32-1270.

K. A facility that offers dental services to the public by persons licensed under this chapter shall be registered by the board unless the facility is any of the following:

1. Owned by a dentist who is licensed pursuant to this chapter.

2. Regulated by the federal government or a state, district or territory of the United States.

L. Except for issues relating to insurance coding and billing that require the name, signature and license number of the dentist providing treatment, this section does not:

1. Authorize a licensee in the course of providing dental services for a business entity registered pursuant to this section to disregard or interfere with a policy or practice established by the business entity for the operation and management of the business.

2. Authorize a business entity registered pursuant to this section to establish or enforce a business policy or practice that may interfere with the clinical judgment of the licensee in providing dental services for the business entity or may compromise a licensee's ability to comply with this chapter.

M. The board shall adopt rules that provide a method for the board to receive the assistance and advice of business entities licensed pursuant to this chapter in all matters relating to the regulation of business entities.

N. An individual currently holding a surrendered or revoked license to practice dentistry or dental hygiene in any state or jurisdiction in the United States may not have a majority ownership interest in the business entity registered pursuant to this section. Revocation and surrender of licensure shall be limited to disciplinary actions resulting in loss of license or surrender of license instead of disciplinary action. Dentists or dental hygienists affected by this subsection shall have one year after the surrender or revocation to divest themselves of their ownership interest. This subsection does not apply to publicly held companies. For the purposes of this subsection, "majority ownership interest" means an ownership interest greater than fifty percent.

# 32-1263.02. Investigation and adjudication of complaints; disciplinary action; civil penalty; immunity; subpoena authority; definitions

A. The board on its own motion, or the investigation committee if established by the board, may investigate any evidence that appears to show the existence of any of the causes or grounds for disciplinary action as provided in section 32-1263. The board or investigation committee may investigate any complaint that alleges the existence of any of the causes or grounds for disciplinary action as provided in section 32-1263. The board shall not act on its own motion or on a complaint received by the board if the allegation of unprofessional conduct, unethical conduct or any other violation of this chapter against a licensee occurred more than four years before the complaint is received by the board. The four-year time limitation does not apply to:

1. Medical malpractice settlements or judgments, allegations of sexual misconduct or an incident or occurrence that involved a felony, diversion of a controlled substance or impairment while practicing by the licensee.

2. The board's consideration of the specific unprofessional conduct related to the licensee's failure to disclose conduct or a violation as required by law.

B. At the request of the complainant, the board or investigation committee shall not disclose to the respondent the complainant name unless the information is essential to proceedings conducted pursuant to this article.

C. The board or investigation committee shall conduct necessary investigations, including interviews between representatives of the board or investigation committee and the licensee with respect to any information obtained by or filed with the board under subsection A of this section or obtained by the board or investigation committee during the course of an investigation. The results of the investigation conducted by the investigation committee, including any recommendations from the investigation committee for disciplinary action against any licensee, shall be forwarded to the board for its review.

D. The board or investigation committee may designate one or more persons of appropriate competence to assist the board or investigation committee with any aspect of an investigation.

E. If, based on the information the board receives under subsection A or C of this section, the board finds that the public health, safety or welfare imperatively requires emergency action and incorporates a finding to that effect in its order, the board may order a summary suspension of a licensee's license pursuant to section 41-1092.11 pending proceedings for revocation or other action.

F. If a complaint refers to quality of care, the patient may be referred for a clinical evaluation at the discretion of the board or the investigation committee.

G. If, after completing its investigation or review pursuant to this section, the board finds that the information provided pursuant to subsection A or C of this section is insufficient to merit disciplinary action against a licensee, the board may take any of the following actions:

1. Dismiss the complaint.

2. Issue a nondisciplinary letter of concern to the licensee.

3. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

4. Assess a nondisciplinary civil penalty in an amount not to exceed $500 if the complaint involves the licensee's failure to respond to a board subpoena.

H. If, after completing its investigation or review pursuant to this section, the board finds that the information provided pursuant to subsection A or C of this section is sufficient to merit disciplinary action against a licensee,

the board may request that the licensee participate in a formal interview before the board. If the licensee refuses or accepts the invitation for a formal interview and the results indicate that grounds may exist for revocation or suspension, the board shall issue a formal complaint and order that a hearing be held pursuant to title 41, chapter 6, article 10. If, after completing a formal interview, the board finds that the protection of the public requires emergency action, it may order a summary suspension of the license pursuant to section 41-1092.11 pending formal revocation proceedings or other action authorized by this section.

I. If, after completing a formal interview, the board finds that the information provided under subsection A or C of this section is insufficient to merit suspension or revocation of the license, it may take any of the following actions:

1. Dismiss the complaint.

2. Order disciplinary action pursuant to section 32-1263.01, subsection A.

3. Enter into a consent agreement with the licensee for disciplinary action.

4. Order nondisciplinary continuing education pursuant to section 32-1263.01, subsection B.

5. Issue a nondisciplinary letter of concern to the licensee.

J. A copy of the board's order issued pursuant to this section shall be given to the complainant and to the licensee. Pursuant to title 41, chapter 6, article 10, the licensee may petition for rehearing or review.

K. Any person who in good faith makes a report or complaint as provided in this section to the board or to any person or committee acting on behalf of the board is not subject to liability for civil damages as a result of the report.

L. The board, through its president or the president's designee, may issue subpoenas to compel the attendance of witnesses and the production of documents and may administer oaths, take testimony and receive exhibits in evidence in connection with an investigation initiated by the board or a complaint filed with the board. In case of disobedience to a subpoena, the board may invoke the aid of any court of this state in requiring the attendance and testimony of witnesses and the production of documentary evidence.

M. Patient records, including clinical records, medical reports, laboratory statements and reports, files, films, reports or oral statements relating to diagnostic findings or treatment of patients, any information from which a patient or a patient's family may be identified or information received and records kept by the board as a result of the investigation procedures taken pursuant to this chapter, are not available to the public.

N. The board may charge the costs of formal hearings conducted pursuant to title 41, chapter 6, article 10 to a licensee it finds to be in violation of this chapter.

O. The board may accept the surrender of an active license from a licensee who is subject to a board investigation and who admits in writing to any of the following:

1. Being unable to safely engage in the practice of dentistry.

2. Having committed an act of unprofessional conduct.

3. Having violated this chapter or a board rule.

P. In determining the appropriate disciplinary action under this section, the board may consider any previous nondisciplinary and disciplinary actions against a licensee.

Q. If a licensee who is currently providing dental services for a registered business entity believes that the registered business entity has engaged in unethical conduct as defined pursuant to section 32-1263, subsection D,

paragraph 16, the licensee must do both of the following before filing a complaint with the board:

1. Notify the registered business entity in writing that the licensee believes that the registered business entity has engaged in a policy or practice that interferes with the clinical judgment of the licensee or that compromises the licensee's ability to comply with the requirements of this chapter. The licensee shall specify in the notice the reasons for this belief.

2. Provide the registered business entity with at least ten calendar days to respond in writing to the assertions made pursuant to paragraph 1 of this subsection.

R. A licensee who files a complaint pursuant to subsection Q of this section shall provide the board with a copy of the licensee's notification and the registered business entity's response, if any.

S. A registered business entity may not take any adverse employment action against a licensee because the licensee complies with the requirements of subsection Q of this section.

T. For the purposes of this section:

1. "License" includes a certificate issued pursuant to this chapter.

2. "Licensee" means a dentist, dental therapist, dental hygienist, denturist, dental consultant, restricted permit holder or business entity regulated pursuant to this chapter.

# 32-1298. Dispensing of drugs and devices; conditions; definition

A. A dentist may dispense drugs, except schedule II controlled substances that are opioids, and devices kept by the dentist if:

1. All drugs and devices are dispensed in packages labeled with the following information:

(a) The dispensing dentist's name, address and telephone number.

(b) The date the drug or device is dispensed.

(c) The patient's name.

(d) The name and strength of the drug or device, directions for its use and any cautionary statements required by law.

2. The dispensing dentist enters into the patient's dental record the name and strength of the drug or device dispensed, the date the drug or device is dispensed and the therapeutic reason.

3. The dispensing dentist keeps all drugs and devices in a locked cabinet or room, controls access to the cabinet or room by a written procedure and maintains an ongoing inventory of its contents.

B. Before dispensing a drug or device pursuant to this section, the patient shall be given a written prescription on which appears the following statement in bold type: "This prescription may be filled by the prescribing dentist or by a pharmacy of your choice."

C. A dentist shall dispense for profit only to the dentist's own patient and only for conditions being treated by that dentist. The dentist shall provide direct supervision of an attendant involved in the dispensing process. For the purposes of this subsection, "direct supervision" means that a dentist is present and makes the determination as to the legitimacy or advisability of the drugs or devices to be dispensed.

D. This section shall be enforced by the board, which shall establish rules regarding labeling, recordkeeping, storage and packaging of drugs and devices that are consistent with the requirements of chapter 18 of this title. The board may conduct periodic inspections of dispensing practices to ensure compliance with this section and applicable rules.

E. For the purposes of this section, "dispense" means the delivery by a dentist of a prescription drug or device to a patient, except for samples packaged for individual use by licensed manufacturers or repackagers of drugs or devices, and includes the prescribing, administering, packaging, labeling and security necessary to prepare and safeguard the drug or device for delivery.

House Engrossed

dentists; registration; civil penalty; repeal

State of Arizona
House of Representatives
Fifty-sixth Legislature
Second Regular Session
2024

# CHAPTER 21

# HOUSE BILL 2071

AN ACT

AMENDING SECTION 32-1298, ARIZONA REVISED STATUTES; RELATING TO THE STATE BOARD OF DENTAL EXAMINERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 32-1298, Arizona Revised Statutes, is amended to read:

32-1298. Dispensing of drugs and devices; conditions; definition

A. A dentist may dispense drugs, except schedule II controlled substances that are opioids, and devices kept by the dentist if:

1. All drugs AND DEVICES are dispensed in packages labeled with the following information:

(a) The dispensing dentist's name, address and telephone number.

(b) The date the drug OR DEVICE is dispensed.

(c) The patient's name.

(d) The name and strength of the drug OR DEVICE, directions for its use and any cautionary statements REQUIRED BY LAW.

2. The dispensing dentist enters into the patient's dental record the name and strength of the drug OR DEVICE dispensed, the date the drug OR DEVICE is dispensed and the therapeutic reason.

3. The dispensing dentist keeps all drugs AND DEVICES in a locked cabinet or room, controls access to the cabinet or room by a written procedure and maintains an ongoing inventory of its contents.

~~B. Except in an emergency situation, a dentist who dispenses drugs for a profit without being registered by the board to do so is subject to a civil penalty by the board of not less than three hundred dollars and not more than one thousand dollars for each transaction and is prohibited from further dispensing for a period of time as prescribed by the board.~~

~~C.~~ B. Before dispensing a drug OR DEVICE pursuant to this section, the patient shall be given a written prescription on which appears the following statement in bold type: "This prescription may be filled by the prescribing dentist or by a pharmacy of your choice."

~~D.~~ C. A dentist shall dispense for profit only to the dentist's own patient and only for conditions being treated by that dentist. The dentist shall provide direct supervision of an attendant involved in the dispensing process. For the purposes of this subsection, "direct supervision" means that a dentist is present and makes the determination as to the legitimacy or advisability of the drugs or devices to be dispensed.

~~E.~~ D. This section shall be enforced by the board, which shall establish rules regarding labeling, recordkeeping, storage and packaging of drugs AND DEVICES that are consistent with the requirements of chapter 18 of this title. The board may conduct periodic inspections of dispensing practices to ensure compliance with this section and applicable rules.

~~f.~~ E. For the purposes of this section, "dispense" means the delivery by a dentist of a prescription drug or device to a patient, except for samples packaged for individual use by licensed manufacturers or repackagers of drugs OR DEVICES, and includes the prescribing, administering, packaging, labeling and security necessary to prepare and safeguard the drug or device for delivery.

APPROVED BY THE GOVERNOR MARCH 29, 2024.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 29, 2024.

**F-8.**

**DEPARTMENT OF ENVIRONMENTAL QUALITY**
Title 18, Chapter 11, Articles 4-5

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

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**MEETING DATE:** July 1, 2025

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 17, 2025

**SUBJECT:** **DEPARTMENT OF ENVIRONMENTAL QUALITY**
Title 18, Chapter 11, Articles 4 and 5

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**Summary**

This Five-Year Review Report (5YRR) from the Department of Environmental Quality (Department) covers fourteen (14) rules Title 18, Chapter 11, Articles 4 and 5 related to Aquifer Water Quality Standards and Aquifer Boundary and Protected Use Classification.

In the report approved by the Council in November 2020, the Department proposed to amend 6 rules in order to improve overall clarity, conciseness, understandability, and consistency with other rules and statute. The Department completed the previous Courses of Action via expedited rulemaking approved in September 2023 and regular rulemakings related to R18-11-406, approved by the Council in May 2025 and June 2025.

**Proposed Action**

The Department has indicated that the rules are meeting their intended objective, are aligned with statutes and other rules, and are clear, concise, and understandable. Thus, the Department is not proposing any proposed course of action at this time.

**1. Has the agency analyzed whether the rules are authorized by statute?**

The Department cites both general and specific statutory authority for these rules

**2. Summary of the agency's economic impact comparison and identification of stakeholders:**

Article 4 Rules Under Review: The Department states that an economic impact statement was not required in either the 1990 or 1992 rulemakings. However, the Department still assessed that the rules' impacts on the state's economy, small business and consumers has not changed since the effective date and the only changes would be to adjust any dollar values for costs and benefits to adjust for inflation. The Department further states that any costs would be borne by the permittees and other persons who must ensure that a discharge to an aquifer or remediation impacting an aquifer complies with the aquifer water quality standards. The Department believes the benefits of protection of human health and environment outweigh these costs.

Article 5 Rules Under Review: The Department states that an economic impact statement was not required in either the 1987 or 1989 rulemakings. However, the Department still assessed that the rules' impacts on the state's economy, small business and consumers has not changed since the effective date and the only changes would be to adjust any dollar values for costs and benefits to adjust for inflation. The Department further states that these rules benefit a person who seeks to discharge to an aquifer without unnecessarily meeting the costs of aquifer water quality standards designed to protect groundwater as a drinking water source and implement the standard set in A.R.S. § 49-224 to determine that the short-term and long-term benefits to the public significantly outweigh the short-term and long-term costs to the public (A.R.S. §49-224(C)(3)).

Stakeholders include the Department, regulated parties like permittees, and the general public.

**3. Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

Yes, the Department believes that the benefits of the rules under both Articles 4 and 5 outweigh the costs to the regulated parties subject to the regulatory programs that employ the Aquifer Water Quality Standards (AWQSs), because it is the state's priority and ADEQ's statutory charge to ensure drinking water quality and human health.

**4. Has the agency received any written criticisms of the rules over the last five years?**

The Department indicates it has received a total of 14 written criticisms in the past five years. The criticisms and number of criticisms (in parenthesis) relate to the following rules R18-11-405 (2), R18-11-406 (5), R18-407 (1), R18-11-501 (1), R18-11-502(2), R18-11-503 (1), R18-11-504 (1), and General (1). The Department has indicated to Department staff these

criticisms were provided by interested individuals, municipalities, and wastewater treatment plant representatives. The comments and Department responses are found in Item 7 of the 5YRR.

**5. Has the agency analyzed the rules' clarity, conciseness, and understandability?**

The Department indicates the rules are clear, concise, and understandable.

**6. Has the agency analyzed the rules' consistency with other rules and statutes?**

The Department indicates the rules are consistent with other rules and statutes.

**7. Has the agency analyzed the rules' effectiveness in achieving its objectives?**

The Department indicates the rules are effective in achieving their objectives.

**8. Has the agency analyzed the current enforcement status of the rules?**

The Department indicates the rules are enforced as written.

**9. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

The Department indicates that the rules are not more stringent than corresponding federal law. The Department has stated that the following federal laws and rules apply to the subject matter of the rules in Article 4: The Safe Drinking Water Act, specifically at 42 U.S.C. 300f, 300g-1, 300g-2, 300g-3, 300g-4, 300g-5, 300g-6, 300j-4, 300j-9, and 300j-11. The primary drinking water maximum contaminant levels can be found in 40 CFR 141.11, 141.12 and 141.13. There is no corresponding federal law for Article 5.

**10. For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department has indicated that the rules do not require the issuance of a regulatory permit or license.

**11. Conclusion**

This Five-Year Review Report (5YRR) from the Department of Environmental Quality (Department) covers fourteen (14) rules Title 18, Chapter 11, Articles 4 and 5 related to Aquifer Water Quality Standards and Aquifer Boundary and Protected Use Classification. The Department has completed the previous Course of Action proposed in their previous 5YRR with an expedited rulemaking approved by the Council in September 2023 and rulemakings approved by the Council in May 2025 and June 2025. The Department is not proposing any amendments in this report.

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. Staff recommends approval of this report.

ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY

1110 W. Washington St.
Suite 160
Phoenix, AZ 85007
602-771-2300

KATIE HOBBS
GOVERNOR

KAREN PETERS
DIRECTOR

April 22, 2025

SENT VIA EMAIL ONLY

Jessica Klein, Chair
Governor's Regulatory Review Council
100 N. 15th Ave., #302
Phoenix, AZ 85007
grrc@azdoa.gov

Re: Submittal of Five-Year Review Report for A.A.C. Title 18, Chapter 11, Articles 4 and 5

Dear Chair Klein:

I am pleased to submit to you, pursuant to A.R.S. § 41-1056 and A.A.C. R1-6-301, our agency's Five-Year Review Report for A.A.C. Title 18, Chapter 11, Articles 4 (Aquifer Water Quality Standards) and 5 (Aquifer Boundary and Protected Use Classification).

Pursuant to A.R.S. § 41-1056(A), I certify that ADEQ is in compliance with A.R.S. § 41-1091 requirements for filing of notices of substantive policy statements and annual publication of a substantive policy statement directory.

Please contact Trevor Baggiore, Director of Water Quality Division at 602-771-2321 or baggiore.trevor@azdeq.gov, if you have any questions.

Sincerely,

Karen Peters
Director

Enclosure

**Arizona Department of Environmental Quality**

**Five-Year-Review Report**

**Title 18. Environmental Quality**

**Chapter 11. Department of Environmental Quality – Water Quality Standards**

**Article 4. Aquifer Water Quality Standards**

**Article 5. Aquifer Boundary and Protected Use Classification**

**April 30, 2025**

**1. Authorization of the rule by existing statutes**

**Article 4:**

General Statutory Authority: A.R.S. § 49-104(B)(4).

Specific Statutory Authority: A.R.S. §§ 49-221 and 49-223.

**Article 5:**

General Statutory Authority: A.R.S. § 49-104(B)(4).

Specific Statutory Authority: A.R.S. § 49-224.

**2. The objective of each rule:**

The purpose of the rules in Article 4 is to establish a set of aquifer water quality standards for various regulatory programs to utilize. The purpose of the rules in Article 5 is two-fold: (1) to provide a mechanism in rule for the aquifers of the state to be classified, reclassified or rescinded from classification concerning drinking water and nondrinking water protected use; (2) to provide a mechanism in rule for the boundaries of the aquifers in the state to be defined or redefined. The objective is to define and designate the aquifers so that regulatory programs have a jurisdiction upon which to operate.

| Rule | Objective |
|---|---|
| **R18-11-401** | This rule provides specific explanation for certain terms used in this Article. |
| **R18-11-402** | This rule is repealed. |
| **R18-11-403** | This rule specifies which analytical methods are used to determine compliance with an aquifer water quality standard. |
| **R18-11-404** | This rule determines which laboratories are approved for specific analysis when testing for compliance with the aquifer water quality standards. |
| **R18-11-405** | This rule describes narrative standards that will be applied to discharges to aquifers of the state. |

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| **R18-11-406** | This rule establishes numeric aquifer water quality standards for aquifers that are classified for drinking water protected use. |
| **R18-11-407** | This rule establishes a process for the Director to set standards in an aquifer if it is reclassified for a use other than drinking water. |
| **R18-11-408** | This rule establishes procedures to petition the Director to adopt a numeric aquifer water quality standard as well as procedures for the Director to follow in granting or denying the petition. |
| **R18-11-501** | This rule provides specific explanation for certain terms used in this Article. |
| **R18-11-502** | This rule identifies and defines the boundaries of aquifers in Arizona using, to the maximum extent practicable, data available from the Arizona Department of Water Resources (ADWR). Most of the State is deemed to be underlain by aquifers, which are classified for drinking water protected use. The rule distinguishes between aquifers and low-yielding bedrock areas. In this manner, certain areas inside of the groundwater basin boundaries are excluded from designation as aquifers. |
| **R18-11-503** | This rule establishes a procedure that a person can use to petition the Director to reclassify an aquifer. The rule specifically identifies the information that a petitioner should submit to ADEQ to allow the findings identified in A.R.S. § 49-224(C). |
| **R18-11-504** | This rule establishes procedures for taking action on a petition to reclassify an aquifer. The rule also triggers actions by ADEQ to initiate rulemaking for aquifer water quality standards when a petition to reclassify an aquifer is granted. |
| **R18-11-505** | This rule establishes procedures for public participation regarding the proposed aquifer reclassification. |
| **R18-11-506** | This rule establishes procedures to rescind an aquifer reclassification. |

**3. Are the rules effective in achieving their objectives?**

**Yes ×  No __**

**4. Are the rules consistent with other rules and statutes?**

**Yes ×  No __**

**5. Are the rules enforced as written?**

**Yes ×  No __**

**6. Are the rules clear, concise, and understandable?**

**Yes ×  No __**

**7. Has the agency received written criticisms of the rules within the last five years?**

**Yes ×  No __**

*If yes, please fill out the table below*

| Rule | Criticisms |
|---|---|
| **R18-11-405** | Criticism 1: The Department received a written criticism of the rule, stating that in subsection (B), it is not clear what a "navigable water of the state" is, and asks whether this should, instead, say "protected surface water"?<br><br>Response 1: ADEQ appreciates the comment. A.A.C. R18-11-405(B) refers to navigable waters of the state. "Waters of the State" is defined at A.R.S. § 49-201(50) and "WOTUS" or "Waters of the United States" is defined at A.R.S. § 49-201(53). The definition of "WOTUS" means "...waters of the state that are also navigable waters as defined by section 502(7) of the clean water act." After reviewing those definitions, it becomes apparent that the intention of the phrase "navigable water of the state" in R18-11-405(B) is intended to scope "waters of the state" as defined at A.R.S. § 49-201(50) that are "navigable waters", as referred to in A.R.S. § 49-201(53). Protected surface water is defined in A.R.S. § 49-201(38) as "...waters of the state listed on the protected surface waters list under section 49-221, subsection (G) and all WOTUS" which includes non-navigable, non-WOTUS waters of the state protected under ADEQ's surface water protection program.<br>Because the rule intends to only scope WOTUS, ADEQ does not believe subsection (B) should be changed to "protected surface water" as the criticism suggests.<br><br>Criticism 2: The Department received a written criticism of the rule, stating that the rule is neither clear on what defines a narrative standard, nor how it is to be applied in the context of an Aquifer Protection Permit.<br><br>Response 2: ADEQ appreciates the comment. A.R.S. § 49-221 requires ADEQ to adopt water quality standards in all aquifers to preserve and protect the quality of those waters. The statute requires water quality standards to be expressed in terms of the uses to be protected through numerical limitations or parameters in addition to any narrative standards the director deems appropriate (A.R.S. § 49-221(D)). To this end, ADEQ assesses and ensures compliance with the Aquifer Water Quality Standards (AWQSs) through the Aquifer Protection Program (APP) and permits. Like the numeric water quality standards apply to APP permittees, so too do the narrative standards in R18-11-405.<br>The narrative standards are intended to be used to create and enforce non-numerical standards in an APP permit when one does not exist in the listed numerical standards in R18-11-406 in the situations described in R18-11-405 subsections (A), (B) and (C). The narrative standards are intended as a "safety net" to guard against impacts not addressed by the limited number of numeric standards or the application of best available demonstrated control technology at a facility under the purview of an APP and may be incorporated into the APP permit. Exactly how the standards are incorporated into the APP permit is left to the permittee and ADEQ to determine on a case-by-case basis.<br>Through the context of the statute and the structure of Article 4 which, itself, establishes both narrative and numerical standards, ADEQ believes the rule to be clear, concise, and understandable.<br>While the narrative standards are clear in rule, ADEQ has previously developed a Substantive Policy Statement (SPS) on "Using Narrative Aquifer Water Quality Standards to Develop Permit Conditions for Aquifer Protection Permits". This |

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| | SPS provides some guidance on ways narrative standards can be incorporated into APP permits and can be found at ADEQ's SPS webpage here: https://azdeq.gov/substantive-policy-statement-listing. From the webpage, navigate to the "3000 - Water Quality" subsection and the "Permits Section" to find a link to SPS 3010. |
| **R18-11-406** | Criticism 1: The Department received a written criticism of the rule, stating that in subsection (E)(3), it would be better for the aquifer water quality standard for beta particle and photon radioactivity be specified in pCi/L since that is how labs report it for a water sample.<br><br>Response 1: ADEQ appreciates the comment. ADEQ is required to adopt the Environmental Protection Agency's (EPA) Safe Drinking Water Act Maximum Contaminant Levels (SDWA-MCLs) verbatim as Aquifer Water Quality Standards (AWQS) per A.R.S. § 49-223(A), unless "substantial opposition" is received from stakeholders. In the case of the MCL for radionuclides, ADEQ adopted 40 CFR 141.66(b) as R18-11-406(E)(2), 40 CFR 141.66(c) as R18-11-406(E)(1), 40 CFR 141.66(d)(1) as R18-11-406(E)(3), and 40 CFR 141.66(d)(2) as R18-11-406(E)(2). Specifically for beta particle and photon radioactivity, ADEQ adopted 40 CFR 141.66(d)(1) as R18-11-406(E)(3).<br>At this time, ADEQ does not believe changing the MCL units from millirems per year to picocuries per liter is necessary. For more information on the background of the MCL for beta particle and photon radioactivity that ADEQ adopted as an AWQS pursuant to A.R.S. § 49-223, please review 65 *Federal Register* 76748.<br><br>Criticism 2: The Department received a written criticism of the rule, stating that in subsection (F), Total Coliform should be changed to Fecal Coliform or *E coli*.<br><br>Response 2: ADEQ appreciates the comment. ADEQ recently submitted a regular rulemaking to Council on March 18, 2025, which adjusted or established for the first time, seven (7) Aquifer Water Quality Standards (AWQSs), including an alternative AWQS for Microbiological Contaminants. During the rulemaking's docket opening, in an attempt to adopt 40 C.F.R. 141.63(c), the Department received "substantial opposition" from stakeholders (*see* A.R.S. § 49-223(A)) which prompted ADEQ to review the assumptions EPA used to establish the Microbiological Contaminants MCL, and resulted in ADEQ's determination that the MCL was not appropriate as an AWQS. ADEQ then developed an alternative AWQS, which is based upon the detection or non-detection of either Fecal Coliform or *E.coli* in a 100-milliliter sample (depending on the requirement of the permit). Upon detection during a routine Fecal Coliform sample, a repeat sample of either Fecal Coliform or *E.coli* with a detect result constitutes a violation of the AWQS for microbiological contaminants. Upon a detect result of a routine *E.coli* sample, a repeat sample of *E.coli* with a detect result constitutes a violation of the AWQS for microbiological contaminants.<br>The AWQSs rulemaking is in progress and is expected to make the change requested by the commenter to this rule.<br><br>Criticism 3: The Department received a written criticism of the rule, stating that the numeric water quality standards, except Fluoride, have only one significant figure which causes confusion and erroneous rounding that should not be permissible. The commenter recommended updating the table such that every parameter has two significant figures. |

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| | Response 3: ADEQ appreciates the comment. ADEQ recently submitted a regular rulemaking to Council on March 18, 2025, which adjusted or established for the first time, seven (7) Aquifer Water Quality Standards (AWQSs). Six of the seven AWQSs that were adjusted or established for the first time utilize two specific figures. The seventh being Microbiological Contaminants, which utilized a sampling procedure and a detect, non-detect approach to violation. ADEQ is required to adopt the Environmental Protection Agency's (EPA) Safe Drinking Water Act Maximum Contaminant Levels (SDWA-MCLs) verbatim as Aquifer Water Quality Standards (AWQS) per A.R.S. § 49-223(A), unless "substantial opposition" is received from stakeholders. Notably, the MCLs adopted as AWQSs before the 2025 rulemaking mentioned above only utilize one significant figure. Assuming the 2025 rulemaking is approved by Council, the AWQSs at A.A.C. R18-11-406 will match the corresponding MCLs, predominantly found at 40 CFR 141, Subpart G, from a significant figure perspective.<br>At this time, ADEQ does not believe changing the significant figures for the AWQSs is necessary. For more information on the background of the MCLs and the one significant figure approach that ADEQ has adopted as an AWQS pursuant to A.R.S. § 49-223, please review the historical notes associated with the MCLs in 40 CFR 141, Subpart G. These notes, in most cases, reference the rulemaking documentation in the *Federal Register*.<br><br>Criticism 4: The Department received a written criticism of the rule, stating that subsection (E)(1) should be updated from "gross alpha particle activity" to "adjusted gross alpha particle activity" because most laboratories run this analysis and include in their reports "adjusted gross alpha" .<br><br>Response 4: ADEQ appreciates the comment. ADEQ is required to adopt the Environmental Protection Agency's (EPA) Safe Drinking Water Act Maximum Contaminant Levels (SDWA-MCLs) verbatim as Aquifer Water Quality Standards (AWQS) per A.R.S. § 49-223(A), unless "substantial opposition" is received from stakeholders. In the case of the MCL for radionuclides, ADEQ adopted 40 CFR 141.66(b) as R18-11-406(E)(2), 40 CFR 141.66(c) as R18-11-406(E)(1), 40 CFR 141.66(d)(1) as R18-11-406(E)(3), and 40 CFR 141.66(d)(2) as R18-11-406(E)(2). Specifically for gross alpha particle radioactivity, ADEQ adopted 40 CFR 141.66(c) as R18-11-406(E)(1).<br>At this time, ADEQ does not believe changing the term "gross alpha particle activity" to "adjusted gross alpha particle activity" is necessary. For more information on the background of the MCL for gross alpha particle radioactivity that ADEQ adopted as an AWQS pursuant to A.R.S. § 49-223, please review 65 *Federal Register* 76748.<br><br>Criticism 5: The Department received a written criticism of the rule, stating that rule should address the prevention of Total Trihalomethane (TTHM) formation due to chlorine residuals. The commenter adds that dechlorination is required prior to recharge in order to prevent TTHM formation resulting from chlorine reacting with organics.<br><br>Response 5: ADEQ appreciates the comment. The commenter's questions and recommendations are more suitable for the individual Aquifer Protection Program (APP) article 18 AAC 9, Article 2. This article, 18 AAC 11, Article 4 houses |

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| | water quality standards. ADEQ recently submitted a regular rulemaking to the Governor's Regulatory Review Council on March 18, 2025, which adjusted or established for the first time, seven (7) Aquifer Water Quality Standards (AWQSs), including the establishment of the AWQSs for disinfection byproducts Bromate, Chlorite and Haloacetic Acids (HAA5) at 0.010, 1.0, and 0.060 mg/l, respectively. Additionally, disinfection byproduct Total Trihalomethanes (TTHMs) was adjusted through the rulemaking from 0.1 mg/l to 0.080 mg/L.<br>These AWQSs are standards designed to protect Arizona's aquifers, which are all classified for drinking water protected use (*see* A.R.S. § 49-224). Therefore, requirements for sampling and monitoring of disinfection byproducts under an individual APP permit are better addressed in the APP rules or in a specific APP permit, not the Numeric Aquifer Water Quality Standards rule. |
| **R18-11-407** | Criticism 1: The Department received a written criticism of the rule, stating that an appendix should be added which lists reclassified aquifers.<br><br>Response 1: ADEQ appreciates the comment. No aquifers have been reclassified since the inception of Article 4 or 5. Therefore, ADEQ does not believe it necessary to update R18-11-407 or any other section in Article 4 to list reclassified aquifers. |
| **R18-11-501** | Criticism 1: The Department received a written criticism of the rule, stating that it lacks a definition for "aquifer".<br><br>Response 1: ADEQ appreciates the comment. While there is no definition for "aquifer" in the Article 5 definitions (R18-11-501), the language in R18-11-501 states that the listed definitions apply to Article 5, "[i]n addition to the definitions contained in A.R.S. § 49-201". A.R.S. § 49-201(2) defines an "aquifer" as "a geologic unit that contains sufficient saturated permeable material to yield usable quantities of water to a well or spring". Therefore, the definition of "aquifer" in the statutes applies to Chapter 11, Article 5, R18-11-501, and does not need to be re-defined therein. Furthermore, A.A.C. Chapter 11 "Water Quality Standards" falls within the purview of Title 49 ("The Environment"), Chapter 2 ("Water Quality Control"), Article 2 ("Water Quality Standards") of the A.R.S. Therefore, even without a direct reference to A.R.S. § 49-201 in R18-11-501, the definitions in A.R.S. Title 49, Chapter 2, Article 1 would nevertheless apply to rules adopted pursuant to Chapter 2.<br>ADEQ does not believe it is necessary for the "aquifer" definition to be added to the rule. |
| **R18-11-502** | Criticism 1: The Department received a written criticism of the rule, stating that the rule is not clear on if the Aquifer Protection Program applies to areas of bedrock shown on the referenced map of aquifer boundaries, or if these areas are excluded from the definition of an aquifer boundary.<br><br>Response 1: ADEQ appreciates the comment. Article 5, and R18-11-502 specifically, clarifies aquifer boundaries for the aquifers classified as drinking water protected use which are therefore subject to protection through the Aquifer Protection Program (APP) by regulating discharging facilities. R18-11-502(A) includes a comprehensive scope of aquifer boundaries and subsection (B) describes the exclusions from those boundaries. All areas within the aquifer boundaries are subject to the APP which applies to "any person who discharges or who owns or operates a facility that discharges" (A.R.S. § 49-241(A)). |

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| | Additionally, all areas outside the aquifer boundaries (identified in subsection (B)) are subject to the APP pursuant to R18-11-502(D) which states, "[f]acilities located outside of the boundaries defined in these rules shall be subject to A.R.S. § 49-241 except as provided therein."<br>The language in the rule demonstrates that all discharging facilities are subject to APP and ADEQ does not believe it necessary to update the rule.<br><br>Criticism 2: The Department received a written criticism of the rule, stating that it should make the aquifer boundary maps accessible.<br><br>Response 2: ADEQ appreciates the comment. Wherever material is incorporated by reference in the rules, there is specific language providing that the material is "on file [with ADEQ] and available for public inspection". The aquifer boundary maps are available to the public upon request, which may be made through a records request, https://azdeq.gov/records. |
| **R18-11-503** | Criticism 1: The Department received a written criticism of the rule, stating that there does not appear to be public notice requirements in the rule for reclassification petitions.<br><br>Response 1: ADEQ appreciates the comment. R18-11-503 regulates the process of petitioning the Department to reclassify an aquifer from a drinking water protected use to a nondrinking water protected use. The processes prescribed in subsections (A) and (B) of this rule, in addition to other rules within Article 5 such as R18-11-505 do, in fact, include a public notification and participation procedure. Specifically, subsection (A) provides that "any person may petition the Director to reclassify an aquifer…pursuant to A.R.S. § 49-224(C)". A.R.S. § 49-224(C) requires the Department to satisfy two conditions prior to initiating a further review to change an aquifer classification. First, the Department must consult with the appropriate groundwater users advisory council (pursuant to Title 45, Chapter 2, Article 2) if the aquifer is in an Active Management Area; and second, the Department must hold a public hearing (pursuant to A.R.S. § 49-208). Additionally, subsection (E) states that the director "shall provide for public participation in proceedings under this section…and shall hold at least one public hearing at a location as near as practicable to the aquifer proposed for reclassification".<br>The public participation requirements may, furthermore, be found in rule, in R18-11-505. R18-11-505, pursuant to the statutory requirements in A.R.S. § 49-224 described above, requires the Department to give public notice of a proposed reclassification and hold one public hearing at a location as near as practicable to the aquifer proposed for reclassification and shall give notice of each public hearing.<br>If the Department decides to grant a petition for aquifer reclassification, it shall initiate rulemaking proceedings accordingly, either to promulgate aquifer water quality standards in A.A.C. Chapter 11, Article 4, or update the aquifer boundary designation in Article 5 (*see* R18-11-504(C)). The rulemaking process, under the Administrative Procedure requirements, incorporates due process through a notice and comment period.<br>There are multiple public notice and participation requirements that must be satisfied to reclassify an aquifer by rule. The Department believes the rules in Article 5 remain clear, concise, and understandable to this point. |

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| **R18-11-504** | Criticism 1: The Department received a written criticism of the rule, stating that subsection (C) should be updated with an appendix listing reclassified aquifers.<br><br>Response 1: ADEQ appreciates the comment. The addition of an appendix to this rule is not necessary because no aquifers have been reclassified. R18-11-504, entitled "Agency Action on Petition", describes the Department's required process upon receipt of a petition for reclassification, with subsection (C) providing, "[u]pon a decision to grant a petition for aquifer reclassification, the Director shall initiate proceedings for promulgation of aquifer water quality standards and, if applicable, for aquifer boundary designation for the reclassified aquifers". R18-11-502 includes a comprehensive scope of aquifer boundaries (subsection (A)) and the exclusions from those boundaries (subsection (B)). If the Department grants a petition for reclassification and conducts a rulemaking to update the rule, R18-11-502 may be updated accordingly, or the reclassified aquifers may be added to the Article in a separate section. However, no aquifers have been reclassified since the inception of this Article and ADEQ believes there is no reason to update R18-11-504 or any other section in Article 5 to this effect. |
| **General** | Criticism 1: The Department received a written criticism of the rule, stating that it's not clear whether the rules in Articles 4 and 5 are related to effluent/discharge only, and not of water pumped from an aquifer.<br><br>Response 1: ADEQ appreciates the comment. ADEQ is charged, through the Arizona Revised Statutes (A.R.S.) to adopt rules relating to water pollution control, through numeric drinking water aquifer water quality standards (A.R.S. § 49-223) and the identification of the boundaries of all aquifers in the state which are classified for drinking water protected use (A.R.S. § 49-224). Pursuant to this authority, and statutory charge, ADEQ developed A.A.C. Chapter 11 Articles 4 & 5. Article 4 identifies and regulates the water quality standards to which all discharging activities must comply in order to protect the aquifers and preserve them for drinking water use. Article 5 identifies and defines aquifer boundaries to clarify which aquifers are classified for drinking water protected use and prescribes a procedure to reclassify aquifers.<br>Both of these Articles are directly related to protecting aquifers from water pollution through discharging activities. The Articles do not apply to pumping activities. |

**8. Economic, small business, and consumer impact comparison:**

**Article 4:**

An economic impact statement was not required in either the 1990 or 1992 rulemakings. Regardless, ADEQ's assessment is that the rules' impacts on the state's economy, small business and consumers has not changed since the effective date and the only changes would be to adjust any dollar values for costs and benefits to adjust for inflation. Article 4 still sets standards that are implemented through other programs, such as the Aquifer Protection Permits (APP), Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), Water Quality Assurance Revolving Fund (WQARF), and Underground Storage Tanks (UST). Any costs would be borne by the permittees and other persons who must ensure that a discharge to an

aquifer or remediation impacting an aquifer complies with the aquifer water quality standards. ADEQ continues to believe that these costs are exceeded by the benefits of protection to human health and the environment.

**Article 5:**

An economic impact statement was not required in either the 1987 or 1989 rulemakings. Regardless, ADEQ's assessment is that the rules' impacts on the state's economy, small business and consumers has not changed since the effective date and the only changes would be to adjust any dollar values for costs and benefits to adjust for inflation. Under A.R.S. § 49-223(A), aquifer water quality standards were set at the federal primary maximum contaminant levels for drinking water; under A.R.S. § 49-224(B), all aquifers in the state are classified as for drinking water protected use. The Article 5 rules establish a procedure for the Director to reclassify an aquifer from a drinking water protected use to a nondrinking water protected use pursuant to A.R.S. § 49-224(C). If the Director decides to reclassify an aquifer, ADEQ must initiate proceedings for new aquifer water quality standards for the aquifer classification (R18-11-504(C)).

The Article 5 rules benefit a person who seeks to discharge to an aquifer without unnecessarily meeting the costs of aquifer water quality standards designed to protect groundwater as a drinking water source. The Article 5 rules implement the standard set in A.R.S. § 49-224 to determine that the short-term and long-term benefits to the public significantly outweigh the short-term and long-term costs to the public (A.R.S. §49-224(C)(3)).

**9. Has the agency received any business competitiveness analyses of the rules?**

**Yes __ No ×**

No such analysis was received for any rule in this Article.

**10. Has the agency completed the course of action indicated in the agency's previous five-year-review report?**

Yes, ADEQ proposed amending R18-11-403, R18-11-406, R18-11-407, R18-11-502, R18-11-504 and R18-11-506 in the previous Five-Year Review Report for A.A.C. Title 18, Chapter 11, Articles 4 and 5, submitted to the Council on August 26, 2020, amended on November 2, 2020, and approved by the Council on November 3, 2020. As demonstrated in the table below, all rulemaking commitments in the previous Five-Year Review Report have been, or are on-track to be, executed.

| Rule | Explanation |
|---|---|
| R18-11-403 | Proposed Course of Action (2020): There's an incorrect citation R9-14-607(B) which should be updated to R9-14-610(C). ADEQ anticipates opening R18-11-403 in an expedited rulemaking by November 2021.<br><br>Completed: Yes.<br><br>Explanation: In an expedited rulemaking, effective September 22, 2023 (40 AAR 2344), the commitment was addressed by updating the language in the rule to reflect the correct reference, R9-14-610(C). |
| R18-11-406 | Proposed Course of Action (2020): ADEQ has not adopted the following 12 Safe Drinking Water Act (SDWA) Maximum Contaminant Levels (MCLs), in accordance with A.R.S. § 49-223: aldicarb, aldicarb sulfoxide, aldicarb sulfone, bromate, chlorite, copper, haloacetic acids, lead, uranium, arsenic, total trihalomethanes, and total coliform. ADEQ anticipates opening the more involved rulemaking in R18-11-406 by June 30, 2023.<br><br>Completed: In progress.<br><br>Explanation: In a regular rulemaking, submitted to Council on March 18, 2025, ADEQ addressed the Five-Year Rule Review commitments for R18-11-406. The rulemaking adopts the following seven (7) MCLs as AWQSs under A.R.S. § 49-223: Arsenic, Bromate, Chlorite, Haloacetic Acids, Microbiological Contaminants, Total Trihalomethands and Uranium.<br><br>Of note, the previous course of action made a mistake in representing the scope of MCLs that were not adopted according to A.R.S. § 49-223. The correct scope of the MCLs in line for adoption as AWQSs under A.R.S. § 49-223 is the seven (7) listed above, not the full twelve (12) listed in the course of action. Aldicarb, Aldicard Sulfoxide, Aldicarb Sulfone do not have MCLs pursuant to 40 CFR 141, Subpart G, but rather MCLGs, pursuant to 40 CFR 141, Subpart F (40 CFR 141.50(b)(4), (5) & (6). A.R.S. § 49-223 does not include MCLGs in its scope. Additionally, Lead and Copper are addressed in a separate regulation under the CFR (40 CFR 141, Subpart I), not the MCLs. |
| R18-11-407 | Proposed Course of Action (2020): The rule is consistent with all applicable state and federal and statutes and rules. However the reference to A.R.S. § 49-223(D) is incorrect and should be changed to A.R.S. § 49-223(E). ADEQ anticipates opening R18-11-407 in an expedited rulemaking by November 2021.<br><br>Completed: Yes.<br><br>Explanation: In an expedited rulemaking, effective September 22, 2023 (40 AAR 2344), the commitment was addressed by updating the language in the rule to reflect the correct reference, A.R.S. § 49-223(E). |
| R18-11-502 | Proposed Course of Action (2020): Incorporations in subsections (A) and (B) do not comply with all requirements of A.R.S. § 41-1028(B) and (C), and R1-1-414, specifically that the rule does not mention that the incorporated items contain no later |

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| | editions or amendments. Also, even though permitted under R1-1-414(E), stating that copies of the incorporated item are on file at the Secretary of State's office is not the current method of identifying the location. ADEQ anticipates opening R18-11-502 in an expedited rulemaking by November 2021.<br><br>Completed: Yes.<br><br>Explanation: In an expedited rulemaking, effective September 22, 2023 (40 AAR 2344), the commitment was addressed by fixing the language to adhere to the incorporation by reference statutory requirements in A.R.S. § 41-1028(A). |
| R18-11-504 | Proposed Course of Action (2020): The rule is generally consistent with all applicable state and federal statutes and rules. However the reference to A.R.S. § 49-204 should be deleted. At the time the rule was written, A.R.S. § 49-204 established a Water Quality Advisory Council. The topic of A.R.S. § 49-204 now is grey water reuse. ADEQ anticipates opening R18-11-504 in an expedited rulemaking by November 2021.<br><br>Completed: Yes.<br><br>Explanation: In an expedited rulemaking, effective September 22, 2023 (40 AAR 2344), the commitment was addressed by removing the reference to A.R.S. § 49-204 within the rule. |
| R18-11-506 | Proposed Course of Action (2020): The rule is generally consistent with all applicable state statutes and rules. However the reference to A.R.S. § 49-204 should be deleted. At the time the rules were written, A.R.S. § 49-204 established a Water Quality Advisory Council. The topic of A.R.S. § 49-204 now is grey water reuse. ADEQ anticipates opening R18-11-506 in an expedited rulemaking by November 2021.<br><br>Completed: Yes.<br><br>Explanation: In an expedited rulemaking, effective September 22, 2023 (40 AAR 2344), the commitment was addressed by removing the reference to A.R.S. § 49-204 within the rule. |

**11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

| Rule | Explanation |
|---|---|
| **Article 4: Aquifer Water Quality Standards** | The costs of Article 4 are to the regulated parties subject to the regulatory programs that employ the Aquifer Water Quality Standards (AWQSs) therein. Predominantly affected are the permittees of the Aquifer Protection Program (APP). The benefits of these rules are that they house the AWQSs, which ADEQ must maintain according to statute at A.R.S. § 49-223. Another benefit is that the standards are designed to protect the environment and public health through ensuring the aquifers in the state are protected to |

| | |
|---|---|
| | a drinking water use standard as required by statute at A.R.S. § 49-224(B). ADEQ believes that the benefits of these rules outweigh the costs because it is the state's priority and ADEQ's statutory charge to ensure protection of drinking water quality and human health. |
| **Article 5: Aquifer Boundary and Protected Use Classification** | The costs of Article 5 are to the regulated parties subject to the regulatory programs that employ the Aquifer Water Quality Standards (AWQSs) therein. Predominantly affected are the permittees of the Aquifer Protection Program (APP). The benefits of these rules are that they establish the aquifer boundaries within the state, create a classification system, designate all of the aquifer to the "drinking water protected use" class, and establish a reclassification process as required by statute at A.R.S. § 49-224. Another benefit is that the rules help to effectively protect the environment and public health through ensuring the aquifers in the state are defined and protected. ADEQ believes that the benefits of these rules outweigh the costs because it is the state's priority and ADEQ's statutory charge to ensure drinking water quality and human health. |

**12. Are the rules more stringent than corresponding federal laws?**

**Yes __ No ×**

Concerning Article 4, the primary drinking water maximum contaminant levels were established pursuant to the Safe Drinking Water Act. No aquifer water quality standards are more stringent than the Federal maximum contaminant levels. The relevant authority in the Safe Drinking Water Act can be found in 42 U.S.C. 300f, 300g-1, 300g-2, 300g-3, 300g-4, 300g-5, 300g-6, 300j-4, 300j-9, and 300j-11. The primary drinking water maximum contaminant levels can be found in 40 CFR 141.11, 141.12 and 141.13.

The rules in Article 5 do not have corresponding federal law.

**13. For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

The Article 4 and 5 rules were adopted before July 29, 2010, but do not require issuance of a regulatory permit, license or agency authorization.

**14. Proposed course of action**

ADEQ's rules for Articles 4 and 5, as they exist now, provide the necessary information for the regulated community and no action is necessary. All proposed courses of action identified in the previous Five-Year Rule Review have been, or are currently being, addressed.

1. The risk to public health;
2. The degree of public access to the site where the reclaimed water is reused and human exposure to the reclaimed water;
3. The level of treatment necessary to ensure that the reclaimed water is aesthetically acceptable;
4. The level of treatment necessary to prevent nuisance conditions;
5. Specific water quality requirements for the intended type of direct reuse;
6. The means of application of the reclaimed water;
7. The degree of treatment necessary to avoid a violation of surface water quality standards or aquifer water quality standards;
8. The potential for improper or unintended use of the reclaimed water;
9. The reuse guidelines, criteria, or standards adopted or recommended by the U.S. Environmental Protection Agency or other federal or state agencies that apply to the new type of direct reuse; and
10. Similar wastewater reclamation experience of reclaimed water providers in the United States.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 870, effective January 22, 2001 (Supp. 01-1).

**Table A. Minimum Reclaimed Water Quality Requirements for Direct Reuse**

| Type of Direct Reuse | Minimum Class of Reclaimed Water Required |
|---|---|
| Irrigation of food crops | A |
| Recreational impoundments | A |
| Residential landscape irrigation | A |
| Schoolground landscape irrigation | A |
| Open access landscape irrigation | A |
| Toilet and urinal flushing | A |
| Fire protection systems | A |
| Spray irrigation of an orchard or vineyard | A |
| Commercial closed loop air conditioning systems | A |
| Vehicle and equipment washing (does not include self-service vehicle washes) | A |
| Snowmaking | A |
| Surface irrigation of an orchard or vineyard | B |
| Golf course irrigation | B |
| Restricted access landscape irrigation | B |
| Landscape impoundment | B |
| Dust control | B |
| Soil compaction and similar construction activities | B |
| Pasture for milking animals | B |
| Livestock watering (dairy animals) | B |
| Concrete and cement mixing | B |
| Materials washing and sieving | B |
| Street cleaning | B |
| Pasture for non-dairy animals | C |
| Livestock watering (non-dairy animals) | C |
| Irrigation of sod farms | C |
| Irrigation of fiber, seed, forage, and similar crops | C |
| Silviculture | C |

Note: Nothing in this Article prevents a wastewater treatment plant from using a higher quality reclaimed water for a type of direct reuse than the minimum class of reclaimed water listed in Table A. For example, a wastewater treatment plant may provide Class A reclaimed water for a type of direct reuse where Class B or Class C reclaimed water is acceptable.

**Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 870, effective January 22, 2001 (Supp. 01-1).

## ARTICLE 4. AQUIFER WATER QUALITY STANDARDS

**R18-11-401. Definitions**

In addition to the definitions contained in A.R.S. §§ 49-101 and 49-201, the terms of this Article shall have the following meanings:

1. "Beta particle and photon radioactivity from man-made radionuclides" means all radionuclides emitting beta particles or photons, except Thorium-232, Uranium-235, Uranium-238 and their progeny.
2. "Dose equivalent" means the product of the absorbed dose from ionizing radiation and such factors as account for differences in biological effectiveness due to the type of radiation and its distribution in the body as specified by the International Commission on Radiological Units and Measurements.
3. "Drinking water protected use" means the protection and maintenance of aquifer water quality for human consumption.
4. "Gross alpha particle activity" means the total radioactivity due to alpha particle emission as inferred from measurements on a dry sample.
5. "Mg/l" means milligrams per liter.
6. "Millirem" means 1/1000 of a rem. A rem means the unit of dose equivalent from ionizing radiation to the total body or any internal organ or organ system.
7. "Non-drinking water protected use" means the protection and maintenance of aquifer water quality for a use other than for human consumption.
8. "pCi" means picocurie, or the quantity of radioactive material producing 2.22 nuclear transformations per minute.
9. "Total trihalomethanes" means the sum of the concentrations of the following trihalomethane compounds: trichloromethane (chloroform), dibromo-chloromethane, bromodichloromethane and tribromo-methane (bromoform).

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).
Amended effective August 14, 1992 (Supp. 92-3).

**R18-11-402. Repealed**

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**R18-11-403. Analytical Methods**

Analysis of a sample to determine compliance with an aquifer water quality standard shall be in accordance with an analytical method specified in A.A.C. Title 9, Chapter 14, Article 6 or an alternative analytical method that is approved by the Director of the Arizona Department of Health Services pursuant to A.A.C. R9-14-610(C).

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).

Amended effective August 14, 1992 (Supp. 92-3).
Amended by final expedited rulemaking at 29 A.A.R. 2344 (October 6, 2023), with an immediate effective date of September 22, 2023 (Supp. 23-3).

**R18-11-404. Laboratories**

A test result from a sample taken to determine compliance with an aquifer water quality standard shall be valid only if the sample has been analyzed by a laboratory that is licensed by the Arizona Department of Health Services for the analysis performed.

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).
Amended effective August 14, 1992 (Supp. 92-3).

**R18-11-405. Narrative Aquifer Water Quality Standards**

**A.** A discharge shall not cause a pollutant to be present in an aquifer classified for a drinking water protected use in a concentration which endangers human health.

**B.** A discharge shall not cause or contribute to a violation of a water quality standard established for a navigable water of the state.

**C.** A discharge shall not cause a pollutant to be present in an aquifer which impairs existing or reasonably foreseeable uses of water in an aquifer.

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).
Amended effective August 14, 1992 (Supp. 92-3).

**R18-11-406. Numeric Aquifer Water Quality Standards: Drinking Water Protected Use**

**A.** The aquifer water quality standards in this Section apply to aquifers that are classified for drinking water protected use.

**B.** The following are the aquifer water quality standards for inorganic chemicals:

| Pollutant | mg/L) |
|---|---|
| Antimony | 0.006 |
| Arsenic | 0.05 |
| Asbestos | 7 million fibers/liter (longer than 10 mm) |
| Barium | 2 |
| Beryllium | 0.004 |
| Cadmium | 0.005 |
| Chromium | 0.1 |
| Cyanide (As Free Cyanide) | 0.2 |
| Fluoride | 4.0 |
| Lead | 0.05 |
| Mercury | 0.002 |
| Nickel | 0.1 |
| Nitrate (as N) | 10 |
| Nitrite (as N) | 1 |
| Nitrate and nitrite (as N) | 10 |
| Selenium | 0.05 |
| Thallium | 0.002 |

**C.** The following are the aquifer water quality standards for organic chemicals:

| Pollutant | (mg/L) |
|---|---|
| Benzene | 0.005 |
| Benzo (a) pyrene | 0.0002 |
| Carbon Tetrachloride | 0.005 |
| o-Dichlorobenzene | 0.6 |
| para-Dichlorobenzene | 0.075 |
| 1,2-Dichloroethane | 0.005 |
| 1,1-Dichloroethylene | 0.007 |
| cis-1,2-Dichloroethylene | 0.07 |
| trans-1,2-Dichloroethylene | 0.1 |
| 1,2-Dichloropropane | 0.005 |
| Dichloromethane | 0.005 |
| Di (2-ethylhexyl) adipate | 0.4 |
| Di (2-ethylhexyl) pthalate | 0.006 |
| Ethylbenzene | 0.7 |
| Hexachlorobenzene | 0.001 |
| Hexachlorocyclopentadiene | 0.05 |
| Monochlorobenzene | 0.1 |
| Pentachlorophenol | 0.001 |
| Styrene | 0.1 |
| 2,3,7,8-TCDD (Dioxin) | 0.00000003 |
| Tetrachloroethylene | 0.005 |
| Toluene | 1 |
| Trihalomethanes (Total) | 0.10 |
| 1,2,4-Trichlorobenzene | 0.07 |
| 1,1,1-Trichloroethane | 0.20 |
| 1,1,2-Trichloroethane | 0.005 |
| Trichloroethylene | 0.005 |
| Vinyl Chloride | 0.002 |
| Xylenes (Total) | 10 |

**D.** The following are the aquifer water quality standards for pesticides and polychlorinated biphenyls (PCBs):

| Pollutant | (mg/L) |
|---|---|
| Alachlor | 0.002 |
| Atrazine | 0.003 |
| Carbofuran | 0.04 |
| Chlordane | 0.002 |
| Dalapon | 0.2 |
| 1,2-Dibromo-3-Chloropropane (DBCP) | 0.0002 |
| 2,4,-Dichlorophenoxyacetic Acid(2,4-D) | 0.07 |
| Dinoseb | 0.007 |
| Diquat | 0.02 |
| Endothall | 0.1 |
| Endrin | 0.002 |
| Ethylene Dibromide (EDB) | 0.00005 |
| Glyphosate | 0.7 |
| Heptachlor | 0.0004 |
| Heptachlor Epoxide | 0.0002 |
| Lindane | 0.0002 |
| Methoxychlor | 0.04 |
| Oxamyl | 0.2 |
| Picloram | 0.5 |
| Polychlorinated Biphenols (PCBs) | 0.0005 |
| Simazine | 0.004 |
| Toxaphene | 0.003 |
| 2,4,5-Trichlorophenoxypropionic Acid (2,4,5-TP or Silvex) | 0.05 |

**E.** The following are the aquifer water quality standards for radionuclides:

1. The maximum concentration for gross alpha particle activity, including Radium-226 but excluding radon and uranium, shall not exceed 15 pCi/l.
2. The maximum concentration for combined Radium-226 and Radium-228 shall not exceed 5 pCi/l.
3. The average annual concentration of beta particle and photon radioactivity from man-made radionuclides shall

not produce an annual dose equivalent to the total body or any internal organ greater than 4 millirem/year.

4. Except for the radionuclides listed in this subsection, the concentration of man-made radionuclides causing 4 millirem total body or organ dose equivalents shall be calculated on the basis of a 2-liter-per-day drinking water intake using the 168-hour data listed in "Maximum Permissible Body Burdens and Maximum Permissible Concentration of Radionuclides in Air or Water for Occupational Exposure," National Bureau of Standards Handbook 69, National Bureau of Commerce, as amended August 1963 (and no future editions), incorporated herein by reference and on file with the Office of the Secretary of State and with the Department. If two or more radionuclides are present, the sum of their annual dose equivalent to the total body or to any organ shall not exceed 4 millirem/year. The following average annual concentrations are assumed to produce a total body or organ dose of 4 millirem/year:

| Radionuclide | Critical Organ | pCi/l |
|---|---|---|
| Tritium | Total body | 20,000 |
| Strontium-90 | Bone Marrow | 8 |

**F.** The aquifer water quality standard for microbiological contaminants is based upon the presence or absence of total coliforms in a 100-milliliter sample. If a sample is total coliform-positive, a 100-milliliter repeat sample shall be taken within two weeks of the time the sample results are reported. Any total coliform-positive repeat sample following a total coliform-positive sample constitutes a violation of the aquifer water quality standard for microbiological contaminants.

**G.** The following are the aquifer water quality standards for turbidity:

1. One nephelometric turbidity unit as determined by a monthly average except that five or fewer nephelometric turbidity units may be allowed if it can be determined that the higher turbidity does not interfere with disinfection, prevent maintenance of effective disinfectant agents in water supply distribution systems, or interfere with microbiological determinations.
2. Five nephelometric turbidity units based on an average of two consecutive days.

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).
Amended effective August 14, 1992 (Supp. 92-3).
Amended effective May 26, 1994 (Supp. 94-2).

**R18-11-407. Aquifer Water Quality Standards in Reclassified Aquifers**

**A.** All aquifers in the state are classified for drinking water protected use except for aquifers which are reclassified to a nondrinking water protected use pursuant to A.R.S. § 49-224 and A.A.C. R18-11-503.

**B.** Aquifer water quality standards for drinking water protected use apply to reclassified aquifers except where expressly superseded by aquifer water quality standards adopted pursuant to subsection (C).

**C.** The Director shall adopt, by rule, aquifer water quality standards for reclassified aquifers within one year of the date of the order reclassifying the aquifer to a nondrinking water protected use. The Director shall adopt aquifer water quality standards for reclassified aquifers only for pollutants that are specifically identified in a petition for reclassification as prescribed by A.R.S. § 49-223(E) and A.A.C. R18-11-503(B). Aquifer water quality standards for reclassified aquifers shall be sufficient to protect the use of the reclassified aquifer.

**Historical Note**

Adopted effective January 4, 1990 (Supp. 90-1).
Amended effective August 14, 1992 (Supp. 92-3).
Amended by final expedited rulemaking at 29 A.A.R. 2344 (October 6, 2023), with an immediate effective date of September 22, 2023 (Supp. 23-3).

**R18-11-408. Petition for Adoption of a Numeric Aquifer Water Quality Standard**

**A.** Any person may petition the Director to adopt, by rule, a numeric aquifer water quality standard for a pollutant for which no numeric aquifer water quality standard exists.

**B.** Petitions for adoption of a numeric aquifer water quality standard shall be filed with the Department and shall comply with the requirements applicable to petitions for rule adoption as provided by A.R.S. § 41-1033 and A.A.C. R18-1-302, except as otherwise provided by A.R.S. § 49-223 or this Section.

**C.** In addition to the requirements of A.A.C. R18-1-302, a petition for rule adoption to establish a numeric aquifer water quality standard shall include specific reference to:

1. Technical information that the pollutant is a toxic pollutant.
2. Technical information upon which the Director reasonably may base the establishment of a numeric aquifer water quality standard.
3. Evidence that the pollutant that is the subject of the petition is or may in the future be present in an aquifer or part of an aquifer that is classified for drinking water protected use. Evidence may include, but is not limited to, any of the following:
   a. A laboratory analysis of a water sample by a laboratory licensed by the Arizona Department of Health Services which indicates the presence of the pollutant in the aquifer.
   b. A hydrogeological study which demonstrates that the pollutant that is the subject of the petition may be present in an aquifer in the future. The hydrogeological study shall include the following:
      i. A description of the use that results in a discharge of the pollutant that is the subject of the petition.
      ii. A description of the mobility of the pollutant in the vadose zone and in the aquifer.
      iii. A description of the persistence of the pollutant in the vadose zone and in the aquifer.

**D.** Within 180 calendar days of the receipt of a complete petition for rule adoption to establish a numeric aquifer water quality standard, the Director shall make a written determination of whether the petition should be granted or denied. The Director shall give written notice by regular mail of the determination to the petitioner.

**E.** If the petition for rule adoption is granted, the Director shall initiate rulemaking proceedings to adopt a numeric aquifer water quality standard. The Director shall, within one year of the date that the petition for adoption of a numeric aquifer water quality standard is granted, either adopt a rule establishing a numeric aquifer water quality standard or publish a notice of termination of rulemaking in the Arizona Administrative Register.

**F.** If the petition for rule adoption is denied, the Director shall issue a denial letter to the petitioner which explains the reasons for the denial. The denial of a petition for rule adoption to

establish a numeric aquifer water quality standard is not subject to judicial review.

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).

**Appendix 1. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**Appendix 2. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**Appendix 3. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**Appendix 4. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**Appendix 5. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**Appendix 6. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

**Appendix 7. Repealed**

**Historical Note**
Adopted effective January 4, 1990 (Supp. 90-1).
Repealed effective August 14, 1992 (Supp. 92-3).

## ARTICLE 5. AQUIFER BOUNDARY AND PROTECTED USE CLASSIFICATION

**R18-11-501. Definitions**

In addition to the definitions contained in A.R.S. § 49-201, the words and phrases of this Article shall have the following meaning:

1. "Drinking water protected use" means the protection and maintenance of aquifer water quality for human consumption.
2. "Hardrock areas containing little or no water" means areas of igneous or metamorphic rock which do not yield usable quantities of water.
3. "Nondrinking water protected use" means the protection and maintenance of aquifer water quality for a use other than human consumption.
4. "Usable quantities" means five gallons of water per day.

**Historical Note**
Adopted effective October 22, 1987 (Supp. 87-4).

**R18-11-502. Aquifer Boundaries**

**A.** Except as provided in subsection (B), aquifer boundaries for the aquifers in this state are identified and defined as being identical to the hydrologic basin and subbasin boundaries, as found by the Director of the Department of Water Resources, Findings and Order In the Matter of The Designation of Groundwater Basins and Subbasins In The State of Arizona (dated June 21, 1984), pursuant to A.R.S. §§ 45-403 and 45-404, which is incorporated herein by reference, on file and available for public inspection at the Department of Environmental Quality. No later amendments or editions are incorporated by reference.

**B.** Excluded from the boundaries of the aquifers are hard rock areas which contain little or no water, as identified in Plate 1 of the Department of Water Resources, Water Resource Hydrologic Map Series Report Number 2 (dated January 1981) and as further identified in the Bureau of Mines, University of Arizona County Geologic Map Series (individual county maps dated 1957 through 1960), which are incorporated herein by reference, on file and available for public inspection at the Department of Environmental Quality. No later amendments or editions are incorporated by reference.

**C.** The Director may, by rule, modify or add an aquifer boundary provided that one or more of the following applies:

1. The Department of Water Resources modifies the boundaries of its basins or subbasins.
2. The Director is made aware of new technical information or data which supports refinement of an aquifer boundary.

**D.** Facilities located outside of the boundaries defined in these rules shall be subject to A.R.S. § 49-241 except as provided therein.

**Historical Note**
Adopted effective October 22, 1987 (Supp. 87-4).
Amended by final expedited rulemaking at 29 A.A.R. 2344 (October 6, 2023), with an immediate effective date of September 22, 2023 (Supp. 23-3).

**R18-11-503. Petition for reclassification**

**A.** Any person may petition the Director to reclassify an aquifer from a drinking water protected use to a nondrinking water protected use pursuant to A.R.S. § 49-224(C).

**B.** A written petition for reclassification pursuant to A.R.S. § 49-224(C) or A.R.S. § 49-224(D) shall be filed with the Department and shall include the following categories of information:

1. The proposed protected use for which the reclassification is being requested.
2. The pollutant and affected aquifer water quality standards for which the reclassification is being requested.
3. A hydrogeologic report which demonstrates that the aquifer proposed for reclassification is or will be hydrologically isolated, to the extent described in A.R.S. § 49-224(C)(1). This report and demonstration of hydrologic isolation for the area containing such aquifer, and immediate adjacent geologic units, shall include at least the following:
   a. Hydrogeologic area maps and cross sections.
   b. An analysis of subsurface geology, including geologic and hydrologic separation.
   c. Water level elevation or piezometric level contour maps.
   d. Analysis of hydrologic characteristics of the aquifer and the immediate adjacent geologic units.
   e. Description of existing water quality and analysis of water chemistry.
   f. Projected annual quantity of water to be withdrawn.
   g. Identification of pumping centers, cones of depression and areas of recharge.

h. A water balance.
i. Existing flow direction and evaluation of the effects of seasonal and future pumping on flow.
j. An evaluation as to whether the reclassification will contribute to or cause a violation of aquifer water quality standards in other aquifers, or in parts of the aquifer not being proposed for reclassification.

4. Documentation demonstrating that water from the aquifer or part of the aquifer for which reclassification is proposed is not being used as drinking water. This documentation shall include at least the following:
a. A list of all wells or springs including their location, ownership and use within the aquifer or part of the aquifer being proposed for reclassification.
b. Identification of groundwater withdrawal rights, on file with the Department of Water Resources, within the aquifer or part of the aquifer being proposed for reclassification.
c. A comprehensive list of agencies, persons and other information sources consulted for aquifer use documentation.

5. A cost-benefit analysis developed pursuant to the requirements of A.R.S. § 49-224(C)(3), except for petitions submitted pursuant to A.R.S. § 49-224(D). This analysis shall identify potential future uses of the aquifer being proposed for reclassification, as well as other opportunity costs associated with reclassification, and shall contain a description of the cost-benefit methodology used, including all assumptions, data, data sources and criteria considered and all supporting statistical analyses.

**Historical Note**
Adopted effective October 22, 1987 (Supp. 87-4).

**R18-11-504. Agency Action on Petition**

**A.** Upon receipt of a petition for reclassification, the Director shall review the petition for compliance with the requirements of R18-11-503. If additional information is necessary, the petitioner shall be notified of specific deficiencies in writing within 30 calendar days of receipt of the petition.

**B.** Within 120 calendar days after receipt of a complete petition, and after consultation with the appropriate advisory council pursuant to A.R.S. §§ 49-224(C), the Director shall make a final decision to grant or deny the petition and shall notify the petitioner of such decision and the reason for such determination in writing.

**C.** Upon a decision to grant a petition for aquifer reclassification, the Director shall initiate proceedings for promulgation of aquifer water quality standards and, if applicable, for aquifer boundary designation for the reclassified aquifers.

**Historical Note**
Adopted effective October 22, 1987 (Supp. 87-4).
Amended by final expedited rulemaking at 29 A.A.R. 2344 (October 6, 2023), with an immediate effective date of September 22, 2023 (Supp. 23-3).

**R18-11-505. Public participation**

**A.** Within 30 days of receipt of a complete petition for reclassification filed pursuant to A.R.S. § 49-224(D), or if the Director deems it necessary to consider a reclassification under A.R.S. § 49-224(C), the Director shall give public notice of the proposed reclassification pursuant to A.A.C. R18-1-401.

**B.** The Director shall hold at least one public hearing at a location as near as practicable to the aquifer proposed for reclassification. The Director shall give notice of each public hearing and conduct the public hearing in accordance with the provisions of A.A.C. R18-1-402.

**Historical Note**
Adopted effective June 29, 1989 (Supp. 89-2).

**R18-11-506. Rescission of Reclassification**

The Director may, by rule, rescind an aquifer reclassification and return an aquifer to a drinking water protected use if he determines that any of the conditions under which the reclassification was granted are no longer valid. If the Director initiates a change under this Section, he shall consult with the appropriate advisory council pursuant to A.R.S. §§ 49-224(C).

**Historical Note**
Adopted effective October 22, 1987 (Supp. 87-4).
Amended by final expedited rulemaking at 29 A.A.R. 2344 (October 6, 2023), with an immediate effective date of September 22, 2023 (Supp. 23-3).

## ARTICLE 6. IMPAIRED WATER IDENTIFICATION

*Article 6, consisting of Sections R18-11-601 through R18-11-606, made by final rulemaking at 8 A.A.R. 3380, effective July 12, 2002 (Supp. 02-3).*

**R18-11-601. Definitions**

In addition to the definitions established in A.R.S. §§ 49-201 and 49-231, and A.A.C. R18-11-101, the following terms apply to this Article:

1. "303(d) List" means the list of surface waters or segments required under section 303(d) of the Clean Water Act and A.R.S. Title 49, Chapter 2, Article 2.1, for which TMDLs are developed and submitted to EPA for approval.
2. "Attaining" means there is sufficient, credible, and scientifically defensible data to assess a surface water or segment and the surface water or segment does not meet the definition of impaired or not attaining.
3. "AZPDES" means the Arizona Pollutant Elimination Discharge System.
4. "Credible and scientifically defensible data" means data submitted, collected, or analyzed using:
a. Quality assurance and quality control procedures under A.A.C. R18-11-602;
b. Samples or analyses representative of water quality conditions at the time the data were collected;
c. Data consisting of an adequate number of samples based on the nature of the water in question and the parameters being analyzed; and
d. Methods of sampling and analysis, including analytical, statistical, and modeling methods that are generally accepted and validated by the scientific community as appropriate for use in assessing the condition of the water.
5. "Designated use" means those uses specified in 18 A.A.C. 11, Article 1 for each surface water or segment whether or not they are attaining.
6. "EPA" means the U.S. Environmental Protection Agency.
7. "Impaired water" means a Navigable water for which credible scientific data exists that satisfies the requirements of A.R.S. § 49-232 and that demonstrates that the water should be identified pursuant to 33 United States Code § 1313(d) and the regulations implementing that statute. A.R.S. § 49-231(1).
8. "Laboratory detection limit" means a "Method Reporting Limit" (MRL) or "Reporting Limit" (RL). These analogous terms describe the laboratory reported value, which

# 49-104. Powers and duties of the department and director

A. The department shall:

1. Formulate policies, plans and programs to implement this title to protect the environment.

2. Stimulate and encourage all local, state, regional and federal governmental agencies and all private persons and enterprises that have similar and related objectives and purposes, cooperate with those agencies, persons and enterprises and correlate department plans, programs and operations with those of the agencies, persons and enterprises.

3. Conduct research on its own initiative or at the request of the governor, the legislature or state or local agencies pertaining to any department objectives.

4. Provide information and advice on request of any local, state or federal agencies and private persons and business enterprises on matters within the scope of the department.

5. Consult with and make recommendations to the governor and the legislature on all matters concerning department objectives.

6. Promote and coordinate the management of air resources to ensure their protection, enhancement and balanced utilization consistent with the environmental policy of this state.

7. Promote and coordinate the protection and enhancement of the quality of water resources consistent with the environmental policy of this state.

8. Encourage industrial, commercial, residential and community development that maximizes environmental benefits and minimizes the effects of less desirable environmental conditions.

9. Ensure the preservation and enhancement of natural beauty and man-made scenic qualities.

10. Provide for the prevention and abatement of all water and air pollution including that related to particulates, gases, dust, vapors, noise, radiation, odor, nutrients and heated liquids in accordance with article 3 of this chapter and chapters 2 and 3 of this title.

11. Promote and recommend methods for the recovery, recycling and reuse or, if recycling is not possible, the disposal of solid wastes consistent with sound health, scenic and environmental quality policies. The department shall report annually on its revenues and expenditures relating to the solid and hazardous waste programs overseen or administered by the department.

12. Prevent pollution through regulating the storage, handling and transportation of solids, liquids and gases that may cause or contribute to pollution.

13. Promote the restoration and reclamation of degraded or despoiled areas and natural resources.

14. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

15. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.

16. Unless specifically authorized by the legislature, ensure that state laws, rules, standards, permits, variances and orders are adopted and construed to be consistent with and not more stringent than the corresponding federal law that addresses the same subject matter. This paragraph does not adversely affect standards adopted by an Indian tribe under federal law.

17. Provide administrative and staff support for the oil and gas conservation commission.

B. The department, through the director, shall:

1. Contract for the services of outside advisers, consultants and aides reasonably necessary or desirable to enable the department to adequately perform its duties.

2. Contract and incur obligations reasonably necessary or desirable within the general scope of department activities and operations to enable the department to adequately perform its duties.

3. Use any medium of communication, publication and exhibition when disseminating information, advertising and publicity in any field of its purposes, objectives or duties.

4. Adopt procedural rules that are necessary to implement the authority granted under this title but that are not inconsistent with other provisions of this title.

5. Contract with other agencies, including laboratories, in furthering any department program.

6. Use monies, facilities or services to provide matching contributions under federal or other programs that further the objectives and programs of the department.

7. Accept gifts, grants, matching monies or direct payments from public or private agencies or private persons and enterprises for department services and publications and to conduct programs that are consistent with the general purposes and objectives of this chapter. Monies received pursuant to this paragraph shall be deposited in the department fund corresponding to the service, publication or program provided.

8. Provide for the examination of any premises if the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed on the premises. The director shall give the owner or operator the opportunity for its representative to accompany the director on an examination of those premises. Within forty-five days after the date of the examination, the department shall provide to the owner or operator a copy of any report produced as a result of any examination of the premises.

9. Supervise sanitary engineering facilities and projects in this state, authority for which is vested in the department, and own or lease land on which sanitary engineering facilities are located, and operate the facilities, if the director determines that owning, leasing or operating is necessary for the public health, safety or welfare.

10. Adopt and enforce rules relating to approving design documents for constructing, improving and operating sanitary engineering and other facilities for disposing of solid, liquid or gaseous deleterious matter.

11. Define and prescribe reasonably necessary rules regarding the water supply, sewage disposal and garbage collection and disposal for subdivisions. The rules shall:

(a) Provide for minimum sanitary facilities to be installed in the subdivision and may require that water systems plan for future needs and be of adequate size and capacity to deliver specified minimum quantities of drinking water and to treat all sewage.

(b) Provide that the design documents showing or describing the water supply, sewage disposal and garbage collection facilities be submitted with a fee to the department for review and that no lots in any subdivision be offered for sale before compliance with the standards and rules has been demonstrated by approval of the design documents by the department.

12. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious conditions at those places. The rules shall prescribe minimum standards for the design of and for sanitary conditions at any public or semipublic swimming pool or bathing place and provide for abatement as public nuisances of premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of health services and shall be consistent with the rules adopted by the director of the department of health services pursuant to section 36-136, subsection I, paragraph 10.

13. Prescribe reasonable rules regarding sewage collection, treatment, disposal and reclamation systems to prevent the transmission of sewage borne or insect borne diseases. The rules shall:

(a) Prescribe minimum standards for the design of sewage collection systems and treatment, disposal and reclamation systems and for operating the systems.

(b) Provide for inspecting the premises, systems and installations and for abating as a public nuisance any collection system, process, treatment plant, disposal system or reclamation system that does not comply with the minimum standards.

(c) Require that design documents for all sewage collection systems, sewage collection system extensions, treatment plants, processes, devices, equipment, disposal systems, on-site wastewater treatment facilities and reclamation systems be submitted with a fee for review to the department and may require that the design documents anticipate and provide for future sewage treatment needs.

(d) Require that construction, reconstruction, installation or initiation of any sewage collection system, sewage collection system extension, treatment plant, process, device, equipment, disposal system, on-site wastewater treatment facility or reclamation system conform with applicable requirements.

14. Prescribe reasonably necessary rules regarding excreta storage, handling, treatment, transportation and disposal. The rules may:

(a) Prescribe minimum standards for human excreta storage, handling, treatment, transportation and disposal and shall provide for inspection of premises, processes and vehicles and for abating as public nuisances any premises, processes or vehicles that do not comply with the minimum standards.

(b) Provide that vehicles transporting human excreta from privies, septic tanks, cesspools and other treatment processes be licensed by the department subject to compliance with the rules. The department may require payment of a fee as a condition of licensure. The department shall establish by rule a fee as a condition of licensure, including a maximum fee. The fees shall be deposited, pursuant to sections 35-146 and 35-147, in the solid waste fee fund established by section 49-881.

15. Perform the responsibilities of implementing and maintaining a data automation management system to support the reporting requirements of title III of the superfund amendments and reauthorization act of 1986 (P.L. 99-499) and article 2 of this chapter.

16. Approve remediation levels pursuant to article 4 of this chapter.

17. Establish or revise fees by rule pursuant to the authority granted under title 44, chapter 9, articles 8 and 9 and chapters 4 and 5 of this title for the department to adequately perform its duties. All fees shall be fairly assessed and impose the least burden and cost to the parties subject to the fees. In establishing or revising fees, the department shall base the fees on the direct and indirect costs of the department's relevant duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel and other necessary operational expenses directly related to issuing licenses as defined in title 41, chapter 6 and enforcing the requirements of the applicable regulatory program.

18. Appoint a person with a background in oil and gas conservation to act on behalf of the oil and gas conservation commission and administer and enforce the applicable provisions of title 27, chapter 4 relating to the oil and gas conservation commission.

C. The department may:

1. Charge fees to cover the costs of all permits and inspections it performs to ensure compliance with rules adopted under section 49-203 except that state agencies are exempt from paying the fees.

2. Monies collected pursuant to this subsection shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

3. Contract with private consultants for the purposes of assisting the department in reviewing applications for licenses, permits or other authorizations to determine whether an applicant meets the criteria for issuance of the license, permit or other authorization. If the department contracts with a consultant under this paragraph, an applicant may request that the department expedite the application review by requesting that the department use the services of the consultant and by agreeing to pay the department the costs of the consultant's services. Notwithstanding any other law, monies paid by applicants for expedited reviews pursuant to this paragraph are appropriated to the department for use in paying consultants for services.

D. The director may:

1. If the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed, inspect any person or property in transit through this state and any vehicle in which the person or property is being transported and detain or disinfect the person, property or vehicle as reasonably necessary to protect the environment if a violation exists.

2. Authorize in writing any qualified officer or employee in the department to perform any act that the director is authorized or required to do by law.

# 49-221. Water quality standards in general; protected surface waters list

A. The director shall:

1. Adopt, by rule, water quality standards for all WOTUS and for all waters in all aquifers to preserve and protect the quality of those waters for all present and reasonably foreseeable future uses. For non-WOTUS protected surface waters, the director shall apply surface water quality standards established as of January 1, 2021, until specifically changed by the director pursuant to paragraph 2 of this subsection. Rules regarding the following shall not be adopted or applied as water quality standards for non-WOTUS protected surface waters:

(a) Antidegradation.

(b) Antidegradation criteria.

(c) Outstanding Arizona waters.

2. Adopt, by rule, water quality standards for non-WOTUS protected surface waters, by December 31, 2022, consistent with paragraph 1 of this subsection and as determined necessary in the rulemaking process. In adopting those standards, the director shall consider the unique characteristics of this state's surface waters and the economic, social and environmental costs and benefits that would result from the adoption of a water quality standard at a particular level or for a particular water category.

B. The director may adopt, by rule, water quality standards for waters of the state other than those described in subsection A of this section, including standards for the use of water pumped from an aquifer that does not meet the standards adopted pursuant to section 49-223, subsections A and B and that is put to a beneficial use other than drinking water. These standards may include standards for the use of water pumped as part of a remedial action. In adopting such standards, the director shall consider the economic, social and environmental costs and benefits that would result from the adoption of a water quality standard at a particular level or for a particular water category.

C. In setting standards pursuant to subsection A or B of this section, the director shall consider the following:

1. The protection of the public health and the environment.

2. The uses that have been made, are being made or with reasonable probability may be made of these waters.

3. The provisions and requirements of the clean water act and safe drinking water act and the regulations adopted pursuant to those acts.

4. The degree to which standards for one category of waters could cause violations of standards for other, hydrologically connected, water categories.

5. Guidelines, action levels or numerical criteria adopted or recommended by the United States environmental protection agency or any other federal agency.

6. Any unique physical, biological or chemical properties of the waters.

D. Water quality standards shall be expressed in terms of the uses to be protected and, if adequate information exists to do so, numerical limitations or parameters, in addition to any narrative standards that the director deems appropriate.

E. The director may adopt by rule water quality standards for the direct reuse of reclaimed water. In establishing these standards, the director shall consider the following:

1. The protection of public health and the environment.

2. The uses that are being made or may be made of the reclaimed water.

3. The degree to which standards for the direct reuse of reclaimed water may cause violations of water quality standards for other hydrologically connected water categories.

F. If the director proposes to adopt water quality standards for agricultural water, the director shall consult, cooperate, collaborate and, if necessary, enter into interagency agreements and memoranda of understanding with the Arizona department of agriculture relating to its administration pursuant to title 3, chapter 3, article 4.1 of this state's authority relating to agricultural water under the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112, subpart E) and any other federal produce safety regulation, order or guideline or other requirement adopted pursuant to the FDA food safety modernization act (P.L. 111-353; 21 United States Code sections 2201 through 2252). For the purposes of this subsection:

1. "Agricultural water":

(a) Means water that is used in a covered activity on produce where water is intended to, or is likely to, contact produce or food contact surfaces.

(b) Includes all of the following:

(i) Water used in growing activities, including irrigation water, water used for preparing crop sprays and water used for growing sprouts.

(ii) Water used in harvesting, packing and holding activities, including water used for washing or cooling harvested produce and water used for preventing dehydration of produce.

2. "Covered activity" means growing, harvesting, packing or holding produce. Covered activity includes processing produce to the extent that the activity is within the meaning of farm as defined in section 3-525.

3. "Harvesting" has the same meaning prescribed in section 3-525.

4. "Holding" has the same meaning prescribed in section 3-525.

5. "Packing" has the same meaning prescribed in section 3-525.

6. "Produce" has the same meaning prescribed in section 3-525.

G. The director shall maintain and publish a protected surface waters list. The department shall publish the initial list on the department's website and in the Arizona administrative register within thirty days after September 29, 2021. Not later than December 31, 2022, the department shall adopt by rule the protected surface waters list, including procedures for determining economic, social and environmental costs and benefits. Publication of the list in the Arizona administrative register is an appealable agency action pursuant to title 41, chapter 6, article 10 and may be appealed by any party that provides evidence of an actual adverse effect that the party appealing the decision would suffer as a result of the director's decision. All of the following apply to the protected surface water list:

1. The protected surface waters list shall include:

(a) All WOTUS.

(b) Any perennial, intermittent and ephemeral reaches and any impoundments of the following rivers, not including tributaries or reaches of waters wholly within tribal jurisdiction or reaches of waters outside of the United States:

(i) The Bill Williams river, from the confluence of the Big Sandy and Santa Maria rivers at 113°31'38.617"w, 34°18'22.373"n, to its confluence with the Colorado river at 114°8'9.854"w, 34°18'9.33"n.

(ii) The Colorado river, from the Arizona-Utah border at 111°32'35.741"w, 36°58'51.698"n, to the Arizona-Mexico border at 114°43'12.564"w, 32°43'6.218"n.

(iii) The Gila river, from the Arizona-New Mexico border at 109°2'52.8"w, 32°41'11.2015"n, to the confluence with the Colorado river at 114°33'28.145"w, 32°43'14.408"n.

(iv) The Little Colorado river, from the confluence of the east and west forks of the Little Colorado river at 109°28'7.131"w, 33°59'39.852"n, to its confluence with the Colorado river at 111°49'4.693"w, 36°12'10.243"n.

(v) The Salt river, from the confluence of the Black and White rivers at 110°13'39.5"w, 33°44'6.082"n, to the confluence with the Gila river at 112°18'5.704"w, 33°22'42.978"n.

(vi) The San Pedro river, from the Arizona-Mexico border at 110°9'1.704"w, 31°20'2.387"n, to the confluence with the Gila river at 110°47'0.905"w, 32°59'5.671"n.

(vii) The Santa Cruz river, from its origins in the Canelo Hills of southeastern Arizona at 110°37'3.968"w, 31°27'39.21"n, to its confluence with the Gila river at 111°33'26.02"w, 32°41'39.058"n.

(viii) The Verde river, from Sullivan lake at 112°28'10.588"w, 34°52'11.136"n, to its confluence with the Salt river at 111°39'48.32"w, 33°33'20.538"n.

(c) Any non-WOTUS waters of the state that are added under paragraphs 3 and 4 of this subsection.

2. Notwithstanding paragraph 1 of this subsection, the protected surface waters list shall not contain any of the following non-WOTUS waters:

(a) Canals in the Yuma project and ditches, canals, pipes, impoundments and other facilities that are operated by districts organized under title 48, chapters 18, 19, 20, 21 and 22 and that are not used to directly deliver water for human consumption, except when added pursuant to paragraph 4 of this subsection and in response to a written request from the owner and operator of the ditch or canal until the owner and operator withdraws its request.

(b) Irrigated areas, including fields flooded for agricultural production.

(c) Ornamental and urban ponds and lakes such as those owned by homeowners' associations and golf courses, except when added pursuant to paragraph 4 of this subsection and in response to a written request from the owner of the ornamental or urban pond or lake until the owner withdraws its request.

(d) Swimming pools and other bodies of water that are regulated pursuant to section 49-104, subsection B.

(e) Livestock and wildlife water tanks and aquaculture tanks that are not constructed within a protected surface water.

(f) Stormwater control features.

(g) Groundwater recharge, water reuse and wastewater recycling structures, including underground storage facilities and groundwater savings facilities permitted under title 45, chapter 3.1 and detention and infiltration basins, except when added pursuant to paragraph 4 of this subsection and in response to a written request from the owner of the groundwater recharge, water reuse or wastewater recycling structure until the owner withdraws its request.

(h) Water-filled depressions created as part of mining or construction activities or pits excavated to obtain fill, sand or gravel.

(i) All waste treatment systems components, including constructed wetlands, lagoons and treatment ponds, such as settling or cooling ponds, designed to either convey or retain, concentrate, settle, reduce or remove pollutants, either actively or passively, from wastewater before discharge or to eliminate discharge.

(j) Groundwater.

(k) Ephemeral waters except for those prescribed in paragraph 1, subdivision (b) of this subsection.

(l) Lakes and ponds owned and managed by the United States department of defense and other surface waters located on and that do not leave United States department of defense property, except when added pursuant to paragraph 4 of this subsection and in response to a written request from the United States department of defense until it withdraws its request.

3. Unless listed in paragraph 2 of this subsection, the director shall add the following non-WOTUS surface waters to the protected surface waters list:

(a) All lakes, ponds and reservoirs that are public waters used as a drinking source, for recreational or commercial fish consumption or for water-based recreation such as swimming, wading and boating and other types of recreation in and on the water.

(b) Perennial waters or intermittent waters of the state that are used as a drinking water source, including ditches and canals.

(c) Perennial or intermittent tributaries to the Bill Williams river, the Colorado river, the Gila river, the Little Colorado river, the Salt river, the San Pedro river, the Santa Cruz river and the Verde river.

(d) Perennial or intermittent public waters used for recreational or commercial fish consumption.

(e) Perennial or intermittent public waters used for water-based recreation such as swimming, wading, boating and other types of recreation in and on the water.

(f) Perennial or intermittent wetlands adjacent to waters on the protected surface waters list.

(g) Perennial or intermittent waters of the state that cross into another state, the Republic of Mexico or the reservation of a federally recognized tribe.

4. The director may add additional non-WOTUS surface waters to the protected surface waters list if all of the following apply:

(a) The water is not required to be listed under paragraph 1 or 3 of this subsection.

(b) The water is not excluded under paragraph 2 of this subsection.

(c) The economic, environmental and social benefits of adding the water outweigh the economic, environmental and social costs of excluding the water from the list.

5. The director shall remove any erroneously listed, non-WOTUS waters from the protected surface waters list when the water is excluded under paragraph 2 of this subsection and shall not regulate discharges to those waters in the interim.

6. The director shall remove non-WOTUS waters from the protected surface waters list when the water is not required to be listed under paragraph 3 of this subsection and the economic, environmental and social benefits of removing the water outweigh the economic, environmental and social costs of retaining the water on the list.

7. The director, on an emergency basis, may add a water to the protected surface waters list if the director discovers an imminent and substantial danger to public health or welfare or the environment, if the water would otherwise qualify to be added under paragraph 3 of this subsection. Notwithstanding any other law, the emergency addition shall take effect immediately on the director's determination that describes the imminent and substantial danger in writing. Within thirty days after the director's determination, the department shall publish a notice of that determination in the Arizona administrative register and on the department's website. Waters added

under this subsection shall be incorporated into the protected surface waters list during the next rulemaking that follows the addition.

# 49-223. Aquifer water quality standards

A. Primary drinking water maximum contaminant levels established by the administrator before August 13, 1986 are adopted as drinking water aquifer water quality standards. The director may only adopt additional aquifer water quality standards by rule. Within one year after the administrator establishes additional primary drinking water maximum contaminant levels, the director shall open a rule making docket pursuant to section 41-1021 for adoption of those maximum contaminant levels as drinking water aquifer water quality standards. If substantial opposition is demonstrated in the rule making docket regarding a particular constituent, the director may adopt for that constituent the maximum contaminant level as a drinking water aquifer water quality standard upon making a finding that this level is appropriate for adoption in Arizona as an aquifer water quality standard. In making this finding, the director shall consider whether the assumptions about technologies, costs, sampling and analytical methodologies and public health risk reduction used by the administrator in developing and implementing the maximum contaminant level are appropriate for establishing a drinking water aquifer water quality standard. For purposes of this subsection "substantial opposition" means information submitted to the director that explains with reasonable specificity why the maximum contaminant level is not appropriate as an aquifer water quality standard.

B. The director may adopt by rule numeric drinking water aquifer water quality standards for pollutants for which the administrator has not established primary drinking water maximum contaminant levels or for which a maximum contaminant level has been established but the director has determined it to be inappropriate as an aquifer water quality standard pursuant to subsection A of this section. These standards shall be based on the protection of human health. In establishing numeric drinking water aquifer water quality standards, the director shall rely on technical protocols appropriate for the development of aquifer water quality standards and shall base the standards on credible medical and toxicological evidence that has been subjected to peer review.

C. Any person may petition the director to adopt a numeric drinking water aquifer quality standard for any pollutant for which no drinking water aquifer quality standard exists. The director shall grant the petition and institute rule making proceedings adopting a numeric standard as provided under subsection B of this section within one hundred eighty days if the petition shows that the pollutant is a toxic pollutant, that the pollutant has been, or may in the future be, detected in any of the state's drinking water aquifers, and that there exists technical information on which a numeric standard might reasonably be based. Within one year of the commencement of the rule making proceeding, the director shall either adopt a numeric standard or make and publish a finding that, pursuant to subsection B of this section, the development of a numeric standard is not possible. The decision to not adopt a numeric standard shall, for purposes of judicial review, be treated in the same manner as a rule adopted pursuant to title 41, chapter 6.

D. For purposes of assessing compliance with each aquifer water quality standard adopted pursuant to this section, the director shall for purposes of articles 3 and 4 of this chapter, and may for purposes of other provisions of this title, identify sampling and analytical protocols appropriate for detecting and measuring the pollutant in the aquifers in the state.

E. Within one year from the reclassification of an aquifer to a non-drinking water status, pursuant to section 49-224, the director shall adopt water quality standards for that aquifer. For any pollutants which were not the basis for the reclassification, the applicable standard shall be identical with the standard for those pollutants adopted pursuant to subsections A and B of this section. For any pollutants which were the basis for reclassification, the standard shall be sufficient to achieve the purpose for which the aquifer was reclassified but shall minimize unnecessary degradation of the aquifer by taking into consideration the potential long-term uses of the aquifer and the short-term and long-term benefits of the activities resulting in discharges into the aquifer.

F. The director shall adopt water quality standards for an aquifer for which a petition has been submitted pursuant to section 49-224, subsection D sufficient to achieve the non-drinking water use for which that aquifer was classified, taking into consideration the potential long-term uses of that aquifer and the short-term and long-term benefits of the discharging activities creating that aquifer.

G. In any action pursuant to this title, aquifer water quality protection provisions, including monitoring requirements, may be imposed only for pollutants for which aquifer water quality standards have been established that are likely to be present in a discharge. Indicator parameters and quality assurance parameters appropriate for such pollutants also may be specified.

# 49-224. Aquifer identification, classification and reclassification

A. Not later than June 30, 1987 the director shall, by rule, identify and define the boundaries of all aquifers in this state utilizing, to the maximum extent possible, data available from the department of water resources.

B. All aquifers in this state identified and defined under subsection A of this section and any other aquifers subsequently discovered, identified and defined shall be classified for drinking water protected use unless the classification is changed in the manner provided in subsection C of this section.

C. The director, after consulting with the appropriate groundwater users advisory council established pursuant to title 45, chapter 2, article 2 if the aquifer is in an active management area, and a public hearing held pursuant to section 49-208, may change the classification of an aquifer or part of an aquifer for a protected use other than drinking water on making all of the following findings:

1. The identified aquifer or part of an aquifer is or will be so hydrologically isolated from other aquifers or other parts of the same aquifer that there is no reasonable probability that poorer quality water from the identified aquifer or part of an aquifer will cause or contribute to a violation of aquifer water quality standards in other aquifers or parts of the same aquifer.

2. Water from the identified aquifer or part of an aquifer is not being used as drinking water.

3. The short-term and long-term benefits to the public that would result from the degradation of the quality of the water in the identified aquifer or part of an aquifer below standards established pursuant to section 49-223, subsections A and B would significantly outweigh the short-term and long-term costs to the public of such degradation. Benefits and costs to be considered include economic, social and environmental.

D. Owners or operators of facilities whose discharges are solely responsible for creating an aquifer may petition the director for a classification of the aquifer for a non-drinking water use. The director may, by rule, classify that aquifer for a non-drinking water use upon making the findings prescribed in subsection C, paragraphs 1 and 2 of this section.

E. The director shall provide for public participation in proceedings under this section pursuant to section 49-208 and shall hold at least one public hearing at a location as near as practicable to the aquifer proposed for reclassification.

**G.**

CONSIDERATION, DISCUSSION, AND POSSIBLE ACTION ON PETITION RELATED TO ARIZONA MEDICAL BOARD

# GOVERNOR'S REGULATORY REVIEW COUNCIL

## ATTORNEY MEMORANDUM - PETITION

**MEETING DATE: July 1, 2025**

**TO:** Members of the Governor's Regulatory Review Council (Council)

**FROM:** Council Staff

**DATE:** June 11, 2025

**SUBJECT: Dr. Fowler Petition - Arizona Medical Board**

### Background

On March 18, 2025, GRRC staff received a correspondence ("Petition") from Dr. Stuart Fowler, M.D., certified by the Arizona Medical Board ("Board") to practice allopathic medicine. The Petition requests that the Council expunge four judgments from Dr. Fowler's record as he believes, "the Board has greatly overstepped its authority in this case." These judgments relate to factual and unprofessional conduct findings in the Board's Order for Probation; and Consent to Same dated February 7, 2024 ("Order").[1]

### Analysis

The Council is limited to considering petitions/appeals related to matters that are statutorily authorized. No statutory authority exists for the Council to review the Board's disciplinary actions against individual licensees. While Dr. Fowler states the Board has greatly overstepped its authority in this case, he provides no specific information regarding any existing agency practice, substantive policy statement, final rule or regulatory licensing requirement that he alleges exceeds the agency's statutory authority or is not specifically authorized by statute. *See* A.R.S. § 41-1033(H). On the contrary, the Board's actions at issue here were specifically authorized by statute in the Arizona Medical Practice Act. The Board indicates it was operating within its authority to investigate complaints alleging unprofessional conduct. *See* A.R.S. §§

[1] The Council has no authority to review the substance of the underlying complaints against Dr. Fowler and any facts in the underlying Case No. MD-23-0278A are irrelevant to the Council's analysis.

32-1401(27)(c), (n), (r) and (u), 1403(A). Furthermore, the consent agreement for a disciplinary outcome that Dr. Fowler agreed to consists of probationary terms also identified in the Medical Practice Act. *See* A.R.S. §§ 32-1451(F) and (I)(7).

## Conclusion

Council staff believes this matter is outside the scope of the Council's review as the Council is not statutorily authorized to review agency disciplinary actions. Furthermore, Council staff does not believe the Petition puts forth an agency practice, substantive policy statement, final rule or regulatory licensing requirement alleged to exceed the Board's statutory authority that the Council can review substantively. However, even if it did, the Board actions related to this matter are specifically authorized by statute and do not exceed the agency's statutory authority. Therefore, Council staff does not recommend that this Petition receive a hearing at a future Council meeting.

Council staff also notes, the Board indicates Dr. Fowler was notified in writing that his options to challenge the Board's findings and Order were to participate in a formal interview before the Board or request that the complaint be heard by the Office of Administrative Hearings. Dr. Fowler's probation was terminated on October 16, 2024 after he successfully completed the requirements of the agreement.

To: Governor Katie Hobbs

From: R. Stuart Fowler, M.D.
Mailing Address: 6890 So. 2300 E. Apt 711997 Salt Lake City, Utah 84171
Email address: rsfowler303@gmail.com
Phone: 480-320-0245

Regarding:Petition to Arizona Board Case MD-23-0278A

Requesting: Governor's Regulatory Review Council to Delete Charges

Why Arizona policies A.R.S. 32-1401(27)(c), A.R.S. 32-1401(27)(n), A.R.S. 32-1401(27)(r), and A.R.S. 1401(27)(u) do not apply to Dr. Fowler.

# To: Governor's Regulatory Review Council

Please read the charges the Board filed against me and ask yourself if they seem reasonable particularly because the Board cannot prove whether they are true or not: 1) The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(c). False, fraudulent, deceptive or misleading advertising by a doctor of medicine. 2) The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(n). Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact. 3) The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r). Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. 4) The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(u). Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine. Now, please read through this and see if this dreadful pronouncement of my reputation is deserved. Note that the Az Medical Board Google review rating is 1.6 whereas my practice rating was 4.7 over this course in time.

The Arizona Board claims I advertised false, fraudulent, deceptive or misleading information to my patients.This information referred to is that I claimed to have discovered the underlying etiology of vulvodynia and how it can be successfully treated. The Board does not accept that what I have told my patients is truth; that being the results from an objective approach comprising the findings manifest by a phase-contrast microscope. The findings are either present or not. The microscope does not mislead or provide false information This evidence does not deviate from the truth. Although I do not have proof as would be conveyed by a double-blind randomized control study, I do have the evidence of thousands of women getting great results including many cures. See Appendix A. These testimonies were shared with the Board but the Board ignored them completely having made no reference to them. So

what I'm telling my patients is true but the Board refutes those claims even though they have no evidence to do so. When a discovery is made, you need to start somewhere, it's not reasonable to expect all the research necessary to prove fact be there from the get go. It still does not preclude that the information is indeed the truth.

I have set forth results at a cellular level (five articles) that sustain these claims. While vulvodynia has been long since ( since the 1870's) regarded "as a manifestly incurable disease", someday that was invariably destined to change. That someday is today. My research shows the presence of altered vaginal microflora consistently present in patients presenting with vulvodynia. Vulvodynia symptoms resolves with treatment directed towards resolution of the altered microflora. Despite this, the Board asserted the following: "Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact." I was telling my patients that the treatments I had developed was capable of curing patients. Of the hundreds of testimonies from my patients, a whopping 53% reported being completely cured. So, I was not telling my patients false or misleading information. The Board just refused to believe my data and ignored these reports. Additionally, my protocols do not use alleged "secret" methods or procedures. They employ a combination of bio-identical estrogens. Nearly all institutions in the US that have physicians treating vulvodynia, list among their treatment options, topical and or vaginal estrogens. Therefore, my approach cannot be regarded as a "secret" method. Furthermore, the Board asserters that I should have offered an alternative treatment method. They suggested physical therapy which reveals the degree of their ignorance. Neither of these patients complained of central pelvic pain which is present in all patients who have underlying pelvic floor tension myalgia. Furthermore, nearly every institution that offers providers who treat vulvodynia, recommend the avoidance of external irritants as a treatment option. I have advocated this to every patient in my practice. In fact, I single handedly advocated for this approach in 1997 with my address to the International Society of the Study of Vulvovaginal Disease (ISSVD) World Congress XIV in Baveno Italy, titled, Vulvar Vestibulitis: Response to Hypocontactant Vulvar Therapy;

subsequently published in the Journal of Lower Genital Tract Disease, 2000; 4(4):200-203. This was a meeting of the leading world's experts in vulvovaginal medicine. At the time, none the experts in the field were doing this and neither did they believe it was necessary. The most distinguished member, brushed by me afterwords and sarcastically said, "What dose soap have anything to do with vulvodynia?" It took about ten years before this become mainstream for every vulvodynia patient and I was the nidus that started the whole thing. Needless to say this treatment was given to my patients as well. This was a blatant oversight by the Board because I was treating every patient with bio-identical hormones plus my extensive therapy directed against external irritants. In fact, my protocol is undoubtedly the most extensive one in use in the country.

I have published five peer review articles related to vulvodynia.. At the International Society for the Study of Vulvovaginal Disease (ISSVD) World Congress XX in Edinburgh, Scotland at the Royal College of Physicians, I presented my research findings: 100% Correlation between Vulvodynia and the Presence of Altered Vaginal Micro-flora Patterns. Lower Genital Tract Disease, Supplement, Oct 2009. It's been over 15 years and to my knowledge, still no other providers have pursued this line of research. This research shows results at a cellular level which requires a phase-contrast microscope to accomplish. I surveyed the 200 experts present at the 2009 meeting and only 4 physicians had phase-contrast microscopes and these were the only providers who recognized my findings.  I am one of perhaps only 2 gynecologists in the USA who uses a phase-contract microscope. Moreover, I was first to show what patterns are normal in healthy women with no vulvovaginal symptoms. Journal of Lower Genital Tract Disease, 2012 October; 16(4):437-441. It is necessary to know these patterns because they become the target for a cure. I was first to recommend changing the Classification of Vaginitis to include the spectrum of abnormal microflora. Fowler RS. Expansion of altered vaginal flora states in vaginitis to include a spectrum of microflora. J Reprod Med. 2007 Feb; 52(2):93-9. I have been a leading expert in this field for over 20 years. Then the Board picks a general Ob/Gyn to be the consultant for this case. Her comments were without an expert insight and blatantly misleading.

The cumulative effect of these articles, shown by use of a phase-contrast microscope that altered vaginal microflora exists and plays a role in vulvodynia. Whether the Board understood them or not remains unclear because the Board made no comment about any of my published studies. For this reason alone, their charges against me can be discredited and considered irrelevant. Given the abundant evidence for the success of treating vulvodynia with bio-identical estrogens in unique proportions that correct the altered vaginal microflora, the Board should not be able to disregard it without even a single comment. While I have presented significant proof that I have discovered the underlying etiology of vulvodynia without their offering any proof to the contrary, their rejection now becomes just their opinion. It is true I have not conducted double-blind randomized studies if this is what the Board is looking for to prove fact. I have had one physician recently collaborate my findings. The Board cannot prove what I have presented to my patients is not true. For the Board to destroy my reputation and my lifetime of work which has been collaborated by so many testimonies is just unbelievable. This whole thing started over an email I sent to my patients one-year before my expected retirement to allow women in my practice to find providers willing to continue my treatment approach. Many women in my practice report that I am the only physician in the country who has been able to improve or cure their condition. Women coming to my practice have consistently seen 3-5 other physicians whose treatment had no or minimal benefit on their symptoms. I proposed to write a book for my patients that would explain the details of my treatment approach. Since no other provider is offering this approach, this would enable my patients to continue this therapy after my retirement. Two young women complained to the Board about my proposed treatment manual. One said it was too expensive causing “financial distress” and the other said that advertising to my patients by email and text is “slimy business.” These two complaints lead to the outcome of destroying my entire career in medicine. This seems beyond any reasonable outcome. I believe the Board has greatly overstepped its authority in this case. I would implore you as governor with Arizona Medical Board oversight, to that these four judgements be expunged from my record.

Statistical Data:The breakdown of women from my practice who chose to send in a testimony. For 10 years I ran a small Vulvovaginal practice in Scottsdale. Note that patients came from all across the country because of the reputation  of my success with vulvodynia.

| | | | | | | |
|---|---|---|---|---|---|---|
| **% Resolution of Symptoms** | <70% | 70-79% | 80-89% | 90-99% | 100% | Percentage saying they "got my life back" |
| **N= 411** | 11 | 24 | 74 | 88 | 219 | 112 |
| **Percentage** | 2% | 6% | 18% | 20% | 53% | 27% |

Note: Overall 53% of women reported complete remission of symptoms I.e. cured.  A total of 73% reported >90% or better response. For a condition that hitherto was considered "a manifestly incurable disease," this is a remarkable finding. Rather than being trampled, this work should be heralded for its amazing accomplishment. Now see Appendix A for the 411 testimonies from my patients who chose to write a testimony of their experience and response. I don't believe the Board bothered to read any of them. Note that even those who only got 70% better were thrilled because of how much lifestyle improvement this caused.

With Respect and Appreciation,

R. Stuart Fowler, M.D.
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Salt Lake City, Utah  84171
rsfowler303@gmail.com
480-320-0245

## Appendix A

I came from Albuquerque, New Mexico for my first consult last summer and have experienced **no pain since your treatment plan.** I am so grateful to you. I am a competitive horseback rider who travels the southwest and now I am able to ride again, which is my emotional lifesaver. Dr. Fowler ROCKS! Very best doctor I have ever seen! ***A. Albuquerque, New Mexico***

I have been treated by Dr. Fowler for 3 months and have had a complete remission of my vulvodynia symptoms!! I can wear jeans, sit for extended periods of time, ride my bike, swim in a pool, and have sex as frequently as I like!! I no longer suffer from vaginal burning, irritation, and frequent bv/yeast infections. For the past 3 years or so, I did not know what was going on with my vaginal health. I went from being a healthy, sexually active spin instructor and full-time nurse to someone who was constantly thinking about the discomfort in and around my vagina. I was seen by several doctors....my gynecologist, my general practitioner, a physical therapist, a urologist (specializing in sexual health), and a urogynecologist, as well as trying several online treatments. All of these doctors, some of them my friends/colleagues, said they could treat me/fix me and try as they may. I could not get better, and my quality of life and my confidence got so bad that I was having anxiety and panic attacks. My husband and I scoured the internet looking for help. Thankfully, I stumbled upon Dr. Fowler's website, and I read every single testimonial! Ninety- nine percent of the testimonials were raving, and I figured it was too good to be true, and yeah, he trained at Mayo Clinic, specialized in vulvodynia, etc, but what if it was just a gimmick to suck desperate woman like me in. Well, I am here to tell you that everything he promised, all those positive testimonials, and all of Dr. Fowler's research over the years has led him to find a treatment program that actually works!! I cannot tell you how happy I am to **have my life back** and to have my confidence back, and yes, to have my amazing sex life back. I thank my husband for supporting me through a very challenging time in our life and thank Dr. Fowler for having the education, expertise, and determination in this field of women's health to heal me! So grateful! S. Huntington Beach, Ca My vulvodynia is a lot better. There is no pain with intercourse. I used to have tremendous pain afterward, but now only occasionally and just a little bit. The general burning at the opening is infrequent. I used to get it all the time. No more itching. I have had this pain and itching for the last 28 years. It became worse in the last 5 years when I entered menopause. I was treated by other doctors and had no results. I was told to see a vulva doctor. I googled my symptoms and found Dr. Fowler. In 4 months, I am about 70 to 80% better. I highly recommend Dr. Fowler to anyone who has vulva pain and needs relief. C. Chandler Arizona I encourage any woman having similar issues to consult with Dr. Fowler and follow his protocol. My symptoms have drastically improved in a four- month period, much to my surprise, after suffering for 28 years with painful intercourse, it was actually excruciating. There was pain in other physical activities. Also, the external tissues were dry and would crack, which was a huge problem. I saw multiple physicians talking 10-12+ with no hope for improvement. I had given up. My new obgyn referred me to Dr. Fowler, with the advice, "He is the only person who can help your situation." He diagnosed me with vulvodynia and Lichen Sclerosis. After four months

of being on Dr. Fowler's protocol, I'm elated at the physical changes. **I am 100% better** already. Now **I don't think about my vagina at all**. Dr. Fowler just gave me my only wish for Christmas, which was that I now get to wash my hair in the shower rather than the sink! Without hesitation, I recommend Dr. Fowler. **T. Scottsdale, AZ.**

I am so glad that I found Dr. Fowler. I had symptoms for over 30 years. My biggest concern was pain, rawness, burning, and a terrible odor. I was repeatedly tested for a yeast or bacterial infection, but my tests always came back negative. Today, I have **no pain**, rawness, burning, and no odor! Thank you, Dr. Fowler. I will be forever grateful. **R. Gilbert, AZ**

In the beginning, I came to Dr. Fowler with apparent recurrent yeast infections with burning and itching. It felt like I was being stabbed by tiny little needles. I'm so much better now after only four months. I feel calmer in my whole being and more grounded in my body. Thankfully, I was one of those women who responded on the quicker side. I followed the protocol to the letter, and my condition turned around straight away. This is amazing, having had my symptoms for 20 years. In the first 4 months of treatment, I'd say **I'm 80% better.** I have had 2 little flares-ups, but they cleared up within a couple of days. Before treatment, I would hurt for at least 36 hours after intercourse, and now there's minimal to zero irritation. It's such a joy to be with my man and not to have this in the back of my mind. I thank my lucky stars that I found Dr. Fowler. Unlike other doctors I had consulted, Dr. Fowler thoroughly answered every question I brought to him and helped me understand my condition and how to remedy it. I felt seen, heard, respected, and cared for every step of the way -- very different from many other medical experiences I have had. The office and staff are lovely, to boot. I cannot recommend FGI strongly enough! **C. Santa Barbara, CA**

Dr. Fowler is wonderful. I did not think I would ever be pain-free. If you are in pain, I would insist you make that call and get to his office as soon as possible. Dr. Fowler is very caring and understanding. He knows what you have been through. I once had a doctor, who I do not see anymore, tell me that I was basically in the "junkyard of women." There was nothing that could be done for me. I left the office crying because it was such a hurtful thing to say to someone who is living in pain. At my last exam, my GYN, Dr. Jennifer Tatalovich, was amazed that I could withstand a pap smear. She commented my vaginal tissue was not inflamed any longer. **I have ZERO pain**. Are you at home reading that? Read it again. I have ZERO pain. Dr. Fowler is as important to me as my own family member. I cannot urge you enough to make that call. Do it now. Don't wait one more day. All you need is a little prayer and Dr. Fowler:) **A. Mount Juliet, IL.**

“Dr. Fowler literally saved my life. After battling chronic vaginal infection for nearly a year, I developed unprovoked vulvodynia. I saw 9 specialists in my region, and no one knew how to treat me except to numb my pain. I spent over $20,000 on both traditional and alternative medical treatment plans. I was unable to have intercourse for nearly 5 years. I was unable to wear pants or panties for 3 years. I needed to resign from my job because I was unable to function, as the pain was a 10/10. I was hopeless, and my vulva/ vaginal pain was ruining my

life. The first time I spoke with Dr. Fowler on the phone, he was patient, kind, and encouraging. He even allowed me to pray with him. I scheduled my visit to AZ and started treatment immediately. My recovery was slow and, at times, discouraging. Dr. Fowler kept encouraging me and said that for some women, recovery is slow, to be patient, and to stay the course. After nearly 2 years of following his treatment plan, **I am 95% better.** I am so grateful to God for Dr. Fowler and the FGI staff! I'm now in a loving relationship, able to have intercourse and reach orgasm without any pain. I never knew that sexual intimacy could be so pleasurable. Dr. Fowler has given me **my life back** in a manner that I never thought was possible. God bless you, Dr. Fowler! You are changing the lives of women worldwide! Ladies, call Dr. Fowler NOW; he will change your life, too!" **L. Holland, Michigan**

"I've suffered from vulvodynia for 35 years. I've seen a plethora of doctors, so many I've lost count. It's at least 100 doctors. I've spent enough money on homeopaths, natural- paths, acupuncture, physical therapy, supplements, shamans, and allopathic doctors to buy a house. The good news is I finally found Doctor Fowler while scouring the internet in a desperate search for relief. Relief is what I've found. Finally, an expert in this silent, misunderstood, and misdiagnosed syndrome. I **now live free of chronic vaginal and vestibular burning**. I'm not sexually active, but I believe I will be able to engage when the day comes that I'm no longer single. I will continue to see Dr. Fowler for my follow-ups and ongoing care. Dr. Fowler takes the guesswork out of the equation and tailor-makes the right protocol for you. Don't give up!" **C. Ventura, CA**

"I feel so fortunate to have found Dr. Fowler. I had been suffering from vulvodynia for six months and had seen many different doctors with no relief. I went to see three different gynecologists, a urologist, and a chiropractor. I tried acupuncture, special diets, and physical therapy, and nothing was working. Meanwhile, I had to take a leave of absence from work because I was unable to sit for long periods of time because of burning. In addition to physical pain and feeling hopeless about getting relief, I had read some opinions that there is no cure and they don't know what causes it. While researching online, I came across Dr. Fowler's website and read testimonials, and while it seemed too good to be true, I figured I had nothing to lose, so I flew to Phoenix to see him. It was the best decision I've ever made. Really quickly, I began to feel better, and now, 4 months into it, I'm about 90% better, and MANY DAYS **I FEEL 100%**. He really gets results. Thank you, Dr. Fowler for helping me feel so much better." **S. Pacific Palisades, California**

"If I were to put it into one sentence, it would be "**Dr. Fowler saved my life."** I mean that, literally. Every day, I had wished myself dead. Every day, I dwelled on how to end this horrible, all-consuming pain I was experiencing. My only option was dwindling down to ending my life in the two years of hell I experienced before finally getting Dr. Fowler's help. I had seen my general practitioner, 3 gynecologists, a urologist, and a pain clinic totaling over 80 medical appointments. I was a guinea pig and prescribed 28 different medications, costing more than $6000.00, none of which eased the endless suffering. I tried acupuncture, a herbalist, a naturopathic doctor, and a physiotherapist, costing me over $3300.00, all to no avail. My last

hope was Dr. Fowler, so I took a leap of faith and made the 1300-mile trek. It has been 5 months since I first saw Dr. Fowler, and **I am IMPROVING!**!! This journey is not over, but I am seeing the light at the end of this dark long tunnel. If you are wondering, "I've already tried so many different things and spent so much money, and nothing has helped, why would Dr. Fowler be any different?" STOP wondering. He is different. His testing is different. His regimen is different. He is worth every penny. **Get your life back.** Let Dr. Fowler help you. I am so glad I did. Thank you, Dr. Fowler!!!" **G. Manitoba, Canada**

For 20 years, I have suffered from vaginal itching and burning on and off. On my visit to my gynecologist, he said he could no longer help me and suggested that I see Dr. Fowler. I made my appointment, and on my first visit, he recommended changing the soaps that I used and gave me three medications. To my amazement, within 2 days, the itching stopped. For a few days, I still had burning with urination on the 5th day, and that was gone too. It has been 8 weeks, and after 20 years, **I'm 100% better. D. Gilbert, AZ**

I suffered for 30 years with vulvodynia, which included many episodes of intense burning pain. When this occurred, I couldn't work, sleep, or do anything. It felt like I was on fire. I saw countless doctors, none of which helped at all. Then, I found Dr. Fowler by reading an article from Northwestern University about how he had helped another patient. He has **brought me the relief that I NEVER thought was possible**. It only took 2 months to feel the way I had 30 years earlier. If you suffer, don't hesitate to make the trip to Phoenix. **S. Crystal Lake, IL**

Dr Fowler is the best vagina expert. His specialty is vaginal pain and burning. I was suffering from that for years, and his professional treatment **cured me** in about 3 months. He is top-notch in his field and can help women who suffer from chronic vaginal. pain. I highly recommend him and send my patients to him, too! (I'm a physician also). **C. Scottsdale, AZ**

I have been a patient of Dr. Fowler's since 2010 after experiencing chronic intense vaginal pain and discharge. The pain was so intense that I could hardly work out, focus on my job, and wear jeans, among other activities. After no GYNs could help me with the pain in my home state, Dr. Fowler diagnosed me with vulvodynia and immediately started me on an estrogen cream and his hypocontactant regimen. It took a bit of time, but my symptoms slowly subsided, and **I am 95% pain-free now**. My life has returned to normal! I'm so thankful to Dr. Fowler. He helped me when no other doctor could! **A Golden CO.**

After 5 years of having painful, irritating spots/cracks that would not go away, it was so wonderful to meet Dr. Fowler. He was able to address my concerns and improve my skin condition. In 4 months, it's **95% better**, and I no longer feel the pain of tearing or dryness during intercourse. I feel like it took too long to find a solution to my problems, but I am glad I was finally referred to Dr. Fowler! **L. Scottsdale, AZ**

I have been seeing Dr. Fowler for 4 months now, and I am **70% better!** Before going to Dr. Fowler, I had pain and burning almost every day. I never thought I would get better, and every doctor I went to didn't know what was "wrong" with me. Today, I am able to wear tight clothing

without feeling uncomfortable and have more good days than bad days. I am very happy and grateful I found Dr. Fowler. **E. Scottsdale**

Update:

I have been coming to Dr. Fowler for 3 years now for vaginal burning, itching, and pain with intercourse. It has taken time and small adjustments to figure out the perfect medication, but I can truly say I feel like **I am 100% back to my old self**. 3 years ago, when I walked into Dr. Fowler's office, I had seen multiple gynecologists and even a specialized gynecologist, and no one was able to help me. Dr. Fowler was literally my last hope, and I'm so happy that I put my doubts aside and came to him. **A. Glendale, AZ**

I developed a burning sensation about 2 years ago. I thought I had a urinary infection, but every test was negative. No one believed me. I went to several primary doctors, urologists, and gynecologists and even changed doctors. I was about to give up when I saw Dr Fowler's website. My new gynecologist recommended him, so I thought he would be OK. After 4 months, I am feeling much better overall. I would say **75% better**! Dr Fowler has been wonderful and very caring, and I am very comfortable talking to him. I would definitely recommend it. **P. Phoenix, AZ**

Product Testimony (Before starting the VRT):

I just started with Dr. Stuart Fowler about 4 weeks ago with his FeminaRx Pure SkinCare that he recommends, boy, oh boy, let me tell you...I haven't been able to sit on an airplane for almost 4 years. This is the first time I've been able to sit down without horrible stinging pain 24/7. Now, my pain is not all the way gone yet, and it will take some time on his main protocol. I mean, I cannot believe I am going to head to San Diego, California, for a mini vacation next. All because of him. Also, I did go in person, and the staff is lovely. Also, the office is very clean and inviting. The receptionist, Alice, is super sweet too! So, about the products....I love the Lye Soap. The Vanicream Lite Lotion after shaving is a lifesaver, too, and helps with chafing. DO NOT forget to use this, please. I didn't use it the first time after shaving, razor bumps, and chafing. Anyway, that's minor compared to my pain, haha, but also invest in a good shaver, as Dr Fowler suggests, a Schick razor. Just read the Femina kit instructions that he mailed to you, please. Also, you may not get this paperwork if you don't buy the Femina kit, and trust me, you want to buy it. The Boro rinse is a game changer. It helps my burning instantly, and I just place it in 8 oz of water. Make sure to be using a new one every day, and I use the peri bottles after pregnancy for easier squirting use in the vaginal area and pat dry with non- scented toilet paper. Also, use non-scented everything if you can (even non-scented sunscreen.) I had my swab today with 2 Q-tips. It was kind of painful, not bad, but I'll have my results in 10 minutes. Everything Dr Fowler suggests is 100 percent spot on. You have to listen to him, stay humble, and stay patient. Best of luck, and have faith. All of us suffering! We will get better. I know if I can at least sit down, I will get better in a year, maybe even sooner. Wash your hair in the sink separately, too, as Dr Fowler recommends. Just had to add this (lifesaving). Oh, and before the cleaning products, he suggested I was redder than the devil downstairs, and now he said I look normal down there, and

that made me feel awesome! Plus, I take photos down there a lot (weekly), and I know it's better by the pictures, videos, and how it feels. This is just my response after 4 weeks on the recommended “hypocontactant products.” I can’t wait till I see how I do on the main therapy prescribed today! **C. Indianapolis**

Finding Dr. Fowler was such a blessing! I was in so much discomfort for two years and tried what felt like everything before being referred to him. Who knew there was an expert in the field of vulva/vaginal health? Not me. I was treated with great care, and it was nice to know it wasn’t all in my head. I noticed that as I stayed consistent following the steps he gave me, I began to heal and have much less discomfort. For years, I have been **near 100%.** I am so thankful to him and his staff for the great care and help they have given me! You won’t regret asking Fowler GYN Int’l for help! **J Mesa, AZ**

In 1997, at the age of 53, I had a hysterectomy wherein the doctor removed my uterus and ovaries. I was fine for several years thereafter, but as time went on, I started experiencing vaginal dryness. I was prescribed Premarin cream to use for intercourse. It didn’t help a lot, but it made it somewhat better. The last five to ten years of my husband’s Life and intercourse were quite painful, even with the cream. After my husband passed away in 2013, I didn’t see any reason to continue with the Premarin, so I quit using it. A year or two after his passing, I was experiencing extreme itching and discomfort inside the labia and vagina. A visit to my regular gynecologist gave me no relief. I was told not to wear any nylon underwear that was close to the vulva, and if I remember correctly, I could use Vaseline or some type of lubricant to ease the itching. That did nothing. The Physician’s Assistant at my primary care doctor’s office referred me to a urogynecologist. I didn’t know that there was such a branch of gynecology. I began to see him and was diagnosed with lichen sclerosis. At least now I had a name for my discomfort. I had never heard of it before. He prescribed clobetasol ointment every day for two weeks and then twice a week after that. I had some success in feeling better in that area. However, every once in a while, it would flare up. I would go to see him again and was told to just go back to every day for 2 weeks and then twice a week after. Finally, this year, in February, I was at the end of my wits with discomfort. Once again, I was told to keep on with the clobetasol because that was the only thing that was going to help me. Except it wasn’t helping. I had had enough. I thought that I would go on the internet to see if there was some doctor, perhaps a dermatologist even, who knew how to treat my symptoms. The first person I saw actually was a dermatologist who said that he treated the condition, but I didn’t make an appointment. I wanted to think about it for a day or so. Then I went back online, but I couldn’t find that dermatologist again. But for the first time, I found Fowler Gynecology International. When I called Dr. Fowler, I asked if he knew how to treat lichen sclerosis, and he responded that he was an expert at treating it. I learned that he had developed a protocol for it after researching and studying the disease while working at the Mayo Clinic. That was impressive and brought a wonderful sense of relief that perhaps, at last, there was someone who could actually help me with my condition. I had my first appointment with Dr. Fowler in early March of 2022. He was kind enough to see me during his lunch hour to prevent me from having to wait a couple of weeks for the next available appointment. After examining me, he gave me a packet of information regarding his protocol and directions for

following it during the next four months. I also received prescriptions for various medications, some of which, I believe, he had formulated himself. The regimen he had developed required a change in some of my routines but was not too excessive or difficult to follow. I recently had my four-month follow- up visit. I knew I had been feeling more normal in my feminine area for a while and was certain that it was the result of his treatment. I was thrilled when Dr. Fowler told me that I had the vaginal tissue of a forty-year-old woman. I am 78. That was wonderful news for me. I am so grateful for his knowledge and expertise in curing a very troublesome problem. I would want every woman who experiences these symptoms to know of his ability to make them feel normal again. There really is someone who knows how to cure lichen sclerosis and related vulvovaginal conditions. J. Tempe, AZ I will never forget the moment Dr. Fowler diagnosed my condition. After seeing several gynecologists seeking relief, I was finally referred to Dr. Fowler at Mayo Clinic. I had been in such terrible pain for many months. My excitement when I found out that I actually had inflammatory vaginitis, which could be fixed, can't even be described! I have been following Dr. Fowler's treatment plan for 12 years now, with terrific results. I have **not had any pain** for years**,** and I am perfectly happy with his approach. His bedside manner is wonderful, Alice is great, and I highly recommend Fowler Gyn International. This smart medical approach in gynecology has saved me from anxiety and constant discomfort. **C. Phoenix, AZ**

I had this issue for over 20 years. I tried everything, and no one could help me other than give me lidocaine to use as needed. I have seen maybe three different doctors, and I just decided to live with it. I found Dr. Fowler on the web while researching and decided to try his approach. It took a long time for my body to respond, nearly 4 years, and to get the right formulations. Dr. Fowler would encourage me to be patient. I am now **over 90% better**, am able to function normally, and have minimal to no issues. That's a big improvement for me with something I had for 20 years! **B. Lenexa, KS**.

As I have gone through this journey, I have had many times that I felt defeated and thought my vaginal status would be horrific forever. Dr. Fowler continued to tell me, "We will fix this." Thankfully, I stuck with him through the years, and I am now able to wash my hair normally, wear tampons again, and have a sex life! Patience, time, and Dr. Fowler and I am **nearly 100% improved**! **K. Buckeye, AZ.**

I have been seeing Dr Fowler for the past ten years or so, and I cannot start telling how he changed my life. The treatment took a while to get to almost or **close to complete success (95%)**, but along the way, Dr Fowler has been instrumental in finding the right treatment. I can say today that he has been the only doctor listening, searching for a solution, and providing me excellent relief for my vulvodynia issues. This has been a game-changer. **E. Cave Creek, AZ**.

For eight months, multiple doctors told me that I was fine. I came to see Dr. Fowler, and he quickly diagnosed me with Inflammatory Vaginitis, also known as Aerobic Vaginitis. He put me on a very specific regimen. The vaginal pain went away completely in 4 months. I am **feeling much better.** Thank you, Dr. Fowler! I am looking forward to returning to my normal life and not having to worry about having vaginal pain and discomfort. **N. Lakewood, CA**

Dr. Fowler was recommended to me by the Mayo Clinic because no physician could get to the bottom of my vaginal issues that I had for 17 years. Dr. Fowler changed my life. I went from pain, burning, and repeated bacterial vaginal infections to having normal vaginal flora and a normal life. His protocol works. It took only less than 4mo to get **100%**. I am grateful to Dr. Fowler for listening and for not simply putting me on another course of Flagyl and Diflucan. He and Alice are compassionate and wonderful people. **A. Scottsdale, AZ**

I started my treatment with Dr. Fowler over 5 years ago, and I can finally say that my vulvovaginal issues are **100% better!** Before finding Dr. Fowler, I had seen multiple doctors across the country, some of whom were supposed to be experts in this field who could not offer me any more help than the next doctor. I am so glad to have found this treatment. It really is a lifesaver. Dr. Fowler takes the time to explain exactly what your issues are and how your personalized protocol will work for you. The treatment takes patience and diligence because that is the nature of vulvovaginal health issues, but it has been worth every step of the way for a full recovery. **K. Las Vegas**

I started coming to Dr. Fowler over 10 years ago. I couldn't find a doctor who could diagnose my problem. I had constant vaginal and bladder infections and vaginal burning pain for 10yrs. I realized I needed to get to the root of the problem. I was on constant antibiotics, and I never felt well. I found Dr. Fowler online at the Mayo Clinic. He immediately diagnosed my problem. I have been coming to him ever since. He is an awesome doctor, and I fly to Phoenix once a year for a follow-up. Well worth my time and money. I have been **pain-free** and without antibiotics for over ten years. **K. New Albany, IN.**

I have been seeing Dr.Fowler for several years now, and it has been a godsend. He has worked with me on adjusting my treatment to the point that I am now **symptom- free!** I had had the condition for 30 years, and now it's gone. Even though I love my regular gynecologist, she just does not specialize in the area of Dr. Fowler, so I continue to see them both for separate issues. I feel so lucky to live in the local Phoenix area to receive his specialized treatment, but if I had to, I would fly across the country to see him. If you have been suffering for years with vulva/vaginal issues with no relief, please reach out to Dr. Fowler's office...you will not regret it. **D. Phoenix, AZ**

I had dealt with vaginal itching, burning, pain, and a complete stop in intimacy with my husband for almost 2 years before seeing Dr. Fowler. My life was absolutely miserable. I had tried dozens of medicines, creams, over-the-counter options, and prescriptions, as well as had seen several other specialists but found no lasting improvement. My primary care physician, Cheryl Simmons, referred me to Dr. Fowler, and that's the day I began to get **my life back**! Dr. Fowler was confident from day one that he could help me, and his confidence gave me the courage to trust him and follow his protocol to the letter. After seeing Dr. Fowler for the past 2 years, I can honestly say that **my symptoms are gone**, my husband and I are enjoying romance again, and I feel like a new woman. I truly thank God for Dr. Fowler and his staff for their knowledge and care and for giving me my health back! **J. Chandler, AZ**

I was referred to Dr. Fowler by my OB-GYN. **He has saved me from many years of pain.** I highly recommend him for his knowledge and expertise. **N. Scottsdale, AZ**

I had been having severe itching with raised bumps in my vaginal and perianal areas for more than 5 years. It was so bad that it affected my going to work at times or my daily activities at home. My GYN was able to see it in action one day, and she was surprised to see how irritated the area was. She performed a biopsy, and it did not give any conclusive results. I was referred to two dermatologists and an allergist. Still no conclusive results. I gave up until I moved to Arizona. I started researching again and came across the term vulvodynia. Using that term, I was able to find Dr. Fowler. I spent hours reading the testimonials and felt they were exactly what I was going through. The response was fast after I submitted my information. After four months of treatment, I feel that I am **95% better.** When my symptoms return, it is because I did not follow the treatment as prescribed. I am now happily back to normal. **M. Tolleson, AZ**

Being in my early 20s, it was very disheartening to experience the symptoms I had. Burning, dryness, painful intercourse, tearing, discharge, and odor. My gynecologist thankfully referred me to Fowler International, as they did not know how to help me. I have been doing treatments now for about 2 years, and I can finally say **I feel 100% better.** Every visit, I would make more progress with my symptoms subsiding. We have finally found the protocol my body needs, and I couldn't be happier. I can now live a normal, pain-free life and not have to hide from the embarrassment of my symptoms. **A. Gilbert, AZ**

Dr. Fowler is amazing. He saved me from severe depression. I had a strong vaginal odor for 2 years. After 7 different physicians,, I was referred to Dr. Fowler. Within 2 wks the **odor was GONE!**! I had a follow-up 4 months later. Im very happy with my results, and I highly recommend Dr. Fowler. **J. Laveen, AZ**

After experiencing chronic and regular yeast infection symptoms, I was so frustrated! I had seen doctor after doctor with no solution. I was a puzzle to everyone. I had constant irritation, strange discharge, and non-stop discomfort. My sister recommended Dr. Fowler to me because he had helped her immensely! My first appointment with him gave me hope. I am one year into treatment, and **I finally feel like myself**. I have an occasional slight. irritation, but that continues to fade. Dr. Fowler is kind and comfortable. I would recommend him to anyone who has chronic vaginal issues. He is worth driving or flying to get to and is truly a rare expert in the field. **A. Glendale, AZ**

After taking the antibiotic Flagyl, I ended up with a bacterial infection in my vagina and vulva. It was so bad I could not wear pants, and it was hard to sit. I was recommended to Dr. Fowler by my gynecologist. In short, **he saved my life**. His unique combination of natural and pharmacological **remedies worked beautifully**. You must follow the directions explicitly. As a result of his practices, I am one hundred percent better. **C. Scottsdale, AZ**

I found Doctor Fowler online while searching out help for my symptoms that my regular gynecologist was unable to help me with over multiple visits. I was having a lot of vaginal pain,

discomfort that felt like an intense bladder infection, discomfort during sex, and cramps. Doctor Fowler immediately understood what was going on with me and explained the complex role of hormones, cell health, and bacterial balance that was causing my symptoms. Through his treatment protocol, I have been able to regain my vaginal health and am **feeling so much better.** I highly recommend him. **D. Tucson, AZ.**

When I found Dr. Fowler, I was at the end of my rope. Just to give some back story, I was training to be a professional athlete. I was in the gym 4 hours a day, 5 days a week, practicing hand-to-hand combat. I was a paralegal working in a prestigious law firm, and I was on the up. I loved my life, but in one weekend, that was OVER. On a Friday in May 2018, I felt something wasn't right 'down there.' By Sunday, I was in excruciating pain. My lady parts (that's what I call them) were on fire. I felt burning, swelling, aching, irritation, dryness, and incessant pain. It did not go away, and nothing helped. I remember being so thankful that I was in a long-distance relationship because the thought of being intimate was traumatic at best. I went to my GYN several times, and he put me on a little of this and a little of that. He was treating me for BV and yeast, yet all my testing results came back negative. Finally, he said to me, I can't do anything else. There's nothing wrong with you. I'm referring you to a specialist. So off I went, 2 hours away, to a specialist in female pain symptoms. That was even more traumatic, seeing as they wanted to perform surgery and cut out the painful areas. Now, as much as I thought, "I'd love to chop this thing off," I did NOT feel surgery was the answer. 4 MONTHS LATER...I had to quit training. Bye-bye to that dream. The pain was now completely intolerable. No tight pants, no cute jeans...I could NOT wear anything but summer dresses. I couldn't work. The constant doctor appointments and the pain led to my having to quit my job. DO YOU HEAR THAT...I quit my amazing job. I would clench my teeth when I was intimate with my now fiancé because sex felt like razor blades and fire all at once, but I didn't want him to know. This was now completely out of control. I was desperate, depressed and hopeless. AND THEN MY LIFE CHANGED! I searched the internet and found Dr. Fowler. I read all the testimonials and thought, "WOW, that sounds like me." So, I called and left a voicemail, and Dr. Fowler called me back. YES! An actual doctor called me back. I spoke with him, explained my situation, and he said the words that gave me hope: "I think I can help you." I cried. He walked me through how to schedule an appointment, which was important because I was coming from New York. He recommended products to get me through while waiting to see him. The products cut down my pain by about 30%, and that was HUGE. Some relief was better than nothing. My first appointment came. Dr. Fowler and his staff were every bit as wonderful as I thought they'd be. Understanding, wise, and patient. It was like a normal GYN visit, faster, actually, so don't be scared. Upon testing and immediate results, Dr. Fowler came back with my results and a plan of attack. He calls it your "Protocol". I began my protocol, did it exactly as he prescribed, and never wavered (do not slack on your protocol). I did my regular tele-testing and visit...and things got 70% better in 4 months. CURRENTLY: I am now 2 years past my first visit with Dr. Fowler. This week, he actually called me and said, you are perfect. All your numbers are normal. I **haven't felt pain in about 1 year**. I am back training. I am able to have sex with my fiancé with little to no pain. I am currently running a finance investment company, and those days of pain and hopelessness are over. I cannot thank Dr. Fowler enough. I can't give enough money or gifts

or appreciation for how he changed my life. So, this is my encouragement to anyone reading this. THERE IS HELP, WHAT YOU ARE EXPERIENCING IS TEMPORARY! I promise you that it will get better. If you are contemplating whether it's worth seeing Dr. Fowler, because of the distance, booked the flight. It's worth it. Dr. Fowler cares and has put in the research and time to help you live a normal life. THANK YOU, DR. FOWLER...you are an angel. **G. Bayshore, NY.**

Dr Fowler and Alice, Words can't express my gratitude. I truly appreciate you. I wish you both good health and happiness always. **Y. Glendale, AZ**

My husband and I rarely had sex because it caused so much burning and irritation inside my vagina. It felt like a hairbrush grating up inside. It was also worse when I sat, so often I would just stay on my feet all day teaching because it was too uncomfortable to sit. It was awful and so difficult because I didn't feel like I could talk to anyone about it. I had seen numerous doctors, and none of them could help me with any long-lasting improvement. My family doctor referred me to Dr. Fowler. Dr. Fowler was honestly an answer to my prayers! He listened, understood what my symptoms were, and was confident from day one that he could help me. That was so reassuring, as so many other doctors just seemed confused by all my symptoms. I had felt pain, irritation, and discomfort for so long that I almost forgot what it felt like not to be aware of my vagina all the time! Fast forward to today, 15 months later, and I am a new person! My symptoms are **almost completely gone**, and my husband and I are beginning to have our love life back. Wherever you live and whatever you have to do to see Dr. Fowler, it's totally worth it. He can help you get your life back! You're not alone, and your symptoms are not just in your head. You have real physical issues that Dr. Fowler has dealt with many times before, and he can help you, too. **J. Chandler, AZ**

I am so grateful to have found Dr. Stuart Fowler. I suffered for years (I cannot even remember now how many) with itching, burning, frequent urination, and, most of all, painful intercourse. The intense itching would wake me up from a sound sleep. I no longer have any itching or burning, and my nighttime trips to the bathroom have decreased. I'm working on getting back to having relations with my ever-patient and understanding husband. I am confident I will be able to have sex again with Dr. Fowler's treatment plan - **I'm almost there**! Dr. Fowler is amazing! He is truly a blessing! I encourage all women who have any symptoms like I have had to please make an appointment and get a treatment plan. My life has improved immensely. Dr. Fowler is the only person who has helped me, and I have been to countless doctors and have also tried numerous things on my own to no avail. Thank you, thank you, Dr. Fowler -- God bless you and your staff! **S. Rio Verde, AZ**

Finding Dr. Fowler has been such a blessing. I saw multiple doctors, a gynecologist, and even another vulvovaginal specialist, and no one could identify the issue. I was repeatedly tested and treated for yeast and bacterial infections with no improvement. I contemplated seeing another doctor and spending more money than I had already, but I decided to give it one last try. Dr. Fowler was my last hope, and I am so glad I made that decision. My symptoms were constant itching and burning inside my vagina and itching around my vulva. It was terrible. I ranked the

discomfort 10/10. At my very first visit, he was able to do the testing, and I got my results within 15 minutes. I had a mild case of lichen sclerosis, as well as very low estrogen and an overgrowth of bad bacteria. It's now been 4 months, and after the proper medication and following Dr. Fowler's specific protocol, I am feeling about **70% better.** It is such a relief to know that I will soon be completely back to my normal self. **A. Glendale, AZ**

It has impacted my life tremendously as I am married at 23 and cannot have sex with my husband. Luckily, I have been with him since I was 16 and did not have sexual issues at the start of our relationship. Only after I started taking birth control did I have issues. It has caused me to become extremely depressed and has increased my anxiety. I am emotionally and physically drained, and my relationship suffers because of it. I have lost all sexual drive and fear, even the thought of intimacy. Searching out of desperation, I found an article about a female who shared her success story by visiting FGI. I wanted to feel the way she did, and I decided to fly from Kentucky to Arizona to see if Dr. Fowler could help fix my issues. No doctor that I had seen previously even knew where to start with my condition. Dr. Fowler was able to diagnose me and give me a protocol to start my healing process. After being in such pain for so long, I can finally say that I am on my road to recovery, and I would say that I am **80% better.** My overall pain and symptoms have decreased significantly, and I am just working on the last 20%. Intercourse is still an issue, both mentally and physically, but I am hoping to get through that since my pain has gone down. I am so thankful to have found a Doctor who was able to diagnose and understand my condition. Can't wait to be 100%! **K. Taylorsville, KY**

I am so grateful for finding Doctor Fowler! Within a year, I have become **80% better** after suffering from vulvodynia for 9 years. I plan to continue to see Dr. Fowler. It's well worth the trip! **S. Cleveland, OH**

I had suffered for 6 years with chronic vaginal infections before meeting Dr. Fowler. I had gone to numerous doctors who could not figure out how to help me. They would treat me, and my symptoms would come right back. I felt miserable and hopeless that no one would ever be able to help me after countless attempts. I met Dr. Fowler one year ago because my sister helped me find a doctor that specialized in vaginal health. She found Dr. Fowler on the internet. I decided to make a trip from New York to Arizona because I was desperate to find a cure for my symptoms. I was so hopeful that Dr. Fowler would be the one who could help me when no other Doctor was able to. I have followed all of Dr. Fowler's protocols to solve my issues and am so happy to say that I feel **90% better!**!!! I honestly can say that **I have my life back** after years of feeling chronically in pain. I would recommend to any woman who hasn't been able to figure out a solution to her issues to make an appointment today to see Dr. Fowler. If you are questioning if making an appointment to see Dr. Fowler makes sense for you, my advice to you would be: Run, don't walk, and make an appointment today!!!!! Thank you, Dr Fowler, for **giving me my life back** and allowing me to feel like myself again. **J. Port Washington, NY**

At my initial appointment, I described my symptoms as follows: My vaginal discharge burns, followed by a strong odor, and causes itchiness. Discharge appears thick white or green and

sometimes looks like cottage cheese, but tested negative for yeast infections. It hurts to sit and have sex. Vaginal burning gets worse after workouts and hot days. Vaginal discharge has a constant "fish-like" odor that is subtle but has been recurrently testing negative for BV. It is embarrassing to have sex before my cycle due to odor. It is killing my self-esteem, and vaginal burning and pain are annoying. I found out about Dr. Fowler from a patient's testimony online and how Dr. Fowler changed their life. Since I've been seeing Dr. Fowler, my symptoms have improved tremendously! Overall, I'm **95% better.** I am thankful and blessed to have found a doctor who listens, cares, and is able to treat my condition. My self-esteem and sex life are better again, and I could not be more grateful! I sincerely thank you, Dr. Fowler. **R. Redlands, CA**

Six years ago, I was diagnosed with Vulvodynia, and I was asked by a doctor in L.A. to take six pills of Gabapentin daily, but the pain and burning continued. I could not work, and neither did any of my daily life activities. It was horrible. Also, there was no sexual life. As time passed, instead of getting better, I got worse. I asked my doctor, and she said that it was a flare-up and I would have to learn to live this way. My husband and I disagreed, so we kept searching for more help. Then, my husband found Dr. Fowler's FGI practice in Phoenix doing an internet search. We immediately set up an appointment. Dr. Fowler explained in detail what was wrong and what the necessary steps were in order to get me well. He told us that in four months, I would be 50% better. Today, on Nov 29th, the day after Thanksgiving and 4 months since my initial evaluation, Dr. Fowler was so nice that he opened his office just to see me. I am very excited and happy to tell him that my pain is indeed 50% less, but moreover, I'm **90% better** with intercourse, and I have returned to work! Dr. Fowler is a great person, and there should be more doctors like him. I thank God that we found him. **C. San Pedro, CA**

By chance, I found an article about Dr. Fowler and his practice during one of my late-night quests to find out what was wrong with me. When I found this article, I'd been struggling with a then unknown-to-me diagnosis of vulvodynia for about five years, and I was at my limit. I'd been struggling with severe pain while sitting down, going to the restroom, and during intercourse. I was in constant pain, and my social life, employment, and mental health were at a breaking point. I'd been to see several local OBGYNs, GPs, and even a urologist to try and get a diagnosis. All of these doctors were sure I had some kind of severe bladder infection that was causing UTI symptoms. Test after test, I'd hear, "You have no infection that we can detect, but take these antibiotics and come back in 10 days or so, and we'll screen you again". This wouldn't go anywhere because I didn't have a UTI. I quit going to my local practices and decided to be my own advocate. That's when I found Dr. Fowler. At about 8 months, I was **already 80% better,** and I was astonished by his treatment plan and unwavering commitment to getting me better. Dr. Fowler truly has your best interest at heart, and he wants to get your life and your health back in check. I cannot express how wonderful it is. "Thank you" doesn't even begin to cover it. Do yourself a favor and go see Dr. Fowler. **J. Middlesex, NJ**

I was referred to Dr. Fowler by my OB-GYN after dealing with bouts of a fishy odor and white discharge, which was misdiagnosed as bacterial vaginosis, which had been going on for 5-6 years. As time went on, the bouts, which started out as infrequent, became almost constant in the

last year. I was so frustrated and embarrassed by the odor. I was at my wit's end! To make matters worse, the treatments I was prescribed gave me constant yeast infections. It was an unending cycle of having a fishy odor or terrible yeast. I am so relieved that I saw Dr. Fowler. After my first treatment, the odor went away; it's been nearly 5 months now, and I am symptom-free, virtually **100% better!** If my story sounds familiar, come see Dr. Fowler & Alice. They are exceptional. Dr. Fowler has a wonderful bedside manner and takes the time to explain exactly what's wrong and the treatment protocol. Thank you, Dr. Fowler, you changed my life and saved my sanity. I am forever grateful! **E. Cave Creek, AZ**

Several years ago, I was in extreme pain and at the end of my rope. Suffering from extreme pain and a swollen vaginal area, and repeated UTIs. Simply sitting or wearing certain clothes was not only uncomfortable but impossible. Of course, it had a negative impact on my life. I had been to many doctors who prescribed multiple medications that actually made things worse. I had spent many hours frustrated and actually crying. I spent so many hours searching the internet and buying products I hoped would work. I sat down one day crying and praying God would help me. I again went to the internet in search of answers, and that was where I found Dr. Fowler. I knew this was the answer to my prayers. Dr. Fowler put me on the right customized plan and medicines to fully heal my body. No more UTIs after years of antibiotics. No more pain. **I am fully healed**, thanks to Dr. Fowler. Gives me permission to email back to her to post on other websites. **L. Cleveland, OH.**

Suffered for years with vulvodynia, and Dr. Fowler has a wonderful treatment plan. Have to follow the rules, but **I am symptom-free now** since I started with him. Finally! I'm in my late 50's, and it began in my 30's. So many doctors and so much pain. Rarely do I recommend, but in this instance, I do highly. Dr. Fowler is so empathetic and extremely knowledgeable. I'm so happy I came and gave it one last shot. Having a life again and it's wonderful. Hope your journey is as successful as mine. UPDATE: Now, it's been over three and a half years, and I continue to be in remission. My best advice is you must follow the protocol. **C, Scottsdale, AZ.**

During menopause, I had a terrible vaginal odor that lasted for two years. It was an extremely embarrassing problem. When I would go to work, my coworkers noticed and made nasty comments about it. Dr. Fowler started me on compounded vaginal estrogen tablets and hydrocortisone cream. Slowly, the odor went away. The most difficult thing about the treatment was that it took time. But, alas, vaginal odor is **100% gone**. **P. Peoria, AZ**

I had vulvodynia for 8 years prior to seeing Dr. Fowler. The vulvodynia was so bad that on some days, I could not wear pants or sit for prolonged periods of time. It interfered with all aspects of my life. I had been to many doctors in many states before finding Dr. Fowler. Dr. Fowler **gave me my life back**. At my one-year follow- up appointment, **80% of my pain is gone**. I no longer think about it all of the time. I know if I stick with Dr. Fowler's regimen, I will continue to get better!

UPDATE: I have continued to improve every year with Dr. Fowler's treatment. At this point, I would say **I am 95% better** and continuing to improve. Dr. Fowler's treatment has been such a

lifesaver for me. I am now at the point where vulvodynia does not interfere with my everyday activities. I don't know what I would have done without him! **K. Cincinnati, Ohio.**

After years of having a cracking and splitting vaginal area and 10 years of abstaining from intercourse, I am pleased to say things are almost completely back to normal. This happened one year after a visit to Dr. Fowler. A niece of mine, who also sees Dr.Fowler told me about her success and encouraged me to make an appointment. So glad I did! T. Aurora, CO. I went to the Gynecology Department at Mayo Clinic, and they felt that the best Dr. to treat me for this rare disease was Dr. Fowler. I went to Dr. Fowler in tremendous pain and confusion, needing answers. Dr. Fowler explained to me what my problem was and how he was going to help me. After just 4 months of following the protocol that he devised for my problem, I was relieved of all my symptoms! **I'm cured** of vulvodynia. Also, my LS is now suppressed and not active. I can't say how grateful I am for having gone to a doctor that has the expertise of Dr. Fowler. **B. Scottsdale, AZ**

I had a dream to have children with the love of my life, who I was with for 10 years. I had so many medical procedures, including in vitro, etc. Finally, my dream came true. I had my twin boys! I was breastfeeding for thirteen months, and then my nightmare began. I started feeling itching and burning with vaginal discharge, and there was no doctor in Phoenix who could even put the right diagnosis on my condition. It took me another 10 years to find D. Fowler, and all the while, I was living in hell. My happiness, my love towards my husband, my children, my friends, and even myself got ripped away by the misery that I had to suffer day in and day out with no hope for me. Everything changed when my gynecologist sent me to Dr. Fowler. It took us 2 years to get **things back to normal**, but **I have my life back now**. Dr. Fowler did for me what my own mother did. He gave me life. He saved me and my family! I will be thankful for his help until the day I die. **N. Scottsdale, AZ**

I started having constant yeast infections last year and spent 8 months just completely miserable. I went to many different doctors trying to get help, and they all seemed baffled. I watch two of them google my symptoms, trying to figure out what to do with me. I had yeast infections that felt like they never really went away. The meds I was prescribed didn't help. Monistat didn't help. I felt itchiness and burning down there constantly. It hurt so bad I got to the point where I only left my house when I absolutely had to. I was so discouraged and wished I could go back to the days when I hardly gave my vagina a second thought! Finally, I got on Google and looked for specialists for vaginal problems and found Dr. Fowler. I've been following his treatment for around 5 months now, and I am feeling **95% better!** He has literally changed my life. Now I can walk the mail, chase my kids around, and work without worrying that it will aggravate the condition or hurt down there! **M. Gilbert, AZ**

I kept having the same symptoms recurring after intercourse, that being odor, discharge, and some pain. I would see my gynecologist, and they would prescribe me medication for bacterial vaginitis, and the symptoms always came back after intercourse. I found a new gynecologist who suggested removing my IUD, but that also did not work. I could not find any relief, so I started

searching the internet for specialists and found Dr Fowler in Arizona online. I have now been seeing him for 4 years, and I am **nearly symptom-free.** I can live normally, which didn't seem possible 4 years ago. I haven't been happier or more comfortable in a very long time. **C. Dallas, TX**

Hello! My name is Seline. When I turned 22 years old, I found myself feeling distraught with unbearable pain. This pain was on the outside and inside of my vagina. I was unable to wear underwear or jeans due to this pain. I was not able to sit down for long periods of time or have sexual intercourse. When I did attempt to have sex, it felt like glass shards were stabbing me. I tried to find an answer with my local gynecologists, but they were never able to pinpoint what was causing my pain. For many months, my gynecologist would diagnose me with yeast infections, but I never felt any relief from this ongoing pain. In the end, they all ended up saying that the pain was neurological. They even ran a test to check my hormones, but they all came out normal. They prescribed me antidepressants that did nothing to help with the pain. I was extremely desperate to find any type of relief, so I went onto a medical forum where I explained my pain and a lady told me I had vulvodynia. After hearing this term for the first time, I found a forum on Facebook called Vulvodynia Support, where I found Dr. Fowler. After coming to see Dr. Fowler and starting his protocol, I instantly found relief and started to feel myself again. It took about a year and a half to **completely feel normal**. Now, I'm able to do all the things I wasn't able to do before, thanks to the help of Dr. Fowler. I highly recommend coming to see him. He changed my life. **S. Edinburg, Tx**

I was referred to Dr. Fowler by my gynecologist after she ran out of treatment options for me. I was on antibiotics, metro gel, and others, and nothing was working for almost 2-3 months. Every test came back that I had a bacterial infection. I was in so much vulvar and vaginal pain constantly. I had just gotten married to my husband, and we were unable to have intercourse for over 6 months due to the pain. After just a few months of the regimen and treatment from Dr. Fowler, I was significantly better and able to be with my husband finally. It took about a year and a half, and now I am **almost completely symptom-free!** My quality of life is so much better now, and I finally feel like a normal person again. Everything was so worth it, and I am so so grateful! **A. Palm Springs, CA.**

Married at a young age and only having one sexual partner, I didn't realize that the intimate life I shared with my husband was supposed to be any different than it was. For ten years, I had chronic yeast infections and pain with intercourse without exception. After ten years, I was finally referred to a vaginal specialist who treated me for Vulvar pain. I went through lots of variety in treatments, including creams, shots, and a partial vulvectomy. It was then discovered that my diagnosis was Lichen Planus. I had success with the surgery until the one-year mark, and all the terrible symptoms I had previously had were back. Through prayer and the help of my general OB, we found Dr. Fowler. After reading through the website in its entirety, I had complete peace knowing this was the right place to seek out some answers. After our initial meeting, I was overwhelmed with his knowledge and understanding of the process I had previously been through. Within two months of starting the new medical treatment plan with Dr.

Fowler, I was not only optimistic about the upcoming months but **feeling incredible**. After six months, I was having intercourse that I never dreamed possible. My husband and I have four beautiful boys and a healthy, vibrant, intimate life thanks to the direction of those at Fowler Gyn International. **D. Glendale, AZ**

I started seeing Dr. Fowler 1 year ago. I had been doctoring for 6 months with Bacterial Vaginosis and Yeast. The symptoms never went away: constant burning and irritation. The infections made me uncomfortable enough at times that I don't attend HS basketball games, which I love to go and watch, and I just really don't feel like going anywhere or doing anything. I searched the internet, and I finally found Dr. Fowler. I hope he can help me. I started using the products for sensitive skin about a month before I saw Dr. Fowler. I felt much better just by using those products alone. After 6 months, I was **95% better**. I am able to go and do the things I enjoy without discomfort. I even started work outside the home, which I never would have been able to do before starting my treatment. I am so thankful that my life is back to normal! **D. Carson, ND**

I had been dealing with what was being diagnosed as recurrent BV infections for approximately 7 years, with the longest lasting 9 months before one of my pregnancies. I was put on antibiotic after antibiotic to treat the infection, and oftentimes, they would not heal. I dealt with extreme itching, burning, swelling, and discomfort for months on end, affecting every avenue of my life, from my marriage to my activity level. Not to mention the havoc being on antibiotics that much had on my health and gut. Finally, after a 5 month long infection and no improvement with the antibiotics being used, I was referred by my PA to Dr. Fowler in Phoenix. Dr. Fowler was able to diagnose the true issue behind my symptoms and put me on a protocol to begin to heal my body. 4 months into my program, I had a 60% improvement in my labs. Following a surprise pregnancy, soon after that, I halted my treatment, and during pregnancy, I was fully better. At 4 weeks postpartum, I started to feel some symptoms returning. I did what Dr. Fowler had recommended, resuming the protocol. Now, 4 months later, my **symptoms are basically nonexistent**. Dr. Fowler has given me the knowledge and tools needed to help my body heal and take **my life back**. I am very thankful for the referral to his office and for his knowledge. The staff is very helpful, and although I live in a different state and it is harder to get to see them, they are very good about returning messages and making phone calls to answer questions I may have. **K. Burley, ID.**

UPDATE: Now, after 15 months **100% better,** with no symptoms of burning or symptoms from my LS. Feel normal again and not worrying about the issue every day. Thanks to Dr. Fowler for **giving me my life back!** Life is too short to be miserable. Make an appointment today! **B. Gold Canyon, AZ**

When I initially came to see Dr Fowler, I had spent over 5 years seeing multiple physicians, including urologists and gynecologists, for what presented as reoccurring bladder infections with frequency, urgency, and pain during intercourse. This was extremely frustrating as I was continually informed there was nothing wrong with my bladder, and my vaginal exams came back as normal; however, I was still experiencing a good deal of pain. A recommendation from a

colleague from Alberta, Canada, who had visited Dr Fowler and had experienced significant improvement, sent me to Phoenix to see him. It was such a relief after my exam that Dr Fowler finally had an answer for what had been causing my symptoms and pain over these many years. He was very kind and took the time to explain all the details of my condition, along with providing a detailed course of action. After 5 months, I am so very happy that I have seen upwards of **80% improvement** in regards to my bladder issues and pain surrounding intercourse. I highly recommend any woman with similar issues to book an appointment with Dr Fowler. It will truly change your life! **T. Vancouver, BC.**

UPDATE: I just finished my fourth appointment with Dr. Fowler in almost 3 years. I am **literally 100% better** from when I came to see Dr. Fowler the first time. When I first came to see him, I had such bad pain for over 6 months that I had stopped wearing underwear and pants. I was concerned about my future with a potential partner (single at the time) and couldn't fathom ever having intercourse again, although I, of course, wanted to. Now, I am in a wonderful, loving relationship with an amazingly great sex life and lots of intimacy. I had never been too excited about intercourse with other relationships because it was always partially painful and not enjoyable enough. I am able to have intercourse every day if we desire. I am open with my partner, and he is totally accepting of my past pain and so thankful that we are able to have such a passionate and loving relationship. I have had my life completely saved and changed by Dr. Fowler. I am no longer scared about childbirth. I am sexually active with my partner because I want to be, not because I feel I have to be. I am so happy and so grateful and feel very blessed to have found him. I suggest following his protocol at 100%, not partially, but perfectly, **to feel 100% better**. I also suggest proper follow-up with Dr. Fowler to ensure you can become 100% better, as I feel so grateful for these follow-up appointments, based on how amazing my vulvovaginal health has become. H. Edmonton, Alberta, Canada For over 3 years, I had been having so much pain, from burning to itching to painful intercourse. It was horrible. I went to so many different Gynecologists/OBGYNs looking for answers & nobody could figure it out. It is such a blessing that I found Dr. Fowler. My mother-in-law actually was experiencing the same problems & she found Dr. Fowler & referred me to him! Thankfully, after just 4 short months, I am feeling 60-70% better! After just 2 weeks of using the medication that Dr. Fowler prescribed me, I was already noticing a huge difference! I would highly recommend coming to see Dr. Fowler if you are experiencing this pain & can't find any answers! **J. Queen Creek, AZ**

I have been seeing Dr. Fowler for more than 8 years now. He has helped me with pain, itching, dryness, etc. I went to multiple doctors before finding him at the Mayo Clinic. I never had such a comprehensive exam. All the other doctors gave me messy creams and uncomfortable rings to use. Dr. Fowler really looks at the individual concerns of each patient. Care is customized and adjusted accordingly for each person's body chemistry. I have had much success with his treatments. My vulvodynia has been **100% better** now for years. I highly recommend his care. The years of bacterial infections, etc, are over. If you have been suffering, see him. **V. Mesa, Az**

Dr. Fowler's **protocol gave me my life back**! I suffered from vaginal rawness, burning, and pain for about three years, for which I saw over five specialists, including doctors at Mayo Clinic in

Rochester, MN. I was "diagnosed" with IC, vulvodynia, vaginitis, and other vague disorders that didn't really have a cure. After feeling hopeless, a therapist who counseled women dealing with these issues gave me Dr. Fowler's name. Within a few weeks of his recommended protocol, I began to feel a bit better. Within four months, I felt that I improved sixty percent. I no longer stay home from social events because of pain and depression. I am able to function and live my life thanks to Dr. Fowler and his expert treatment and care. He is kind, understanding, and extremely knowledgeable.Thanks again!

UPDATE: Two years later, I'm still **100 % free of pain** from vulvodynia and any symptoms from Lichen Sclerosus! The protocol is not as extensive as when I first started and is extremely easy to follow. I no longer give any thought to the pain that once held me back from life--it is a distant memory. I will always be grateful for Dr. Fowler's expertise and treatment! **L. Byron Center, MI**

The pain I was initially feeling was so disruptive to my life. I Had it for 5 years, and it was a 10/10. I would feel it off and on throughout the whole day. It was terrifying because I didn't know what was wrong or how to fix it. I found 2 through a vulvodynia FaceBook page. With Dr. Fowler's help for these 12 months, I've seen so much improvement in my daily functioning: I'm down to very little pain, I would say **80% healed,** and I can even wear my jeans again! **C. San Jose, CA**

Before I met Dr. Fowler, I was going through probably one of the worst experiences of my life. For about 18 months, I would get BV every single month the week after my period. It was a daily hassle of changing liners every hour with the amount of discharge I was having, and the odor was humiliating. It was a constant cycle of getting my period, causing BV, and getting antibiotics, which would then lead to a yeast infection. I knew I had to find someone who could truly help me. My gynecologist, whom I would see monthly, did not know what was causing my issues, so she was no help to me. After doing my research, I stumbled upon FGI's website, and I knew I had to meet Dr. Fowler and his team. I arrived at his office, where he was able to pinpoint what was going on with me specifically and how to change my hormonal levels. I can proudly say after only 3 months of being on the protocol, I am **symptom-free**. I have had ZERO issues and haven't had BV or any smell/ discharge. If you are struggling with any vaginal issues and are unable to get help from your gyno, PLEASE visit Dr. Fowler. He has changed my life for the better, and I know with his knowledge, he will be able to help you! **C. Scottsdale, AZ**

I have had issues for about 7 years of vaginal tearing, itching, constant reoccurring BV (Bacteria Vaginosis), and painful intercourse. I had been to a few Gynecologists, and all I would get was vaginal cream and antibiotics which only worked for about 2 months at best. I was so frustrated that I searched the web constantly until I came across Dr. Fowler's website and testimonies. I was impressed with what I read, and I booked an appointment. I came to Dr Fowler's office in Scottsdale Az and had my exam. Dr. Fowler discussed with me what was happening with my issues and put me on a regimen that was easy to adhere to. After about 2 months, I started feeling better and have not had any antibiotics since. It has been a year now, and **I feel normal now**,

with no itching, tearing, soreness, or pain with intercourse. I am now even more impressed that **I got my life back**. I would highly recommend Dr Fowler. **V. Phoenix, AZ**

Dr. Fowler has improved my quality of life dramatically. Prior to visiting his office, I had been experiencing what three different gynecologists had labeled "recurring vaginitis" and other bacterial infections, yeast infections, etc. My quality of life was really changing- every day, I lived in discomfort that did not seem to have a solution. Exercise, sex, and even daily living had become a painful struggle. I had been treated unsuccessfully with every cream, pill, and compound. You name it -for about two years before a new gynecologist recommended seeing Dr. Fowler. I was extremely nervous before my visit, but he really helped ease my worry with his calm, caring demeanor and genuine willingness to listen and WANT to help me feel better and get back to my life. I am now 3 months into the regimen he prescribed for me, and my symptoms have improved by about **80%.** I feel like I am FINALLY on the path to getting my life and my body back to normal again. I cannot recommend Dr. Fowler enough- there is absolutely NO ONE with his level of knowledge and expertise. Thank you for all you have done to help me feel like "me" again! **D. Surprise, Az**

Overall, I'm about 70% better. Things are a lot, lot better. Intercourse is so much better, not painful if I'm following all the protocols. Afterward, it can be a little sensitive for a day. I'm able to exercise, and the friction from my clothing is no longer irritating. The protocol was not hard to do, and the benefits were definitely worth it! I'm excited to **have my life back** and grateful to Dr Fowler for finding the causes of my discomfort and healing me when no one else could!"

Update: I've been following the program for 4 years now, with ongoing improvement and success! It's a way of life now, and I finally feel "normal" again. All areas of my life that had been affected are now better and **completely resolved.** I had lichen sclerosis and vulvodynia. There IS hope! There IS a way to get better! What a relief! My husband and I are both so grateful to Dr. Fowler and his commitment to solving this problem for us. **S. Scottsdale, AZ**

I was referred to Dr. Fowler for treatment of extremely painful intercourse and external irritation after traditional treatments failed. My discomfort was interfering with my intimate life as well as my pastime due to the pain. I had nearly completely returned to my pre-menopausal state of "normalcy" by the end of the initial 4 months of treatment and felt back to normal shortly thereafter. The best part is I remain **pain- free** three years later. I appreciate Dr. Fowler's willingness to listen to my concerns and create a treatment plan specifically designed for my particular needs. I highly recommend Dr Fowler and his staff for the utmost in care and treatment of female genital pain. **L. Jerome, ID.**

I am 60 years old and have been suffering from burning and pain for 5 years. I've seen 6 medical doctors who weren't familiar with my condition and didn't know how to help me. My gynecologist fired me. I had to sit in a tub of water each night to survive. I finally found a Dr. in Wichita that knew exactly what I had. Vulvodynia. He was the only one who knew the name of it. He tested my blood and prescribed oral troches with the 3 hormones I was lacking. I was finally able to enjoy sex again; however, I was still uncomfortable with burning, dryness, and

pain. I learned of Dr. Fowler online. I flew over in March to visit him. After only 4 months on protocol, I find myself enjoying sex more than I did in my 20s and 30s before this horrific condition found me. I go for hours, NOT thinking about my vagina. My first thoughts in the morning are of normal daily events as opposed to prior to Dr. Fowler. I would start gauging my pain and thinking about how I would comfort myself. Coconut oil slathered on 6 times a day, no panties, absolutely no jeans, and long car rides were out of the question. Thank you, Dr. Fowler! I've got my whole life back now. I think I am at **about 95%**, as I still have some burning and dryness when I am stressed out. So, I will continue with my protocol and keep going with Dr. Fowler!! Thanks again so much for being here for us ladies when we feel so misunderstood, helpless, and lost. **V. Westmoreland, KS.**

For 3 years, I had terrible itching and burning- I had seen 5 doctors, and no one could get to the bottom of my issue. It was impacting my overall quality of life, and I thought I would have to live with this issue forever. I found Dr. Fowler through an online search and immediately booked an appointment with him. I traveled from the East Coast to see him, and it was worth every penny! **I have my life back!! H. Charlotte, NC.**

Dr. Fowler was a Godsend for me in that I was referred and got in to see him quickly. His treatment, while extensive, made all the difference in the world, and right from the very start, I felt some relief. I followed the print-out pages he gave me religiously. It has taken eight months to reach my goal, but I'm finally there. **I'm 100% better.** I was referred by my gynecologist, and treatment has been easy, just constant attention to all the details, but it was well worth it to have relief from the burning irritation I was experiencing. I was constantly irritated, sore, burning, and dry. It was extremely uncomfortable to sit. So, if you're in the same boat I was in, please contact Dr. Fowler! J**. Phoenix, AZ.**

I researched my way to Dr. Fowler's offices several years ago when I'd almost given up on having a sex life with my husband. I'd been to other specialists who weren't able to assess and provide relief for my inflammatory vaginitis, contact vulvar dermatitis, and lichen sclerosis. Intercourse was painful during and after for days. That was then. Now, after two years of treatment at Fowler Gyn International, I am comfortable and symptom-free when following his protocols. My sex life has returned to normal- yay- without subsequent discomforts. I'm also able to ride my horses again, **free from fear or pain.** I am very glad I found Dr. Fowler and didn't listen to other gynecologists who said I didn't need to travel out of state to get my issues resolved- even after they had tried to treat me with no success. **B. Sacramento, CA.**

Over a year ago, I suddenly developed several symptoms: odor, discharge, itching, burning with urination, and abdominal discomfort. I saw at least ten doctors who diagnosed me with BV and sent me home with antibiotics, only for the symptoms to get worse and worse until I was at the point of feeling embarrassed to be around people at all because of the smell. I had pretty much stopped dating and became very depressed. None of the GYN specialists that I saw could offer me anything, and I was becoming more and more hopeless and uncomfortable, as well as fearing for my own health and what the consequences of remaining sick for so long would be. I found

Dr. Fowler online, and after doing some research and speaking to him on the phone for a consultation, I decided to fly from DC to Arizona to pay him a visit. Now, a year later, I am 80 percent better, with only slight discharge at this point, but the **discomfort and odor are 100 percent** gone! If it was not for this practice, my life would be very different. Now that the symptoms are manageable, I can work on my own health and nutrition, which is also having a huge effect on my symptoms. I don't mind the trip out to Arizona once a year either, as his office is in one of my favorite places on Earth! If anyone else is suffering like I was, you should take the risk on this, even if it seems odd, because you and your health are worth it!!! **L. Silver Springs, MD**.

I am so incredibly grateful to have found Dr. Fowler! I had suffered with recurring Bladder infections, UTIs, and overall vaginal pain for over 16 years. After seeing Dr. Fowler and using his protocols, I noticed a significant improvement within just two months. It has now been 1 year, and I have been **free from pain** and without any infection for 8 months now!! For those who know how all-consuming the pain is, I can truly say this is a God-send. I can live my life and genuinely focus on what matters most to me without the distraction of pain and ill health. Don't wait any longer! See Dr. Fowler and begin your path to LIFE! **M. Twin Falls ID**.

I came to see Dr. Fowler in October of 2017 after suffering from vaginal pain/irritation for a total of 7 ongoing months as a result of being wrongly prescribed an anti-fungal from my medical doctor. After seeing my local gynecologist multiple times with no relief, I was blessed to find Dr. Fowler through an online search done by a concerned sibling. Dr. Fowler did the proper testing to help me understand the cause of my pain, and I started seeing symptom relief within 4-6 weeks of his protocol. It has taken about 12 months to see the **90% improvement** today, and I am extremely grateful. It was well worth the wait to correct the underlying disturbances, and if you are suffering from vaginal problems, please do not hesitate to make an appointment. The staff was very friendly, and scheduling was very easy. Thank you, Dr. Fowler, for all of your help. **A. Oak Lawn, IL**

Dr. Fowler has helped me achieve comfort again by following his protocol. I was suffering from itchy, raw, and burning for 2 years. I saw three providers, and the 3rd at Mayo Clinic referred me to Dr. Fowler. After 8 months, I am **80 percent healed** and have to remind myself to stay true to his regiment. Overall, I would recommend him to any female who is having issues that make her want to scream. He fixed me right up. I highly recommend him. **L. Tuscon, AZ**

My 18-year-old daughter was diagnosed with vulvodynia and complained of severe pain when areas of her vagina were touched by her clothes. She was unable to wear jeans or other button/ zipper pants, nor was she able to wear a tampon. My Gynecologist referred us to Dr. Fowler, and with his specialized protocol, she has made a **full recovery** in about 16 months' time. She is so happy to be able to live a normal life and wear whatever she wants and is now able to use a tampon without being in pain. I would recommend Dr. Fowler to anyone who is experiencing vulvodynia. **W. Scottsdale, AZ**

About 3 years ago, I started having chronic burning and irritation in my vaginal area. This caused so much chaos in my life. I was unable to have much intercourse with my newlywed husband, exercise, and was in constant pain throughout the day. After seeking help from multiple providers, I was finally diagnosed with Vulvodynia. I tried looking for different ways to improve, but as anyone with this condition knows, treatment is tricky and not always successful. I first heard about Dr. Fowler through a Facebook support group. After months of trying more conventional treatments with little improvement, I decided to take the punch and schedule an appointment. That was in October of 2017, exactly a year ago. By far, it's been one of the best decisions I've ever made. Today, I am feeling about **80% better.** So much so that for this year's appointment, my husband and I will be doing a 10-mile/3-day hike into Havasupai Falls in the Grand Canyon! We are using this appointment as an excuse to travel and get this crossed off our bucket list. Last year, I wouldn't have even considered making a day trip with the horrible, unexpected, and unpredictable flares I would get. Dr. Fowler is a true blessing to women! **D. Austin, TX.**

When I first had vaginal issues, I saw several doctors who misdiagnosed my problem multiple times or claimed there was nothing abnormal after they performed tests on me. Finally, my gynecologist referred me to Dr. Fowler, who was able to diagnose the problem right away. I had to change my whole routine and the products I used on a daily basis. Although it took longer for me to respond than the average patient, and my therapy had to be adjusted slightly by Dr. Fowler a few times, I now am **feeling so much better**. Initially, I wasn't able to walk without being in pain, but now I can work out and do my normal activities with rare occurrences of irritation. I am so thankful for his help and the attention he gave me as a patient. He was always willing to answer my questions and talk about my concerns. I definitely recommend him for any woman having vaginal issues! **S. Tucson, AZ**

I found Dr. Fowler online after receiving a diagnosis of Lichen Sclerosis from my dermatologist. I was having itching, and paper cuts on my vulvar skin. Intercourse became painful. Also, I was having urinary tract infections one after another for 1yr. In about a year, Dr. Fowler's protocol has helped me not only overcome Lichen Sclerosis but also **stop the chronic UTIs** I had been getting. I have not had a single UTI since starting his treatment. I'm thankful every day!!! **K. Tucson, AZ**

I have been dealing with odor, discharge, and burning in my vulvovaginal area for decades. I have been to so many doctors I can't even count. Every doctor would do the standard test for vaginal infections, which would come out negative. It got to the point where I actually wondered if the symptoms were all in my head. For many years, I wore a full-sized pad all the time because the discharge and odor were so bad. It was terribly embarrassing. I hated having sex with my husband because I was so self-conscious about the odor. I finally got on Google and searched "Doctor vaginal odor Phoenix" and found Dr. Fowler. I read several testimonials on his website and thought I might actually have found a doctor who could help me. I first saw Dr. Fowler in February 2018. I left his office after that first visit with all the information I needed to fix the problem that had plagued me for thirty years. Seven months later, I am **85-90% better** and have

total confidence that in the next few months, I'll be 100% improved. I literally cannot express how happy this has made me; it has literally changed my entire outlook on life. **K. Chandler, AZ**

When I first met Dr. Fowler, I was a newlywed who couldn't have sex with my husband due to extreme pain. Having seen five different doctors over the past 10 months with no change in my symptoms, I was nervous during my first visit to FGI, but those nerves quickly went away after a few minutes. I could see that unlike my other doctors, who seemed unsure and not confident in the treatments they were prescribing me, Dr. Fowler's approach was based on sound evidence, and within 10 minutes, I got several pages describing exactly what was wrong with me and how to fix it. I had a diagnosis, and it felt great! A year later, after following Dr. Fowler's treatment protocol, I now have **control over my symptom**s, and **my life is back to normal.** I would recommend him to anyone struggling with the same symptoms. Thank you, Dr. Fowler! **J. Chicago, IL**

Dr. Fowler is the ONLY gynecologist I have seen who knew exactly how to treat my condition. I had symptoms of sticky, itchy, and very dry. I had seen my gynecologist in Las Vegas for 5 years, and she had no idea how to treat it. My husband searched online for a specialist. Since visiting Dr. Fowler, I have seen **significant improvement**. I do not know what I would do without Dr. Fowler. His staff is friendly and courteous, and it is always a pleasure to visit. **S. Las Vegas.**

When I presented with severe burning anally and vaginally in August 2017, I had no clue what was going on, and I truly thought I was going to die. I went to 16 different doctors before seeing no improvement. Some of them told me it was in my head. I found Dr. Fowler online. Eight and one-half months after my initial visit, I am feeling **70-80% better**. I am able to function much better, have resumed many activities I had completely ceased, and owe so much to the help I have been and continue to receive from Dr. Fowler. He has a unique approach to diagnosis that others do not have and personalizes the treatment for your individual condition. Coming to see Dr. Fowler for a situation I never imagined I would be in has been one of the best decisions I have ever made. **L. San Jose, CA**

Dr. Fowler's treatment and program are magical. I have been having issues with painful, unbearable sex for the last few years. I am 57 years old and truly did not want to give up on being sexually active. I had tried many doctors and nurses with absolutely no relief and no solution to my issue. The pain was becoming constant, so I started to search online. This is how I found Dr. Fowler, and I began to read the testimonials on his website, which many sounded similar to my own situation. It took me another few months to actually make my first appointment. Looking back, I believe it was because I was scared that there really would be no solution to my problem, and I did not want to face it. One doctor even suggested that I stop having sexual intercourse altogether. But one more romantic vacation with my husband that ended in tears sent me back to Dr. Fowler's website, and I set up my first appointment. What was truly magical was that when I began his treatment protocol and followed it faithfully that, within a couple of weeks, I actually started feeling better. I found hope. Now I'm **95% better**. Anyone who is considering his treatment protocol, I encourage you to not wait and to follow it faithfully

and not be discouraged. Keep to the system, and I believe you will find relief. After about five months, I was able to have sex without the pain, and what a joy and what a surprise I felt that it no longer hurt to be intimate. **S. Flagstaff, AZ**

In August of 2014, I developed severe vaginal burning, redness, and inflammation. My life became consumed by the pain. I saw half a dozen doctors, and no one could figure out what was wrong with me. After searching the internet, I stumbled across Dr. Fowler's website. My gut told me to make an appointment. I was terrified to fly across the country, but I trusted my gut. It was the best decision I ever made. After walking out of my first appointment, I finally had hope again. Within 4 months of starting Dr. Fowler's protocol, I was 60% better. Two years in, and I'm nearly **90% better.** The burning and redness are nearly resolved. This condition is hard to treat, and healing is not linear, but for the first time since developing this condition, I can function normally. I work out, wear what I want, and can be intimate with little worry. This wouldn't have been possible without Dr. Fowler. **K. Algonquin, IL.**

In April 2017, I first experienced a terrible outbreak of lichen sclerosis, and the pain that accompanied it was debilitating. At that time, I really didn't know what I had, but for seven months, I was miserable. The open wounds came and went. I saw my primary care doctor at a time when there was no outbreak, but I was having constant burning. She said everything looked healthy. She ran regular well-woman tests, and all were normal. I sought the opinion of a gynecologist, and I got the same result. Later, when I had full-blown open wounds, I returned to the gynecologist, who did a biopsy and prescribed Clobestol, and that was the extent of my treatment. I could not believe I was going to live in this terrible condition for the rest of my life. I already suffer from an autoimmune condition that has compromised my life, but this completely took away my ability to enjoy such basic things as walking, going to yoga, and even sitting comfortably in a chair. I was devastated. I have seen Dr. Fowler at Sottopelle, where I have received pellet hormone replacement therapy for many years. I remembered he also saw women for vulvovaginal conditions, so I came to see him in October 2017 for this problem. He quickly diagnosed me with inflammatory vaginitis and lichen sclerosis and put me on a detailed treatment regimen for both. I responded very quickly and, by March 2018, was **80% better**. I continue following the treatment carefully. I am thankful I didn't live with this for years before getting a resolution. **P. Phoenix, AZ**

It is with much sincerity that I recommend Dr. Fowler. I had vaginal burning, itching, and inflammation issues for 7 years, often misdiagnosed by doctors as a yeast infection (the prescription for which would ofttimes make the condition worse). It was very frustrating and, at its worst, making it difficult to sleep or walk or be intimate with my husband. I found Dr. Fowler by way of his website, booked an appointment, and he was able to precisely diagnose my issue immediately by way of his on-site lab and prescribe me the exact "protocol" and medicine to help me get free of this issue. Four months later, I was about **80 percent better** and can say the same thing today, over one year later. Most doctors unfortunately just do not have enough knowledge of this condition and frequently misdiagnose it or overlook or neglect it altogether, and what's great is that Dr. Fowler has devoted time and, effort, and talent to research vulvar

conditions and help so many of us by finding a protocol, that, if followed properly, can bring much needed healing. I am very thankful to him and his lovely assistant, Alice, and I thank God that (after I prayed to Him to heal me) he led me to Dr. Fowler's website for help. **S. Sherman Oaks, CA**

Dr. Fowler was recommended to me by my regular gynecologist after having terrible vaginal pain postpartum with my first child. He was very knowledgeable and explained everything very well with what was happening. I followed the protocol and had **relief from symptoms** within a couple of months. He and the staff were great, and I have recommended him to several of my friends having similar discomforts. **N. Mesa, AZ**

I woke up Dec 7, 2017, with extreme vaginal and bladder pain. I went to see both a Urologist and a Gynecologist in Portland. The urologist ended up giving me a piece of paper saying I have IC and sent me on my way, and the Gynecologist gave me lidocaine and some estrogen, which was extremely uncomfortable. In both cases, it looked like the outcome was going to be a lifetime of discomfort. My doctor in Portland referred me to Dr Fowler. She had several other patients who had seen Dr. Fowler and experienced excellent results. I came to Scottsdale with only hope. After examining me, Dr. Fowler told me what was wrong and gave me a specific protocol for healing. I followed his direction completely, and after 4 months, I am 75-80% better, and there are days when I feel no discomfort at all. I have seen many doctors over the last year due to health issues, and this was the first doctor I have seen who specifically diagnosed what was wrong and gave me a plan, and now I see significant improvement. I came to Scottsdale scared but hopeful. I know now I am in the right place. Thank you, doctor Fowler, for helping me. No words can tell you how much I appreciate what you have done for me. M. Lake Oswego, OR I struggled with chronic BV for over a year. I had heard of Dr. Fowler, but because I eat very clean, I thought I could get rid of it with diet and natural supplements. Everything I read said to give up wine and all sugars, which is extremely difficult to do. When the natural route didn't work, I contacted Dr. Fowler, and within four months of his protocol, I am **90 percent better** and am enjoying all the wine I want. Thank you Dr. Fowler for curing me and helping so many women. **M. Phoenix, AZ**

Update: I am so glad to be under treatment with Dr. Fowler. He is the only one I would rely on to get the correct diagnosis for my vulvodynia and to treat it. His protocol has changed my life and I am well on my way to being cured. Now at **80%** and climbing. Don't ever give up and definitely contact Dr. Fowler if you have this condition. He can make a difference. **T. Altaville, Ca.**

Thanks to Dr. Fowler for getting me on the road to recovery. I feel like I'm **70% bette**r in 4 months. Now I'm able to have sex. My life is so much better! **B. Gold Canyon, AZ**

Dr. Fowler's treatment plan has absolutely worked for me. I wish that all specialists would give their patients the amount of detailed information and protocols that Dr. Fowler gives his patients. I was losing hope before I found Dr. Fowler and was fretting that I would have to settle for a life with no exercise, no intercourse, no swimming, no jeans, and more. I had been to my local gynecologist for months and was then sent to an Infectious Disease doctor. I was put on

medications that didn't solve the underlying problem and caused other health complications. I was told that I would just have to battle chronic vaginal infections indefinitely. I refused to accept that and researched extensively to find answers. When I read about Dr. Fowler and what he specialized in, I knew his practice was where I needed to go. Today, I am **80% percent better** after four months of following his treatment plan. Dr. Fowler and I expect that I will reach 100%. To say I am grateful is an understatement. I am 35 years old and hopefully have many years of life left to live and I want to live them to the fullest. Being able to relieve my chronic pain and constant worry over my vagina has given me back a bundle of energy and my joyful spirit! **L. Dallas, TX**

Dr. Fowler has given me the best gift I could have...My life and health are back!! Within 2 weeks of his treatment I had no more pain, no burning! It is a miracle! If you are a woman suffering from severe pelvic pain please go see him. Your suffering can end! I suffered for 1.5 years before seeing him. I had severe acid-like burning pain, fissures, cracks, and fusing. I felt constant pain every day of my life and as a Mom of young children, I had to be healed. I went to multiple local doctors, OBYN's, Uro-gyn's, etc, and they could not help me. I am beyond thankful for Dr. Fowler and his amazing expertise and healing! Dr Fowler diagnosed me with Lichen Sclerous and DIV, and **symptoms resolved** in two weeks from starting his treatment. I know God led me to Dr. Fowler and I am so thankful to be on the path of full healing! **K. Seattle, WA**

I had experienced pelvic pain for going on three years when I found out about Dr. Fowler. My husband and I had stopped having sex for probably close to a year and a half as well. I never had it easy with my vagina since probably my first experience with sex and tampons. Early on there was intermittent pain and infections...Through my twenties I was diagnosed with UTI after UTI as well as yeast infections and BV. So, as you could imagine it was antibiotics central for a good portion of my twenties into my thirties. Those subsided and then the worse began. I would occasionally burn in my vulva area and occasionally I'd experience pain in what I now know is my vestibule. It was tolerable until about 4 years ago when we stopped having sex because the pain was consistent. Every time I inserted anything in my vagina I felt a horrible stabbing pain and sometimes it felt blocked. I saw several doctors, three physical therapists, and tried a chiropractor and acupuncture. I was constantly searching the internet for anything or anybody who was experiencing anything like me. It felt like my gynecologists weren't listening to the pain I was describing and there really weren't answers from them. I say gynecologists because I went to a few different ones trying to find someone who could help me. I would research and ask questions and they would prescribe or refer me to whatever I asked in regards to this because it was pretty clear to me they didn't know how to help me. I finally started searching Facebook using the words I'd been hearing doctors call what I had and from the research I'd been doing on my own, and that's how I found a group of FGI Prospective and Existing Clients. I had also run across Dr. Fowler's name through my searches on the internet, but it all seemed too good to be true. It was scary deciding to travel to Arizona and pay out of pocket to go see this doctor who says he can help. You become pretty skeptical about this because so many say that and nothing seems to help. Well, this is an honest and real testimonial and there is hope. **Dr. Fowler saved me!** His protocol has changed my whole world. It is non-invasive and with commitment and

patience, he knows this condition and can help. I saw him in May of 2017 and this is now Oct. 2017. I am almost 5 months complete, and I am **nearly pain-free** and able to have sex with my husband again. I still have healing to do and there are still bumps in the road, but I am so thankful to have found Dr. Fowler! Dr. Fowler's studies with pain in the vagina have given him years of experience and he's probably heard it all from a lot of desperate, in-pain women and he CAN help! Dr. Fowler has helped me feel whole again and his protocol has literally changed my world. I am so thankful to have taken the chance and have him as my doctor. THANK YOU Dr. Fowler from the bottom and top of my heart. **K. Spokane, WA**

I started having vaginal burning and irritation. I was going to see my doctor every month, sometimes twice a month always being told it was BV, yeast or both. I was tired of the constant doctor visits and after 6 months, decided I needed to see if anyone else was having these kinds of problems. While searching the internet, I found Dr. Fowler's website, ordered the Products for Sensitive Genital Skin and was scheduled to see him a month later. By the time I went to the visit I was **90% better!!** These products work! **D. Carson, ND**

This condition has greatly damaged my sex life and is straining my relationship with my partner. The discomfort and pain make it difficult to focus at work and drain my energy making leisure activities less frequent. Since starting Dr. Fowler's protocol a year ago, I have been able to enjoy life again. I **no longer experience pain** with intercourse and have begun taking part in the things that make my life enjoyable again. Thank you, Dr. Fowler! **S. Denver, CO**

Before I found Dr. Fowler, I was suffering from awful burning, pain, and inflammation. I did not know what was wrong with me. I saw more than 7 different doctors who all told me nothing was wrong. It was the worst pain in my life and affected my quality of living. Finally one of my gynos recommended Dr. Fowler. He was my last resort. Dr. Fowler was the only one to finally diagnose me. I have been seeing him for over a year and feel I'm about **80% better**. I do not have the pain I once did. I would highly recommend him if you are having unexplained vaginal pain. He can make a difference in your life. **L. Gilbert, AZ**

I had been having problems for many years. I decided to see Dr. Fowler because my issue was making it hard to get ready and go to work, my sex life was extremely diminished, and even exercising and shopping were difficult to do at times. Though a lengthy process, Dr. Fowler has provided me with small lifestyle changes and medicine for the vagina that have me feeling about **80% - 90% better** at this point. I wish I hadn't had to wait so long to make my initial appointment. **K. Buckeye, AZ**

I'm so thankful to find D. Fowler. I've suffered for 10 years having symptoms intermittently of burning, soreness and pain in the vulva. I couldn't do anything physical; even walking was difficult. It took a full year and after 2 vestibulectomies with other providers and numerous creams to finally find Dr. Fowler. I was referred to Dr. Fowler by a gynecologist at Mayo Clinic. Now I have had a year of fine- tuning with his treatments, but finally, **I am "normal" again.** I'm able to exercise, work and enjoy life. I feel so blessed and thankful for his expertise. **T. Sun Lakes, AZ.**

For 6 months I had frequent visits to my OB/GYN for symptoms of irritation, itching and burning that were interfering with my daily activities and quality of life. I was diagnosed with BV and yeast infections on multiple visits, but the treatment never left me with sustained relief. My OB/GYN referred me to Dr. Fowler. It was a relief to be seen by Dr. Fowler and receive an accurate diagnosis and treatment plan. After following my protocol for the past 4 months I'm **90% better** and no longer experience frequent irritation and itching or burning. **C. Mesa, AZ**

I have suffered from vulvodynia/altered vaginal microflora for over 20 years. I saw vulvar specialists in Arizona for over 15 years with no permanent results. I continued to have re-current problems that were very painful and miserable. I did a lot of research online, trying to find a doctor that could treat my problem with results. I found Dr. Fowler's name, read his patient reviews, and it sounded like he was someone that could fix my condition. I tried to contact the office and they have a very unconventional way of scheduling an office visit so I was skeptical. However, since I was desperate for a cure I continued through the online process of registering to become a patient. I was seen by Dr. Fowler in November of 2017 and got on his personalized program. It is unlike any other specialist I have ever been treated by in the past. I finally felt relief for the first time in many years. After 4 months of being on his protocol, I would say I am about **70% better** so far. I plan to continue using his specialized treatment indefinitely. He is a lifesaver. I had all but given up on finding a cure, but his treatment has worked for me when no other specialist in Arizona could find a cure. The other providers only treated the symptoms; Dr. Fowler treated the underlying cause and condition. **C. Mesa, AZ**

Dr. Fowler has completely changed my life. I came to see him about 3 years ago after seeing 7 other doctors about vaginal burning. All tests from other doctors came back negative for any kind of infection. I was in so much pain, and I was so sad to feel like no one was listening to me! Then I found Dr. Fowler. He was so kind on the phone with me; he listened, and he said he could help me. For seven months I lived in pain and was sitting on ice packs to ease it. After coming to his office, **I had my life back! No more pain**, no more discharge! I was doing so well I went off the protocol thinking I would be fine. For two and one-half years I did great. Then, about two months ago, I was told I had a bladder infection and was put on antibiotics. About five days later, I started feeling an unbelievable burning again and returned to the ice packs. I got online and scheduled a time to see Dr. Fowler again. The antibiotics caused me to relapse because I had not been following Dr. Fowler's protocol. I can tell you that won't happen again! I'm back on board and so very grateful for this amazing doctor! THANK YOU FROM MY HEART! **S. Tucson, AZ**

Testimony update: Dr. Fowler has **given me my life back.** After just over one year with him I have seen a **complete resolution in my symptoms**. 8 years of recurrent infections and vulvovaginal symptoms and I have not had a single vaginal infection in 12 months. I can't describe what a weight has been lifted. I used to wake up with a vaginal infection every single time I had intercourse because my tissue was so irritated. I can now experience pain free intercourse. I no longer have to worry about struggling with constant yeast infections and chronic redness and pain. I can honestly say his protocol works. I know countless women who also suffer from chronic and recurrent vaginal pain and irritation in Canada and the US. Dr. Fowler and his

clinic in Arizona are the professionals you NEED to see. Trust in his diagnosis, trust in his process and when anyone asks if I would recommend Dr. Fowler one thousand times the answer is YES. **K. Vancouver, BC.**

I am happy to say Dr. Fowler has **helped me get my life back**. I had terrible burning and pain with intercourse. After eight years of dealing with this, I had to do something. I went to countless doctors and was put on all kinds of medication that only masked the problem. I believe in God and know he directed me to Dr. Fowler as I found him on the internet. He is caring and knowledgeable about this condition, and his protocol gets results. I am so grateful that I came and will stay under his care. I had two different specialists try and help but only pushed meds. I am very thankful I found Dr. Fowler. **R. Alfred Station, NY**

Really glad I found Dr Fowler. I was able to make an appointment quickly and he called to schedule me himself. Very personable. He has his own lab equipment in his office and was able to give me a diagnosis quickly and start a treatment schedule. I had vulvodynia due to low estrogen and noninflammatory vaginosis that was giving me chronic yeast infections. It was giving me itching and burning, which was worse with intercourse so I was avoiding it. He informed me of things my regular gyn did not, and I felt relief once I started his protocol. At first the protocol seemed overwhelming but it turned out to not be so difficult to follow. I've just been on treatment for 4 months and **I'm 100% free of symptoms**. I would highly recommend giving him a call. **D. Mesa, AZ**

For about 5 years I was suffering from extreme pain in my vaginal area and I went to specialist after specialist and kept getting diagnosed with yeast infections, and lichen sclerosis and then finally was told it was all in my head. I was at the end of my rope and just kept hoping I could find someone to help me. One night I typed in "feeling like I have glass in my vagina" and a women's testimony popped up and when I read it I felt like I could have written it myself. The testimony was on Dr. Fowler's website and she said he was the only one who could help her. So I made a decision to call and after speaking with Dr. Fowler on the phone I hung up the phone and cried for a half hour as for the first time in the last 5 years someone offered me hope. The one thing that he said to me that I will never forget is "Don't give up, there is hope" a statement so small but it was a stepping stool statement in my journey of recovery both physically and mentally. It's now been 14 months since my first visit and I'm **90% better.** I can sit at work, play sports and do everything I want to do that I was unable to do before. I highly recommend to anyone from anywhere that you make that first step and call as it could change your life as it did mine. **J. Hamilton Ontario, Canada.**

I had been dealing with burning and itching for 2 years when I found Dr. Fowler by searching my symptoms online. Several gynecologists and Urgent Care physicians diagnosed me with Bacterial Vaginosis and I would take multiple rounds of antibiotics with no relief. After I found Dr. Fowler, I got the correct diagnosis (non- inflammatory vaginosis) and began his regimen. As a result, **I'm 90% cured** at 4 months and know I will reach 100% by continuing his plan for me. He is a lifesaver. I was miserable. **C. Scottsdale, AZ.**

I cannot emphasize enough how drastically Dr. Fowler has changed my life. I had been suffering from extreme burning and itching for over 2 years. My gynecologist had prescribed all kinds of different treatments, and nothing had any effect whatsoever. She recommended that I see Dr. Fowler, and I actually put it off because I thought I was beyond help and would suffer with this for the rest of my life. It's been 5 months now since my first visit and I'm **almost symptom-free!** There have been a couple of ups and downs but the downs have become more infrequent and according to Dr. Fowler, they'll be gone soon. It's very important to do everything he tells you to do. I've gotten used to the protocol and it's just part of my life now. Overall I'm 90% better. I don't even think about it. If you're suffering at all, please don't hesitate to see Dr. Fowler. **J. Scottsdale, AZ**

Before finding Dr. Fowler, I had been going to or calling the Gynecologist almost every other week for about two years. I was getting yeast infections continuously. I would have sex and be in pain. Sometimes it lasted for days after sex. Just when I thought I was getting better I would experience more problems. I could not get rid of this on going issue and it was frustrating. My gynecologist tried all that she could and finally gave me Dr. Fowlers card and said that she felt it was time for me to see him. I was hesitant and read a lot of testimonials and googled his background before making an appointment. Dr. Fowler and his staff have made me feel very comfortable despite the pain. It was too the point that my relationship was struggling and I was worried that it would be something very serious. Dr. Fowler gave me a regimen to use. I created a 4 months calendar and followed it! I began to fee changes within the first month! I just finished up my 4 month follow up and feel **almost back to normal.** If you are experiencing any issues that you feel Dr Fowler is able to treat, I can tell you first hand that it is worth it. **R. Gilbert, AZ**

Coming to see Dr. Fowler has totally changed my life! I was ready to try some very radical things do to my pain level but fortunately did not do some of the surgeries that had ended in a nightmare for so many other woman I know! After suffering for 15 years with vaginal burning, I am now close to **80% healed** and **have my life back!** I can't thank Dr. Fowler and his staff enough for their care, professionalism and protocol to help woman live a full and healthy life. **O. Albuquerque, NM**

For seven years I suffered the loss of my femininity and sexual intimacy. I spent many thousands of dollars on numerous physicians, medications and alternative treatments. Every physician diagnosed me with yeast infections or bacterial vaginosis. My symptoms were vaginal itching, severe burning and rawness both internally and externally during and after intercourse. My symptoms were always worse and seemed to be brought on by even the mildest intercourse. I missed time with my husband and months would go by without intimacy because of my pain. Just when I thought the symptoms had resolved and we resumed intercourse, my symptoms and pain would start over again. I found myself in tears for both my husband, myself and our relationship. I had been prescribed creams, borax treatments, homeopathic pills and numerous other treatments. My wonderful husband was always very supportive and understanding, but my self confidence was shattered internally. I felt self conscious and embarrassed during times of intimacy and was always concerned about odor when going out in public, although bathing was a

daily task. I became very depressed and desperate to find a cure for my issue. I combed the internet for a glimmer of hope and finally located Dr. Fowler. I was initially skeptical as I had seen at least eight physicians, all with the same diagnosis and treatments. Prepared to give it one final attempt, I contacted and made my first appointment with Dr. Fowler. In January 2017, I made the trip from Tennessee to Arizona with cautious excitement. Upon arrival, Dr. Fowler was quite familiar with my case due to his thorough questionnaire from my online registration. After completing my examination and testing, he explained the results in extensive detail, both verbally and with written information. For the first time in seven years, I finally had answers that made sense! I felt hopeful and excited to begin my course of treatment. After four months of treatment, I was getting results as expected as explained by Dr. Fowler. He had me continue my course of treatment with a few minor changes. At the six month mark, I had to undergo a partial hysterectomy. I contacted Dr. Fowler to explain and he returned my call personally to discuss my treatment in conjunction with the surgery. Each time I have contacted his office, he has always contacted me personally which I find to be extraordinary service. As of 11/29/17, during my tenth month of treatment, I am **almost symptom free!** I no longer suffer from odor, burning or itching and have resumed normal intercourse! I will continue my treatment until my follow up in January 2018. If anyone else has suffered the symptoms I have described, I encourage you to reach out to Dr. Fowler. As he explained, this area of gynecology is not well understood in the mainstream. It is an area of specialty and most general gynecologists are only trained in the basics of vaginal disorders. When I had lost all hope, **Dr. Fowler changed my life**. I pray he can yours as well. **B. Lebanon, TN**

Over a period of three years, I saw several physicians and tried a variety of treatments for what Dr. Fowler later diagnosed as Inflammatory Vaginitis. I reconnected with Stuart aka Dr. Fowler at our 40-year high school reunion. Even back in high school, Stuart was bright, driven and had a great sense of humor. I knew he would go on to do important things but never did I think that he would help me one day in such a significant way. I had heard him speak years earlier on Hormone Replacement Therapy and asked if he was still doing that. He told me about the years he had been at Mayo Clinic and that he had narrowed his research and work to studying the vagina and various diseases related to it. It was just what I needed to hear! I made an appointment and 9 months later I feel **90% better**. I'm back to doing all of my usual activities including intercourse with little discomfort. **D. Salt Lake City, UT**

When I first made an appointment with Dr. Fowler, I was suffering from frequent bouts of vaginal pain and discomfort for four years; unable to be sexually active, wear jeans, and use a tampon. Any exposure to bath products left me in pain and emotional turmoil. I had seen multiple doctors with minimal results and had almost given up hope when I found out about Dr. Fowler from a Facebook support group. I decided to take the plunge after hearing the success stories of his other patients! It turned out to be a tricky case with a particularly resistant vagina. However Dr Fowler provided encouragement and was very patient, tailoring the treatment protocol. With his help, I slowly **got my symptoms under control** and **got my life back!** I am very pleased with Dr Fowler's level of expertise, persistence and patience in treating this condition. **C. Chicago, IL**

I thought I was going to have to live with my condition forever, and then I found Dr. Fowler who **gave me my life back**...So let me start from the beginning (four years ago). For about four years, with increasing severity I was experiencing chronic yeast infections, and bacterial infections, and I was extremely sensitive to anything touching my vaginal region. I was getting at least one yeast infection per month sometimes multiple, and the bacterial infection truly never went away. Things got to the point where I no longer wanted to be intimate with my husband because I was self-conscious of the "fishy" odor, yeast secretions, and itching that would disrupt my sleep. It made exercise uncomfortable, and no matter what I did I could smell my own odor which made me think others around me could smell it as well. I saw over four different gynecologists and multiple doctors and all of them treated the symptoms, but never were able to explain why my condition was constantly coming back. I changed my diet, switched to only cotton panties, wore loose fitting clothing, spent hundreds on probiotics, tried homeopathic remedies and absolutely nothing worked. I knew there was an underlying reason for what was happening to me, but no one was able to give me an explanation, let alone advise if I could truly be healed. I became very depressed, was miserable, and had all about lost hope for myself and felt so awful for my husband who never once complained. So I tried one last thing, which was to turn to Google and start researching my condition to see if there was a specialist who could possibly treat me. I was desperate and was willing to fly anywhere in the world if that meant I could be treated. That was when I found Dr. Fowler after months of dogged research. I flew to see him in January 2017 and he not only told me what I had but that I would be healed. Now in January 2018 I feeling I am about **80% better** and will soon me at 100%. Dr. Fowler restored my hope, **gave me my life back,** and I am forever thankful for him. **T. Redlands, CA**

My life was totally compromised due to my symptoms. For a year I went to many doctors searching for someone who could help me, with no success. No one could tell me what was going on. Desperate for an answer I searched across the internet for a solution. That is when I stumbled upon the Fowler Gyn International website. After seeing Dr. Fowler only one time and being put on the protocol I was about 80- 90% better in about 6 months. I finally **got my life back.** I was consumed by the vaginal pain and discomfort before seeing Dr. Fowler. The smallest everyday tasks were dreadful. The burning, itching, and inflammation were so bad walking around became something I tried to avoid unless I absolutely had to. Now I **hardly have any discomfort** and if I do it is so minor in comparison to what was going on before that it does not consume my every thought. I wouldn't have been able to get my health back had I not seen Dr. Fowler. **B. Yuba City, CA**

Six months after having a D&C with ablation I began to have severe vaginal pain, burning and tightness. The pain was so severe that I could not even wear underwear or pants. I saw doctor after doctor, acupuncturists, allergists, and dermatologists, and even had biopsies and MRIs. No one could offer any help other than medicating with anti-depressants and eventually they all gave up on me. I cried almost every day for an entire year before I started my search for help online. I came across Dr. Fowler's website and after discussing it with my husband we decided to take the leap and make the call. After talking with Dr. Fowler who stated he thought he could help me, we booked our flight and made the trip. The first year was still a struggle and was slow progress but

Dr. Fowler never gave up and encouraged me not to give up as well. After one year of treatment and a slight change in the base of my compound, within two months I saw a significant improvement. I have been on his protocol for two years now and it **has changed my life.** I have improved by **90 - 95%** since I began this horrible journey. I still have some slight nerve pain but it is very minimal. Dr. Fowler and Alice are my guardian angels and I cannot thank them enough!
**M. St Petersburg, FL**

I have had Vulvodynia for 6 and a half years now. I went in for a pap and explained my pain. They said my results were perfect and there was no reason to be having pain. The pain continued to get worse to the point where not only sex hurt but also just sitting in a chair for more than a few minutes was excruciating. I finally told my boyfriend at the time and my mom. They encouraged me to go to a new doctor. This doctor said the same thing: everything was normal, and I maybe just needed to wash better. Another 6 months passed, and my mom then took it upon herself to take me to a doctor who she really respected. When she looked again, I got that I looked perfectly fine. I told her I was engaged and would like to be able to have sex on my wedding night or at least be able to enjoy sitting at my wedding. She told me to "have a couple of glasses of wine." I then took a trip to Miami to visit another doctor who was a family friend. She put me on an estrogen cream which did nothing. After almost 2 years I was told it was all in my head so many times that I started trying to convince myself of that. My mom wasn't willing to accept that. She finally googled and found the word "Vulvodynia." She found a physical therapist for it and I was just so happy to have a name for it and to stop thinking I was crazy. The physical therapy was SOOOO painful and I would be in a ton of pain for a few days afterwards. I moved to Orlando a few months later and found a "specialist" for Vulvodynia. I became a guinea pig and she tried steroid injections, pudendal nerve blocks, biopsy, physical therapy (internal & external), estrogen cream, antidepressants, nerve medication, muscle relaxants, dilators, lidocaine, more estrogen creams, botox (3 times) and even more. After the Botox injections she decided that was all she could do for me and I stopped seeing her. It was extremely depressing to try so many things and not have anything work so I gave up. My husband and I had been married for over 2 years and we wanted to start a family. It was very discouraging to think about since we could only have intercourse 1-2 times a month depending on the pain. Little to my surprise, God blessed us with a beautiful baby girl in July 2015. During my pregnancy, I felt AMAZING! I stopped using my pillow to sit, I was able to have sex almost pain-free, and I had finally had gone back to a "normal" life. My birth was traumatic and a blood clot was formed on my labia. My pain was back times a million. If I didn't have my daughter, I may have given up on life at this point. My doctor (who had never had a vulvodynia patient) said he would remove my hematoma (blood clot) and while he was in there he could do a partial- vestibulectomy. We decided since I would be under anyway and that's one thing I have never tried, we agreed to do it. The next day, I got another blood clot from the surgery. Several months later after the swelling was down and I was healed up my vulvodynia pain was still there. I really was ready to give up this time. My mom and husband continued to motivate me to find a fix. They continued to do research and decided they didn't care about the travel, the cost, or anything they wanted to make sure it happened. We found a list of names and after review websites and making phone calls we decided to take a trip to Arizona. Little did I know, this trip would change my life! Every time I

have gotten my hopes up for a new treatment I have been so disappointed and devastated. But after my phone consultation with Dr. Fowler, I couldn't help but be hopeful again. Everything I started to say he would finish my sentence. When I met him, it wasn't just "you have vulvodynia," which I had known for years. He sat down with paper/pictures explaining why I felt the pain, what exactly my body was doing and how he was going to fix it. After about 3 months I noticed a HUGE difference. My husband and I were FINALLY able to have sex again. I was retested (through the mail) and Dr. Fowler called to discuss the results and explain to me everything that had changed. After about 6 months **I feel AMAZING!**!! I would say I am **80-90% better** most days! I am able to sit without my pillow most days and I am able to have intercourse 2-3 times a week without pain afterwards. I am so thankful that my family never gave up on me and thankful to God that we were finally led to Dr. Fowler so that I can get **back to a normal life again!** Thank you, Dr. Fowler!!! **H. Sanford, Florida**

I encourage any woman having similar issues to consult with Dr. Fowler and follow his protocol. My symptoms have drastically improved in a four-month period, much to my surprise. After suffering for 28 years with painful intercourse, it was actually excruciating. There was pain in other physical activities. Also, the external tissues were dry and would crack which was a huge problem. I saw multiple physicians talking 10-12+ with no hope for improvement. I had given up. My new ob-gyn referred me to Dr. Fowler with the advice, "He is the only person who can help your situation." He diagnosed me with vulvodynia and Lichen Sclerosis. After four months of being on Dr. Fowler's protocol, I'm elated at the physical changes. **I am 100% better** already. Now I don't think about my vagina at all. Dr. Fowler just gave my only wish for Christmas which was that I now get to wash my hair in the shower rather than the sink! Without hesitation, I recommend Dr. Fowler. **T. Scottsdale, AZ.**

I came to Dr. Fowler about 4 months ago after being in pain for about 1.5 years. I was unable to have intercourse and my vaginal area constantly felt irritated with no relief. I went to my regular gynecologist and she immediately referred me to Dr. Fowler as she said he was the best specialist in this area. Dr. Fowler diagnosed me with Inflammatory Vaginitis and put me on an easy to follow protocol. Within weeks I was feeling better and now at 4 months I feel **80% better** and am able to have regular intercourse that feels just like it used to, which I was very nervous about! I am very thankful I was provided with Dr. Fowler as a resource and am glad I have had him on my journey to improve my health. **J. Tempe, AZ**

I finally found and started seeing Dr. Fowler in 2014 after 3 years of battling bacteria infections that never seemed to go away. During those 3 years I was in and out of several doctors offices with yet another antibiotic prescription that only seem to make my problem worse. After researching on the internet I came across Dr. Fowler who was my last hope to stop this vicious cycle. Thank goodness I did because since seeing him and following his regimen it has been 2 years since I have had any infections and **100% better**. Then I had a pregnancy, and it wasn't until 7 months after pregnancy when the symptoms started to return while I was off Dr. Fowler's protocol. Now I'm getting back on protocol. Thank you, Dr. Fowler! It is definitely worth your visit. **K. Buffalo, NY.**

I first saw Dr. Fowler 4 months ago and am already **85% better.** I would highly recommend Dr. Fowler. I wasted a lot of time with my GYN and wish she had referred me to Dr Fowler- I found him on the internet. I had pain, and fissures and his diagnosis was Lichen Sclerosis and Vulvodynia. The treatment has really made a big difference. Thank you, Dr. Fowler! **L. Carefree, AZ**

Before I found Dr. Fowler, I was in so much pain. I had been to several doctors in my area, but no one could help me. My Gynecologist finally concluded that she had no idea what was wrong with my vagina. I had been treated for yeast and bacterial imbalances for a year and a half without any improvement. After much prayer, I was led to Dr. Fowler. Just prior to my first visit, I wrote the following about my symptoms: 'The swelling, irritation and soreness have made exercise difficult and intercourse with my husband very infrequent. Wearing underwear and even pants is usually very uncomfortable. I do not like to sit for more than 5-10 minutes at a time because of discomfort. I can no longer live without pain each day, and I have tried every possible medication to fix this problem.' Dr. Fowler and his staff were beyond kind and understanding. I was given specific medications and instructions for my personal recovery. Now, 4 months later, I am **SO much better!** I can exercise and be intimate with my husband again. My symptoms are vanishing more and more each day and I feel completely encouraged. Dr. Fowler was an answer to my prayers. I loved that he could perform tests that explained what was happening with MY body so that we could develop a specific plan for me. The best part of that plan is that it has WORKED. My heart is full of gratitude and hope. While these ailments are devastating for those of us who have them, there is help and healing! **A. Parker, CO.**

After I became sexually active, I was treated for recurrent bacterial infections with antibiotics. Little did I know that this would set me down a path of recurrent yeast infections. The skin of my vagina became thick, cracked, and red-hot. I went to countless gynecologists looking for answers and relief. I went to dermatologists. I went to naturopaths. No one could help me. During this time, the gynecologists were seeing no yeast or bacterial infections on my slides, and they said they couldn't find anything wrong with me to cause my symptoms. I began to feel like a crazy person- -like it was all in my head. Only, it most certainly wasn't. I lived with my symptoms every minute of every day. My quality of life was severely diminished. Not only could I not have vaginal intercourse anymore, but the sensation of having a yeast infection was with me 24-7. I literally felt like I was sitting on a cactus, or walking around with one in my vagina at all times. I became very anxious and depressed and wouldn't wish that experience on anyone. After trying so many different doctors to no avail, I felt helpless. I feared I would live my life as half a woman--certainly not a whole one--for the rest of my life, and I was only 31. Late one night, desperate and sobbing, I again searched the internet for clues. I had tried every home cure I could find information on, from inserting salt water up my vagina to bathing in all sorts of home mixes. I just kept hoping I'd find my miracle. That's when I found Dr. Fowler's website. The testimonials written by other women filled me with hope. I decided to fly to AZ from TX, and I was so relieved upon meeting Dr. Fowler. He was the first doctor I spoke with who told me that I wasn't crazy and even better, that he could help fix me. After that first appointment, I was diligent with the entire regimen. At my first four-month check-up, I saw a 20% improvement in my symptoms

and vaginal health. By my first-year check-up, I was **99% percent improved**. **I truly got my life back** when I made the decision to visit Dr. Fowler, it was worth every trip and every penny. My boyfriend has been with me through the whole experience, and he recently remarked that I'm like a different person. For several years, during my worst period, I mentioned my symptoms every day, and I cried all the time. Now I never have a reason to talk about my vagina or my symptoms. I wish any woman who experiences something similar could find Dr. Fowler and get the help he can provide. **E. Plano, TX.**

I had experienced severe pain with intercourse and the insertion of feminine hygiene products ever since I first attempted those activities. I went to multiple doctors in several states who tried different protocols on me. The feeling of strong burning and the sharp stabbing pain never subsided with their methods and I felt I was doomed to forever deal with this unbearable pain and my relationships suffered as a result. Who wants to be with someone who is "broken"? I found Dr. Fowler when I searched for vulvar pain specialists online. I visited him and was pleased with how much he understood what I was going through. I went from being told by others that "the pain was purely psychological" to Dr. Fowler's saying, "I understand. It's your vaginal flora that are imbalanced". I first noticed a reduction in the burning feeling initially following his sensitive skin protocol. When he prescribed me the full regimen for my ailment, the results came after 2-3 months. **I can't tell you how much better I feel** and how this is reflected in my self-confidence! I can be normal, pain- free, and have a normal relationship! Finally, a Doctor and specialist who knew how to help me!! Ladies, please listen to me--he will help you, he is compassionate, he won't say that it's in your head. Dr. Fowler will give you relief and give you hope! **J. Salt Lake City, UT**

After suffering from debilitating and embarrassing vaginal pain for about 12 years, Dr. Fowler has FINALLY **given me my life back.** Prior to discovering FGI, I was feeling as though I was doomed to severe and raw pain for the absolute rest of my life. My local medical team had all but given up on me and seemed to have cast me aside as a suspected "drug seeker." Then, a support group friend suggested Dr.Fowler's services as they had changed her life. It was amazing to meet with a doctor who seemed to really, honestly believe the degree to which I was suffering. Dr. Fowler actually called me as he reviewed my application to offer me encouraging words. Plus, it's completely affordable, which is actually amazing after the thousands I've spent on testing and treatments that did not work. The assessment is largely painless, and you get your results in about 15 minutes. It was amazing to actually have a real, observable diagnosis in a matter of moments. Nothing has been more validating and hope-inducing than having a meaningful and real diagnosis. Treatment has been mostly painless, though there is some discomfort in the beginning. The treatment is also very affordable. If you have been suffering from any degree of vaginal pain, please consider using FGI. It will likely change your life! **C. Tuscon, AZ**

Before I came to Dr. Fowler's practice I had suffered with painful sex for three years, which then led to intolerable sex. I had met with many doctors prior, who all had no answers or guidance to help. I found Dr. Fowler by relentlessly searching for what my problem could be, and I am so glad I found him. Don't disregard his reviews from clients as "the lucky ones." I was skeptical,

but I stuck with the regimens, and after 5 months, I am at least **80% better.** I am beyond ecstatic that I no longer feel constant burning or pain when my fiancé and I engage in sex. Dr. Fowler has **changed my life**, and he can help you too. **R. Mesa, AZ**

Wonderful news! **I'm 80-100% better.** I am 41 years old. It has been one year following Dr. Fowler's protocol. It is my pleasure to write this review for Dr. Fowler. He has a methodology that works. He is the expert. Please believe me with all your heart. You will get better. The pain will go away. Take it one day at a time. **S. Payson, AZ**

I am a 45-year-old woman who struggled for years with what I thought was a reoccurring yeast infection. I went to several gynecologists only to hear that it must be all in my head. I always felt off and had burning and discomfort. After finally hearing about Dr. Fowler, I set up an appointment and met with him. We tried several different protocol dosing and finally found the perfect match. **I'm 100%** back to my normal self and symptom-free! Thank you, Dr. Fowler for getting me back to myself. **K. Phoenix, AZ**

I am so thankful I found Dr. Fowler over two years ago. Months after delivering my second child, I began to have a lot of discharge accompanied by burning and itching at the vaginal opening. Sex with my husband was not possible without repercussions or worsening of symptoms. Tests at my regular ob-gyn came back positive for a high bacterial count, and I was put on antibiotics. This would help temporarily and the problem would always return. I was on antibiotics pretty regularly for close to 7 months before I started to research solutions. I knew that the long-term antibiotic use was not ideal and was most likely making my problem worse by getting rid of the beneficial bacteria in my body. Within a few months after seeing Dr. Fowler, my symptoms improved by 80%, and by 8 months, I was **100% better** and have remained symptom-free for the last two years. If you have had problems for years and have lost hope, please come see Dr. Fowler. It is worth the trip:) I don't believe there is anyone better at helping with these issues. **K. Southlake, TX**

I was struggling with multiple symptoms for 8 months, and I was concerned that all may be lost as my primary care doctor was not helping me. I went online to see if there was any chance I could find a solution. Dr. Fowler had been my gynecologist at Mayo several years ago. I did not know where he had gone when he left Mayo Clinic. I was thrilled to discover his website and to see how many women he was helping. Without hesitation, I filled out the questionnaire and set up an appointment. I always feel comfortable talking to Dr. Fowler. He has extensive knowledge of this subject and is a terrific person. After 7 months of treatment, I'm now **90% better**. Thanks for making my love life possible again, Dr. Fowler!! **E. Goodyear, AZ**

I have struggled with ongoing vaginal infections (BV/yeast) intermittently for 3 years, then had a consistent vaginal infection for 4 years along with a slue of new food allergies. I tried everything before seeing Dr. Fowler, including seeking alternative medicine (naturopathic supplements, garlic, etc), and nothing worked. I might see temporary relief; however, within a day the infection (along with burning/discharge) had returned. Clearly, there was some underlying condition affecting my vaginal sensitivity. However, no OBGYN was able to accurately diagnose

me. I was up late one-night reading blogs of women who had similar vaginal symptoms when I came across Dr. Fowler's name. I made an appointment and immediately I felt some sense of relief after that first visit. He placed me on a customized treatment protocol and one year later I am **100% bette**r, my food allergies have cleared and I am getting married next month. Occasionally, I might feel some symptoms if I drink too much coffee, but these quickly resolve when I consume less and continue with the recommended treatment plan. Dr. Fowler has completely changed my life and I am so grateful for everything he has done! **N. Scottsdale, AZ**

I have been a patient of Dr Fowler for 4 years. It took me several years to find a doctor who could find out why I was in such awful pain. I burnt constantly. The pain was awful. It felt like I had a urinary infection x 10. I had made the decision to go to the Mayo Clinic in Phoenix. It was my last option... they referred me to see Dr Fowler. He had worked at the Mayo Clinic for years and left to open his own practice, which specialized in gyn medical issues like mine. I had spent thousands of dollars seeing multiple doctors, 10 or more, who told me all of the tests were negative. I was honestly scared to see one more doctor who would make me feel crazy. It was emotionally draining. He was the first doctor who found the problem. It took me a full year to fully recover. I'd been **100% better** for 3 years. I see him yearly to re-test my fluids and keep me on track. If you are looking for relief, see Dr. Fowler.... he changed my life! **B. Boulder, NV**

Two months ago, I arrived at Dr. Fowler's office in pain and generally miserable. I had been to three doctors and none could diagnose or help with my situation.....it was very frustrating! I was having burning, redness and marked swelling. It was itching so much I could not stop scratching. Today, I am back for a follow-up and I am **no longer in pain** and well on the way to recovery! **E. Sedona, AZ**

I've suffered from vulvodynia for 35 years. I've seen a plethora of doctors, so many I've lost count. It's at least 100 doctors. I've spent enough money on homeopaths, natural- paths, acupuncture, physical therapy, supplements, shamans, and allopathic doctors to buy a house. The good news is I finally found Doctor Fowler while scouring the internet in a desperate search for relief. And relief is what I've found. Finally, an expert in this silent, misunderstood, and misdiagnosed syndrome. **I now live free of chronic vaginal and vestibular burning**. I'm not sexually active, but I believe I will be able to engage when the day comes that I'm no longer single. I will continue to see Dr. Fowler for my follow-ups and ongoing care. Dr. Fowler takes the guesswork out of the equation and tailor-makes the right protocol for you. Don't give up! **C. Ventura, CA**

Today, I saw Dr. Fowler for a 10-month check-up. I have followed my protocol almost exactly to the instructions. I had not been sexually active in 8 years prior until after 3 months of new treatments and some dilators from Dr Fowler. I am 64 years old. Today, I am joyous that I have **improved by 80%** and having great sex! I highly recommend Dr. Fowler to anyone suffering from LS! I went to 5 physicians before finally getting the right protocol. Some had me on extremely strong steroids, and some wanted me to use the lasers. I even went to an oncologist because I was so fearful I had cancer per my PCP because I had let the LS go so long. I ride horses and my condition was to the point that sometimes after a ride I would be so sore I didn't

know what to do! I would have cracks in the white skin of the vulva with deep fissures, peeling skin, and excruciating pain during urination if it got on the cracks. I thought my intimate life was over! This caused great tension in my marriage of 8 years and then 8 years w/o relations now divorcing after 16 years of marriage because we lost touch with each other. I have a new partner who is following my protocol as well and is very careful with me. We have a wonderful life together intimately. I am so happy to have found Dr. Fowler on the internet as he has **given me my life back! P. Phoenix, AZ**

Living in Mexico City, I suffered for three years from Vulvodynia. I was checked in those three years with many Doctors in Mexico and also in Houston Texas without any result. Searching the internet I found Dr. Fowler's website and I decided to fly to Phoenix. I came to see him first in February 2017. I started the treatment in March and one and half months after I started, I began to feel much better. Now 5 months later I feel about **98% better.** I am so grateful to Dr. FOWLER as I had this pain for so long time I didn't want to do anything. Now, I am living very happily, and **I returned to life again**. **R. Mexico City, Mexico**

I had the acute onset of intense vaginal burning and itching. This was not the typical itching with a yeast infection. I felt like I was exposed to a vaginal torch - it was excruciating. My GYN treated it with estrogen products, which did nothing to relieve the symptoms. I went to the internet and found Dr. Fowler and quickly made an appointment. If his office had been located in Siberia, I would have travelled there. After a year (one visit to Scottsdale and submitting a lab specimen by mail at 6 months) I would estimate my symptoms have **resolved by 80%**. There are no words to express my gratitude for Dr. Fowler's practice. **D. Kensington, MD**

I found Dr. Fowler 3.5 years ago on the internet to help with my extreme discomfort and vaginal leaking. I found him after seeing many doctors who could not diagnose my condition. He saw me immediately and prescribed a course of treatment that I can thankfully say has **resolved my issues 100%**. I can have painless sex again and can put behind me all of the discomfort and pain that I was experiencing on a daily basis. **P. Scottsdale, AZ**

I started having yeast and bacterial infections for the first time 2 years ago. I was constantly at my gynecologist's office for relief. She could not figure out what the issue was and referred me to another specialist. That specialist too, was at a loss. I was not only frustrated but was starting to get depressed due to the constant pain and irritation. I then decided to switch doctors and went to the Mayo Clinic. My new gynecologist at Mayo recommended I see Dr. Fowler in his private, who specializes in Vulvovaginal issues. After meeting with Dr. Fowler he explained to me exactly what was wrong and what our game plan was going forward. I left the office with such a sense of relief. I had been dealing with these issues for two years and I finally had a solution. Within 2 weeks of treatment I finally started to see results. After 3-5 months I was 60% better and within a year I am now **95% better**. The summer in Arizona is extremely hot, and I have slight itching occasionally in the summer months, but I anticipate that resolving too. Dr. Fowler is by far one of the best Vulvovaginal specialists in the country. He figured out in 1 visit what 3 different doctors could not figure out over 2 years. I would highly recommend anyone having

issues meet with Dr. Fowler. You will leave with an understanding of your issues, a game plan and peace of mind. Dr. Fowler changed my life!!!! **J. Scottsdale, AZ**

About 2 years ago I developed a persistent vaginal burning following several rounds of antibiotics for dental work. I saw several doctors who did not help me before finding Dr. Fowler. I found Dr. Fowler online. I have been a patient of Dr. Fowler's for about 15 months, and I am approximately **80% better** and continuing to improve each time we adjust my medication. In my case, this hasn't been a quick fix and patients will need to understand that they need to stick with treatment and let Dr. Fowler adjust the dosage of the medications until your body responds. Unfortunately, one size does not fit all, as with any medical treatment. I am confident that with help from Dr. Fowler's daily hygiene protocol combined with the medications, I will be feeling 100% in the near future. This is a real, science-based treatment cure for this condition. I would highly recommend you see Dr. Fowler if you have had similar issues. **H. Phoenix, AZ**

I went through several doctors before finding Fowler Gyn International. I was having chronic bacterial infections that would come right back after traditional treatments. After a few years of research, I decided to give FGI a try. I am nearing the end of my treatment and I am ecstatic to see an **80 % reduction** in all my symptoms within a year of starting his protocol. Dr. Fowler advises to be patient as treatment takes a while to see results, but it is so worth the wait! **A. Las Vegas**

I've had recurring yeast infections for the past 27 years. My symptoms were itching, dryness, discharge, rawness, odor, irritability, etc. I have seen countless doctors over the years so many I can't count on my two hands. Each doctor would prescribe the usual OTC meds. I also tried boric acid, which didn't work, and other medications, which took away the symptoms, but it always came back. Most recently, I tried Diflucan on an ongoing basis, but the yeast always came back. I'd given up hope that I'd ever be normal when I found Dr. Fowler online and decided to give him a try. I am SO GLAD I did! After only a few weeks following my first visit with him using his hypocontactant regimen and the medications he prescribed, I felt 40% better. He told me I had vulvodynia, and lichen sclerosis, which no doctor has ever told me. After 4 months of treatment, I feel **80% better** and have hope that I will be normal again very soon. I can't thank Dr. Fowler enough. He has changed my world for the better! **L. Wickenburg, AZ**

Prior to seeing Dr. Fowler, I dealt with chronic yeast and bacteria infections for many years. After seeing several OBGYNs for treatment and no results I was referred to Dr. Fowler from my primary OBGYN. I finally decided to make the trip to Scottsdale. After our meeting, Dr. Fowler gave me hope. I was excited to begin treatment. After 4 months of treatment, my yeast and bacteria infections have **improved by 80%**. I am happy with the results I have seen up to this point and look forward to being 100% cured of yeast and bacteria infections. I do wish I had known of Dr. Fowler many years ago. However, I am grateful today for finding him. **M. Tucson, AZ**

I have suffered for about 2 years with pain, burning, itching, discharge, pins and needle feelings, completely raw from the inside out of my vagina. Sex with my fiancee was out of the question. I

saw 31 Doctors with no answers! This is something that was making me not want to live anymore. I was completely miserable with absolutely no hope! I searched for answers day and night for hours upon hours and ran across Dr. Fowler's name a few times. Being as miserable as I was, I was willing to do or see anyone who might be able to help. I took a chance and flew to see him at his office in Phoenix, AZ and it's been about a year of treatment under Dr. Fowler's care, and I finally **have my life back!** If you are someone who's walking in my shoes and have these issues, please do yourself a favor and do whatever it takes to come and get yourself seen and treated by him. You will get your life back and be able to move forward! Put the suffering to an end and get back to being happy again. Put your trust in Him and His staff and you will be 110% satisfied. This has truly been a miracle!!! **E. Riverside, CA**

I met Dr Fowler about two years ago. I had seen my Gynecologists a number of times for a burning sensation. Nothing he recommended helped. I met a former patient of Dr. Fowler's and she referred me to him. I was put on the protocol program and we worked with it for a number of months and **I went from 5% relief to 100% relief**. I was symptom-free for a year and a half until I didn't bother to refill the medicine, and then the symptoms started to come back. Now I'm back on protocol. I would highly recommend Dr. Fowler. **J. Phoenix, AZ**

I'm so glad that I found Dr Fowler! I was suffering on the couch for 2 months with extreme pain. It felt like a fire and it throbbed without any stimulation. I was unable to have any kind of normal activity, including sitting even for 5 minutes, exercise, and intercourse. Another doctor had diagnosed and treated me incorrectly. I found Dr Fowler on the web, and I'm so blessed that I did. With his treatment, I'm **60% better** already, just after 4 months. I would highly recommend him! **L. Scottsdale, AZ**

I started with slight burning in the vaginal area, I hadn't had intercourse for at least two years until I started to date my recent boyfriend, and then the unbearable pain and burning started. I was confused and also I started to blame him for it. I went to several doctors and even to the emergency room because even my ovaries felt inflamed with lots of vaginal discharge. We had a lot of stress and misunderstandings, and my boyfriend thinking the worst. The doctors end up with the same results. Bacterial infections / and or fungi. The same medications and, after that, another infection. It was like a vicious cycle. I got very depressed. I started to think that this vaginal problem was just in my mind, as some of the doctors said. I just can't believe that no one understood me until I saw Dr Fowler's website. And I stopped feeling alone on this, knowing that there were other women like me suffering. One thing that impressed me about Doctor Fowler is how personal he is. He didn't see me as a number. Now, I have been on the treatment for 6 months, and finally, finally, I'm feeling normal again. One thing that helped me recover fast is to be consistent with that treatment. For me, the start of relief started within a few weeks. I could **feel the burning going away**. And I can tell Dr Fowler I have told my testimony to the people who knew my problem. It's like a miracle for me. And if I have the chance to help other women, I will. Referring them to Dr Fowler. Another thing, I have to thank my boyfriend for sticking with me on this and the love and support. Our relationship is stronger. And our sex life is amazing. Well, from the bottom of my heart, thank you so much, Doctor. I don't know how else

to express my appreciation, but God bless you for truly caring for a woman like this. **M. Antioch, CA**

Painful itching, swelling, and soreness made every day uncomfortable and unbearable. It also affected my sex life and caused it to be nonexistent or painful. This had been occurring along with a yeast infection monthly, requiring antibiotics that only provided temporary relief. I was referred to Dr. Fowler by my gynecologist. After 4 months of treatment, I am **50% bette**r, and the unbearable days are now few and far between. I'm also **able to have a sex life once again** that is **not painful**. I definitely recommend Dr. Fowler as I felt as if there would never be any relief and through his treatments and protocol, he has shown me it is possible. **A. Phoenix, AZ**

Being a type 1 diabetic can present a wide variety of health challenges. The most prominent for me was the recurrent vaginal discomfort and discharge that seemed to be a constant infection that never died. Dr. Fowler's specialized treatments were an answer to over 7 years of prayers and trying to live with vaginal pain and burning. After the treatment course, I have had **no signs or symptoms** and can actually **live a life without fear now**. **Dr. Fowler saved my life,** and I hope that many other women will find this as encouragement and the end to a final journey in search of relief. **E. Bristol, VA**

Dr. Fowler is literally the best doctor on the planet. I started out with what I thought was a really bad UTI - dryness, pain, soreness, urinary frequency/urgency, itchiness - I could not walk due to the pain as it even went up into my kidneys! I then went to the ER at Mayo Clinic in AZ, and they prescribed antibiotics, which did not work (as I found out later, I didn't really even have a UTI). I also had to stop taking the bc pill, as I believe this is what caused all of this in the first place. After several visits to my gynecologist at Mayo and many unnecessary tests, I was told I had nothing more than vaginal atrophy and lichen sclerosis. Although he was on the right track, I was still in pain and knew I needed a specialist. That's when I contacted Dr. Fowler. After agreeing to see me, he diagnosed me with inflammatory vaginitis and confirmed my Lichen Sclerosis. It was depressing, but at least I had a diagnosis. However, after 4 months of his protocol, I did not improve much, so I was very discouraged, but I knew I had to be patient. After tweaking my protocol and after another 6 months, I can say I am now **60-70% better!** My advice to all women struggling with these disorders is to be patient and not let it overtake your mind. You will get better - it may not happen immediately - but you will! I can now take long walks again, exercise, sit, etc. I still struggle with urethral irritation and urinary issues, but I know in time that will get better, too. I will just stay the course. Thank you, Dr. Fowler! **C. Peoria, AZ**

I was diagnosed with Lichen Sclerosus in 1997 and suffered from symptoms of itching, cracking, fusing of the labial tissues, and painful cracking during intercourse. I was treated with testosterone cream and various other steroids, which did not help. About two years ago, I was referred to Dr. Fowler and his protocol and treatments have **completely helped me!** I am so grateful to say that all the symptoms are gone! Many thanks to Dr. Fowler, I could not give him a higher recommendation! **N. Phoenix, Az**

I came to Dr. Fowler about four months ago when I was just about to lose hope. I had recurrent bacterial vaginosis and yeast infections for almost a year. I was in constant pain with burning and itching and was in my OBGYN office every month for antibiotics. Nothing seemed to help me, and it was ruining my life. The pain was so bad at times I was in tears when I had to use the restroom. I was afraid to have intercourse, go to the gym, or even wear underwear. My OBGYN recommended Dr. Fowler and I finally feel like I have hope again. I am four months into treatment and feeling 60% better. I immediately felt a significant difference when I started his treatment plan. I **no longer have the constant burning pain** and my tenderness and itching have improved significantly. I have good days and bad days but overall, I feel a **huge improvement** from where I started. I have faith that with Dr. Fowler's treatment plan I will finally be able to be normal again. **M. Peoria, AZ**

Vulvodynia is a seriously life-altering condition that goes beyond words in how debilitating it was for my life partner. The pain and itching were unbearable the depression deep and unyielding. I had to give her hope every day, even when there seemed to be none. Dr Fowler's world-class treatment **saved her life.** Suppose you are at all wondering if this will actually work when nothing seems to, don't hesitate. **All the reviews on the website are accurate**. I can testify from my personal experience that when there is no hope call Dr Fowler. Husband of patient **J. Payson, Az**

Prior to finding Dr. Fowler, I suffered from constant white discharge, vaginal odor and an unbalanced pH level that persistently came back no matter how many rounds of BV medicine my primary doctor was prescribing to me. The biggest problem was that I felt wet all the time and between that and the odor it made me feel self- conscious. So I decided to take matters into my own hands and began researching doctors who specialized in treatments for my symptoms, and that is when I came across Dr. Fowler's practice. After using his treatment plan for approximately 6 months I already feel better and have noticed a tremendous difference in my symptoms. Overall, I feel about **85% better**. It feels wonderful to know I have a doctor who is actually tackling the problem and analyzing the root of the problem rather than prescribing me medicine that would keep the symptoms at bay for only a month. I truly thought I was going to have to continue living the rest of my life, paying money every month for medicine. With Dr. Fowler's treatment, that will no longer be the case and I'm looking forward to living my life symptom-free! Thank you Dr. Fowler and to your wonderful staff as well. **C. Fuller, Phoenix, AZ.**

I am very glad I found Dr. Fowler. My regular gynecologist was at a loss as to what to do with me. I had burns, itching and tearing near the vaginal opening. I was very uncomfortable. Dr Fowler diagnosed me with inflammatory vaginitis and lichen sclerosis. My symptoms improved by **about 80%** within a couple of months of starting treatment. The estrogen cream has given me back my normal vaginal health and functioning. The lichen sclerosus resolved with the treatment as well. Very happy with the services. **S. Phoenix, AZ**

For over a year, I was having problems with vaginal burning and white discharge and I never felt right. I had gone to different doctors having test after test, and I was not getting better. I was told

either it was a yeast infection or nothing was there and to soak in a tub. So I decided to start looking on the web to find someone who could help me. I did a search on my symptoms and came across Dr. Fowler, and I decided to call. I have to say it was the best call I ever made after going through what I was going through for months. I finally found someone who could help me. Now, after 12 months of treatment, **I feel normal again**. It's amazing! To think it was just a phone call away!! Many thanks to Dr. Fowler for helping me to understand what I had and how to fix it. **R. Glendale, Az**

If you find yourself in Dr. Fowler's office you have come to the right place. With a diagnosis in hand and a treatment plan to follow I knew I was finally getting somewhere. My best advice to you is to be patient!!!! This takes time but you will see progress and you will feel better. For me I really started noticing the difference between the fourth and fifth months. His notes are bang-on and describe exactly what it is like your pain will wax and wane. When I did have bad moments, I would call for advice and he would always return my calls and give me guidance and support. Relax.....take a deep breath....sigh it out.....you will find relief...I did. This is how I described my condition and mental state when I first came to see Dr. Fowler: It is a constant nagging burning/ raw pain considerably worse on the left than on the right. It has robbed me of any joy from the physical activities that I used to love; even yoga can't completely get my mind off of it. I have considered suicide. This was when it was really bad for 7 months, rather than continue with the level of pain I began with. Initially, when it started, I had urinary urgency and burning with urination to the point I had to pour water over myself while I urinated. NOW, I'm **80-90% better** at 5 months on the treatment protocol. I'm just so happy and hopeful for continuing recovery and a great future thanks to Dr. Fowler. **C. Princeton, Ontario, Canada.**

I had symptoms starting in November of 2016 and was diagnosed with Lichen Sclerosus in January of 2017. My symptoms of itching, burning and discoloration were extremely distressing and seriously impacting my life. In my research, I found a lot of conflicting information, but I was lucky enough to find Fowler Gyn International's website and make an in-person appointment. Following Dr. Fowler's protocol, I improved over a few months and am happy to state that as of May 2017, both my general gynecologist and Dr. Fowler found no signs of LS. I am **symptom- free** and grateful to Dr. Fowler and his staff. **S. Paradise Valley, AZ**

I have dealt with this condition for over 20 years not knowing what it was really called. The doctors I saw in the past always said it was a yeast infection or something vague. Physical Therapy would help but I would still be symptomatic. It would take me weeks to get better and always leave me dreading the next time something would flare up. Then finally within the last two years, nothing would help. Countless doctor visits and various topical ointments did nothing to alleviate my symptoms or my misery. I started doing research and found Dr. Fowler in social media chat groups. It took me a year to get up the courage to take the plunge and visit him in Phoenix. In 2016, I did just that. I booked an appointment and haven't been the same since. I started his protocol and followed it exactly. In 4 months I was 60% better and now at 10 months I'm feeling **80% better.** I feel like **I have the quality of life** and optimism now and for the future. If you have tried everything and still have no answers why not see Dr. Fowler and give

him a chance? I thank God every day for Dr. Fowler and the opportunity to be on his treatment. **J. Barrington, IL.**

I was seen by Dr. Fowler's practice after coming by his program online in a desperate search for some relief from vaginal pain, burning, and discharge. I have been to many doctors and have told many different things over the past few years. I would only have temporary relief from symptoms. Frustrated and feeling I was going insane, I began Dr. Fowler's hypocontactant hygienic products 1 month prior to seeing him for the first time and already have achieved **30% relief of symptoms!** I can only look forward to more improvement now that I am starting on the main protocol after my specialized testing. I look forward to a life of some sort of normalcy and sanity. **S. Great Falls, MT**

When I first saw Dr. Fowler, it was only 4 months before I was supposed to get married. I had been experiencing vaginal pain intermittently for a year and a half and had completely stopped having sex months before I was referred by my OB- GYN to find a specialist. I was so stressed about what I was going to do to be able to enjoy my wedding night. I went forward with the protocol and achieved amazing results. By my wedding, we were able to have sex, though it was still slightly uncomfortable. By 7 months, I was almost **80% better**, and for about a year afterward, I was able to have enjoyable sex 1-2 times a week! But, then, due to circumstances in my life at the time, I wasn't able to follow up for continued care and slowly stopped the estrogen. It was a horrible mistake as a few months later, my symptoms started worsening again. I was able to finally schedule a follow-up a year and a half later and am very optimistic because I know the results that can be achieved this time. Dr. Fowler is a miracle worker! **R. Chandler, AZ**

Four months ago, this was my reality: I am constantly wet from discharge and feel self-conscious because sometimes the wetness from the discharge will soak my underwear and slightly go through my pants. I am always uncomfortable because it's a constant issue that repeated antibiotics and holistic treatments are not resolving. It is very costly for a college student to continue tests and treatments. I feel gross and do not want to conduct sexual activities. It's a dull but continuous itch/discomfort where I am always aware of and thinking about the issue... Now, because of the understanding and treatment by Dr. Fowler, I feel **80% better. My symptoms are minimal**. I don't think about it and am not as self-conscious about my vagina. I feel confident that my issue with IV can be fully resolved and I can get back to living my life normally. I'm beyond grateful for Dr. Fowler's knowledge and help! **C. Fountain Hills, AZ**

I had been in a lot of pain, discomfort, and itchiness before I went to see Dr. Fowler. I was always having problems with yeast and bacterial infections as I grew up as a child. By the time I turned 19 years of age, it had gotten so bad that I would always be at my doctor's and being prescribed medication that used to get rid of the symptoms I was experiencing. After a few more years I had gotten so bad that I had told my doctor that the medication no longer makes my symptoms cease and that I don't know what is wrong with me. They simply told me that some women are just prone to having reoccurring bacterial infections and that there was nothing else they could do any different than what they have been doing. I then started using all kinds of home remedies to help me. I noticed Monistat, which I used for yeast infections, started to make

my symptoms worse. I then remembered the day I sat on the edge of my bed and I cried about how out of hand this was getting. My soon-to-be husband walked into the room and saw how upset I was and he sat down beside me. I told him how this problem I have would mean that when we get married, I don't know that we can even make love for how much I hurt all the time. He looked at me and told me that everything was going to be ok and that whatever we had to do we would do to see that we figure it out. He encouraged me to look for a specialist to see what was wrong and that there had to be a deeper cause for it that my current doctors couldn't cure. I got up from my bed, and I searched online for specialists that deal with women who have my symptoms. I found Dr. Fowler's website. I read testimonials, and then I read of all the different types of conditions women struggle with that most doctors can't diagnose because of the lack of lab equipment they have. So I talked to my fiancé and we made the decision to fill out new patient forms to get a call from Dr. Fowler himself. As I told Dr. Fowler my symptoms and how I heard about him, he seemed to know exactly what I was talking about. Then, I made an appointment to see Dr. Fowler. My fiancé and I drove all the way from Alabama to Arizona to see Dr. Fowler. When we got there he was very nice, and he gave me a very clear diagnosis of my symptoms. He explained to me that I had inflammatory vaginitis. Then, he started me on the road to recovery. The news I got was a relief to me that I didn't have to live in so much pain for the rest of my life. He sent me home with some very detailed orders I must follow, and I have to say that I experienced relief from my symptoms after the first month. Thank you, Dr. Fowler, for all the studies, time, and hard work you put in to help people like me. Now a year out, I am excited to share with everyone that I am about **90% better**. I continue to follow up with seeing Dr. Fowler to continue in the right course of recovery. I feel better, and I am a lot more confident in myself and also in my ability to do more in my life. Thank you, Dr. Fowler, for all that you do to help all of us women. **J. Gadsden, AL**

I have known Dr. Fowler for over 25 years. He was my gynecologist at the Mayo Clinic, dating back to when he started there. He looked like a Boy Scout back then. I have continued to follow him to this day. He has always fixed my situations along the way and continues to make things better for me. In regard to my vulvar condition, I have remained **asymptomatic for years**. I would recommend him to all women who are unsure if they are having a problem down there. He is quick and tells you immediately what your vulvovaginal condition is and how to fix it and feel great. **S. Scottsdale, AZ**

Before I found Dr. Fowler, I had vaginal discharge and odor that was affecting my personal life, at work as well as in the bedroom. I could smell myself, and so could my co-workers and sex partners. I knew I needed to find someone who could help since there were several failed attempts at my regular OB-GYN. I found Dr. Fowler on Google and was very thankful. Two months into Dr. Fowler's regimen, I was **100% better,** with no more odor or discharge, and continued to be asymptomatic. Thanks so much, Dr. Fowler! **A. Scottsdale, Az**

After many visits to my OBGYN with no resolve, I was relieved to finally be referred to Dr. Fowler. I was in so much pain that I could not even have clothing touching my vagina without it being extremely uncomfortable. It kept me from doing daily things that I enjoyed. After my first

visit with Dr. Fowler, I was committed to the treatment protocol and followed it extremely closely- I wasn't expecting results quickly but found that I was **feeling so much better** after only a few weeks. I could work out again, wear real clothes, go out in public without feeling in extreme pain and be intimate again with my husband comfortably. I was at a point before seeing Dr. Fowler that I would never be "normal" or be without burning pain ever again. I am so thankful for the treatment and told my OB that he is "my favorite person EVER!" **B. Peoria, Az**

I have had Lichen Sclerosus for approximately 5 years. Regular use of Clobetasol for the first 3 years eliminated my symptoms. Clobetasol has not worked for the last 2 years. I have had chronic vaginal discharge that caused constant irritation, burning, and itching. It had become extremely challenging to be active, wear pants or jeans, or even sit at work. I have seen 2 local doctors in Kansas with little to no relief (other than the original LS diagnosis). I found Dr. Fowler's website and decided to purchase the hypocontactant product package before my scheduled appointment in 1 month. I began using this regimen exactly as directed upon receiving it in the mail. I noticed a significant improvement within 1 week. At this point, my symptoms are **50-60% better** before even starting the main vaginal treatment. Not only was this a physical relief but also a huge psychological relief. Finally - some hope to feel better and "normal." **K. Overland Park, KS.**

"I heard about Dr. Fowler from a fellow Kaiser nurse whom I work with, and she mentioned the symptoms that she had before she visited with Dr Fowler. My symptoms were very similar, that being pain when having intercourse, vaginal dryness, and little cuts and cracks on the skin between the labia. I was diagnosed with Lichen Sclerosus by my GYN, but was only given a cream to take care of it. It didn't go away, and there really wasn't any concern by the physician or need for any follow-up. After I heard about Dr. Fowler I made an appointment right away, after reading about his success rate, and knew I had to do something about it. After the first visit following all of his instructions on special things I needed to change in my daily life and the vaginal and vulvar treatment, by the second visit in 4 months, I was already 80% better. What a difference it made in my life. Now 8 months later, I'm **100% better** and not afraid to have a relationship with men again. I would highly recommend any woman with similar symptoms to not give up and go see Dr. Fowler." **S. Navato, CA**

Symptoms of constant vaginal burning and irritation caused me so much stress and worry and anxiety. It affected my life so much that I stopped doing the things I enjoyed like working out and meeting with friends. I got so depressed over my symptoms that I believed I had contracted an incurable disease and no one was going to able to help me. I had seen a number of doctors who could not find out what was wrong with me. I felt so alone and worried about what this could be and how much it was affecting my life. It consumed me every day. My gynecologist in El Paso recommended I see Dr. Fowler in Phoenix and thank God I did! It has been 5 months since I first saw him and my symptoms have improved overall by 80%. He diagnosed me with inflammatory vaginitis. I followed his treatment protocol and I'm seeing and **feeling major improvements in my symptoms** and my life. I am working out again and enjoying time with my family and friends. I feel I'm back to my normal self. I don't constantly think about it like I

used to. I know with Dr. Fowler's help, I will eventually get back to being 100% free from this." **E. El Paso, Texas**

“I started having extreme itching, burning, and pain during intercourse about 8 years ago. The skin on my vagina was red. I felt on fire most of the time, like I was having a yeast infection. My doctors gave me steroid creams and anti-depressant medication. That didn't work. I tried every kind of home remedy for yeast infections and for vulvodynia. Nothing worked. I was miserable. I couldn't have sex, couldn't stand without being itchy and nothing was fixing it. I started searching for specialists that dealt with vulvodynia and chronic yeast infections. I found Dr. Fowler just by searching around on the internet and I liked all the reviews on his website before I saw him. I even started using the specified soaps and lotions he recommends on his website; I couldn't believe the difference just from that. I travelled to Arizona to see him 8 months ago and today, I am 70% better and **100% better** with sexual activity. I finally have a name as to what I have instead of not knowing. The medications he prescribes and the products work so well and I am very happy with my results. I still have a little bit to go before I am fully better. With how I feel now I know that I will get 100% better.” **R. Charlotte, North Carolina.**

“I found Dr. Fowler after doing an intense web search for help with my mystery condition. Almost 1 year prior, I had begun to have heavy discharge and odor. After visiting my doctor, I was told all tests showed no sign of infection. I was given antibiotics as a precaUTIon and sent home. The antibiotics worked for a time but the discharge and odor returned. After seeing 5 other doctors, I was put on long-term Metrogel, which kept symptoms at bay for a while, but then became ineffective. No one could tell me what was going on and why. I found Dr. Fowler one desperate night and decided to just do it. I did! I made an appointment and I remember when he called me for a pre-evaluation. I'll never forget his words that gave me so much hope..."Let's get you healed." That was what I needed to hear shortly after I was on a flight to AZ. It has been 4 months on his protocol and although I am not 100% yet, I am so thankful and happy with my progress. I have so much more confidence and am **so much more normal** than I was the year prior. I am extremely grateful and very happy with the help I am receiving. He has been a Godsend.” **R. Live Oak, Tx.**

'For over 3 years I was dealing with inching, burning, discharge and tearing during intercourse. I went to 3 different gynecologists and no one could figure out what was causing these symptoms. Eventually, I was referred to Dr. Fowler by a gynecologist after dealing with test after test. Dr. Fowler diagnosed lichen sclerosis and vulvar contact dermatitis. The feeling of relief after getting a diagnosis alone brought me to tears. And after 4 months on his regimen my itching, burning and discharge were 50% better. Now after a year **I feel 100%**. I can't thank Dr. Fowler enough for what he has done for me. Not only am I symptom-free but now I can have a healthy and happy sexual relationship with my significant other.' **C. Phoenix, Az**

“Before I found Dr Fowler, I had been suffering from vaginal discharge with a foul odor, itching and burning. I went to 3 different doctors and tried 10+ medications, all with no resolution of my symptoms. I was beyond frustrated at multiple failed treatments and thought I would never find a solution! My husband, although very supportive, was also very frustrated! When you have this

problem it definitely puts a damper on your sex life. Out of desperation, I did an internet search and found Dr. Fowler. I had to fly 4 hours to Arizona but at that point I was willing to do anything. Within 2 months my symptoms were gone! The protocol I was placed on has kept me absolutely **symptom-free**. When no one else was able to help, ¦Dr. Fowler **cured me**! My friends and co-workers think I'm crazy for flying to Arizona for a doctor's appointment but it is WELL worth it to fix my problem!" **R. Fremont, Nebraska**

"I had been suffering with a raw, burning vagina for 4 months before I found Dr. Fowler. I had visited my gynecologist a total of 6 times, who treated my symptoms as everything from a yeast infection to an overgrowth of "good" bacteria. After nothing seemed to work, she finally told me that the pain may be in my "head" because the tests showed that nothing was wrong with me. Meanwhile, the burning and raw pain profoundly impeded my lifestyle in a physical, mental, and emotional manner. Physically, I was unable to exercise, sit in certain positions, wear certain clothing, and engage in sexual intercourse because the pain was too intense. Emotionally and mentally, the pain consumed my thoughts nearly every moment of the day and caused severe anxiety thinking that I was incurable. After a lucky Google search, I found Dr. Fowler! He immediately knew my condition, put me on a regimen to get better, and gave me hope that everything would be okay. More importantly, he took the time to explain the details of my condition and let me know that I was not alone. After about a year of following his protocol, I am 70% better, with about 10 days a month that I do not even feel/think about my condition. This is a **HUGE improvement** from where I was physically and emotionally a year ago. I am confident that with more time, patience, and compliance with Dr. Fowler's protocol, I will be 100% better, and this will be nothing but a distant memory." **J. Phoenix, Az**

"I developed vestibulodynia 19 years ago after a yeast infection. I saw many doctors who would test me for yeast, BV, etc, but the results always showed negative even though my chronic burning pain persisted. In 2012, I had a full vestibulectomy with the belief the procedure was my last resort and would heal me. However, 6 months later the pain was back, and I also developed bladder pain, frequency, and urgency. I was devastated and thought there was no hope until I found Dr. Fowler through a Google search. He immediately found the root cause of my condition and I started his protocol. At the 8 month mark of his treatment, I improved significantly and now 1 year into his treatment, I am a steady **overall 80%** improvement but the bladder frequency/urgency is **100% resolved**. I can sit, walk, and exercise without pain! I have no doubt that with a slight change in my protocol, I will improve 100%! Dr Fowler truly gave me my life back!" L. Durango, CO

"I cannot say enough great things about Dr. Fowler and how he has helped me. I was in a very painful, on some days debilitating state, with what was diagnosed in Canada as vulvodynia. Over six months, I had seen 3 GPs, 1 Ob/Gyn, 2 acupuncturists, a pelvic floor physiotherapist, and an osteopath, had changed my diet, and was trying every natural supplement I could get my hands on. I was prescribed an anti-convulsant used for seizures and an anti-depressant (which I had never required previously) to try to stop 'nerve pain.' Eventually, I needed the anti- depressant to help my mood since I was so down from all the pain I was having. It hurt to walk, sit, drive, go

to the bathroom, etc, along with anything else you would simply do on a daily basis. The most upsetting part of this was no doctor in Canada (particularly in Edmonton) had any idea how to treat my vaginal pain. The Obgyn told me, "I need to come to terms with my vulvodynia and that will help me deal with it better." I was completely devastated at 35 years old, thinking my life was over without any possibility of getting married and having children, never mind even having sexual intercourse ever again. This problem literally changed my life so negatively and there was nothing any doctor could do to help me. After countless hours online researching, one night, I found Dr. Fowler's website and a sense of hope came over me. It looked like he had helped many women with the same issue! I phoned immediately, left a voicemail and he called me the next day to ask me questions to ensure I was a patient he felt he could help. I took the first available appointment about 3 weeks later. Dr. Fowler diagnosed me with inflammatory vaginitis. I was now with a doctor who knew what I had, was able to treat it and had many years experience with helping other patients like myself. The emotional relief was like nothing I'd ever felt before. I was easily able to get the medications compounded in Edmonton and within 1 month, I had a significant improvement in my symptoms. I told every doctor and other specialists I had seen in Edmonton since none of them had any idea how to treat this. At 4 months, I have returned for my follow-up visit and I am about **70% better.** I would recommend that any woman who is having issues that are affecting her life see Dr. Fowler. For me, the cost of the appointment and medication is priceless, considering that. I am now **substantially better** (and very reasonable, actually). Dr. Fowler is the only doctor to see for this. He has really saved me. Thank you, Dr. Fowler!" **H. Edmonton Alberta, Canada**

"I met Dr. Fowler about 7 years ago when he was still at the Mayo Clinic. I had my first ever yeast infection that wouldn't go away. After 5 different Kaiser doctors and 2 years of my time being told, "It's yeast or it's bacterial," repeatedly and following the medication's instructions exactly, only to have my symptoms return, I was lucky enough to find Dr. Fowler through a Lichen Sclerosis message board where I saw he had a subspecialty in recurrent vaginal infections. I was even told I was "too young and that only menopausal women get LS" by another doctor. At the first meeting with Dr. Fowler told me," I know what you have and we are going to get you feeling better." I was so happy! He set me up with protocol and prescriptions and I was on my way back. I am now at least 5 years running, and **I'm nearly 100%**. I swim, cycle and run with minimal discomfort. All of my symptoms are under control and I am feeling great on a day-to-day basis. Thanks, Dr. Fowler!" **T. San Jose, Ca**

"I started experiencing issues of extreme itchiness and discharge around three years ago. I initially thought it was a yeast infection, but after 2 rounds of Monistat and 3 doctors telling me I didn't have yeast, I was at a loss. My symptoms completely mimicked those of a yeast infection. I was in denial when doctors told me it wasn't yeast. As a college student, it was extremely difficult to live a normal life. I felt uncomfortable walking to class, socializing, and just doing things that average 20- year-old individuals do. The discomfort was so severe that I would spend endless hours crying and researching what I could potentially have. I saw over 10 doctors and even a few specialists who either claimed all of my test results "showed normal" or had no idea what was wrong with me. I would try treatment after treatment with little to no success. I would

describe my symptoms to doctors and I could tell they didn't know what was wrong with me. I finally found Doctor Fowler through one of my many online searches. When I first met with Doctor Fowler, I was extremely skeptical (for I had so many doctors fail me in the past) But my experience with him was different. Upon arrival he did new tests and was able to immediately diagnose me. He seemed to understand what was wrong with me and gave me a protocol. I had to initially tweak some parts of my protocol but now, around a year later I am almost better. I can exercise again, socialize again, and not dread running errands because of discomfort. Instead of feeling an itching sensation once every 5 minutes, I now only feel it maybe 3-4 times a day.... which is a **HUGE improvement** for me. I know I'm not fully better but I will continue to follow my protocol till I am. Thank you so much, Dr. Fowler, for helping me!' '**N. San Francisco, CA**

"Dr. Fowler's **protocol gave me my life back!** I suffered from vaginal rawness, burning, and pain for about three years for which I saw over five specialists, including doctors at Mayo Clinic in Rochester, MN. I was "diagnosed" with IC, vulvodynia, vaginitis, and other vague disorders that didn't really have a cure. After feeling hopeless, a therapist who counseled women dealing with these issues gave me Dr. Fowler's name. Within a few weeks of his recommended protocol, I began to feel a bit better. Within four months, I felt that I improved **sixty percent.** I no longer stay home from social events because of pain and depression. I am **able to function and live my life** thanks to Dr. Fowler and his expert treatment and care. He is kind, understanding, and extremely knowledgeable.

Thanks again!" **L. Byron Center, MI**
"My life was so bad I never told any friends only family knew. I had been feeling this pain for 8 years. It was the worst pain in my life, pain so bad I wished I was dead some days. I looked happy, but no one knew the vaginal pain I was in till one day I went to see my usual hairdresser in Winnipeg, Canada and told her. She had heard of it from another lady who had come to see Dr. Fowler. I booked a ticket the next day. I couldn't wait another second. I came in April and from the first week the redness had gone away. Then the itching resolved and now the burning pain is **getting a lot better**. He has **saved my life**. Dr. Fowler is my hero. I am so happy I have met him and I pray every day that I have found him. Thank you." V. Winnepeg, Canada

"After being diagnosed with Lichen Sclerosus by my OBGYN, she referred me to see Dr. Fowler who specializes in this unpleasant condition. After following the treatment protocol that was prescribed to me by Dr. Fowler, my symptoms **drastically began to improve**. I got to the point where I did not even notice any itching or cracking. The unbearable itching no longer kept me awake at night. I could live my everyday life **without even thinking about this unwanted condition** and the symptoms that came along with it. The Grandma's soaps which are pure and natural also work wonders along with the medications and the exact protocol. This treatment will be a lifesaver to anyone with Lichen Sclerosus." **K. Phoenix, Az**

"After suffering from terrible, unbearable symptoms for over TEN YEARS and being misdiagnosed (and truly not listened to) by several other doctors, I count the lucky stars that I met Dr. Fowler in 2010 at Mayo Clinic! I was very fortunate to have been referred to Dr. Fowler

by a friend. Since many of these symptoms are not easily discussed, even amongst girlfriends, it was very ironic that we were both dealing with the same condition, known as lichen sclerosis. I found that even if doctors had heard of this condition, they did not know how to treat it. Prior to meeting Dr. Fowler, I left three other gynecologists and a dermatologist's office, completely frustrated. I was constantly being diagnosed with "chronic yeast infections," which was not the case. My symptoms included severe redness, itching, and burning. Dr. Fowler began treatment on my first visit to him at the Mayo Clinic, and each time I saw him, my symptoms improved more and more. I am pleased to say that I've been **100% symptom-free** on his regimen for over 4 years and continue to see Dr. Fowler in his private practice. Dr. Fowler was a life-saver to me!!! I would highly encourage anyone dealing with similar stories to contact Fowler Gyn International for an appointment and to meet Dr. Fowler as soon as possible. Thank you, Dr. Fowler!!!!" **S. Gilbert, Az**

"Let me start off by saying "Dr Fowler is heaven sent". I found Dr Fowler on the website after doing my own research. I was so frustrated and depressed about my condition. I was having a very awful chemical smell, with burning and dryness. I previously saw 2 physicians in Las Vegas and was told I was fine and all of my tests were normal. However, it still has this embarrassing smell and burns with dryness.The doctors looked at me as if I was crazy while explaining my symptoms. I saw Dr Fowler in April 2016 and by the time I saw him, I was depressed. Dr Fowler was so understanding. He explained it to me the very same day about my condition. It's now been 6months, and I'm **80% better.** Dr Fowler is a blessing from God. If you're having any vaginal problems, I encourage you to see Dr. Fowler. I can just cry right now. I feel so much better. Thank you so much, Dr Fowler." **K. Las Vegas, Nevada**

"I have seen Dr. Fowler for the past 3 years, and he has seriously changed my life. I have had vulvodynia since I was about age 15. I went to maybe 10-15 different doctors to try and figure out what was going on. None of them knew what it was, and most of them just said to "drink more water." I would miss school and work because I was in so much pain. Some days, I wouldn't even be able to walk. But after I found Dr. Fowler, he knew exactly what was wrong and fixed me up. It is 3 years later and I am about **95% to 99% bette**r. I do not have many flare-ups anymore and I can live my life without worrying. I am so grateful for him and highly suggest you see him if you are having any vaginal problems." **M. Flagstaff, Az.**

"After the second year of our marriage, I noticed this burning and frequency issue every time my husband and I were intimate. I ended up seeing three obgyns (one was a urogynecologist) and four urologists. I was about ready to give up. During those eight years, three miracles came into our lives via IVF. So not only did I live with pain from all the procedures, but I also lived with a constant burn in the vaginal area. I had UTI after UTI, and all the urologist did was place me on more medications. This only triggered more burning. After I had a partial hysterectomy (I kept both ovaries, but that was it), I decided to try the Mona Lisa laser for dryness. I did three rounds with NO relief. The dryness and burning continued, as well as the constant medications for UTIs, then yeast infections, and then burning. I knew that there had to be something wrong with the bacteria in my vagina. One evening, I looked under lower GI flora issues. That is when I came

upon Dr. Fowler's brilliant article all about the different flora and how it must be balanced. Immediately, I searched to see if he was practicing medicine at the time. I found his website, and I felt like my prayers had been answered! After many discussions and phone calls to patients either in treatment or who have finished, I knew Dr. Fowler could help me. My husband knew my background in chemistry, so he decided to book our plane tickets to AZ. Everything made sense to me, finally! During our visit, Dr. Fowler took his time listening to my concerns with compassion and made me feel at ease. All I could think in the back of my brain was, Dr. Fowler is a genius! He truly cares about each patient and will not give up until any issues are cleared up. I followed his skin protocol a month prior to my visit, and once on my protocol at home, I followed it exactly how Dr. Fowler set it up. Words cannot express the amount of appreciation and admiration I have for Dr. Fowler. After three and a half months, I was **pain-free!** Dr. Fowler's protocol worked exactly as he had planned for it to work. I will still be completely pain-free at almost 8 months next month! I plan to continue seeing Dr. Fowler because I truly believe he knows exactly how to keep you pain-free. Not only is Dr. Fowler a genius (in my mind), but his passion for helping women overcome severe pain shows through his conscientious behavior. Thank you, Dr. Fowler, for healing me. **I feel like a whole person now**, not one who dreads waking up to constant burning. Thank you also to your family, who probably missed you on many occasions while you created the lab equipment so powerful that it can analyze flora like no other machine, and for all the time you spent methodically thinking out multiple protocols to meet each individual's needs, as well as, giving each patient the time they needed to get better. Thank you, again, for sharing your gift with all the women in need of healing." **N. Trabuco Canyon, California**

"In October 2015, I had a constant burning in the vulvar area that was unbearable. I had been treated with a 7-day cycle of Clindamycin vaginally with no relief. When I touched this area, it burned & made things worse. I could not continue with these symptoms and live my life. It was dramatically affecting my quality of life. Now, in Oct 2016, I've been seeing Dr. Fowler for the last year. He has **worked miracles** to get me **back to a 'normal' condition** with minimal pain. I'm excited to report my condition has improved dramatically. Dr. Fowler is very kind and a great listener. I'm a retired RN. I know how important it is to listen to a patient's concerns. I would highly recommend him to anyone with chronic vulvovaginal problems. I'm so grateful I was able to find Dr. Fowler." **R. Tucson, AZ**

"I have been a patient of Dr. Fowlers since 2008. I had suffered for years with what I thought were constant yeast and bacterial infections. I visited my gynecologist many times for treatments that never worked. The first part of 2008 was an especially tough time for me. Over the course of 6 months, I returned over and over to my gynecologist with complaints of burning and itching. My symptoms were so severe that I could not wear pants/shorts, have sex, sit for a long period of time, work out, or even ride a bike. I was in so much pain that I took prescription meds to fall asleep at night. I was lucky I didn’t have a job because there is no way I could have worked while going through this. I was miserable. My gynecologist prescribed many drugs, tried different unsuccessful treatments, and even told me that I may have genital herpes (which I do not have). I knew I had to go elsewhere. I chose the Mayo Clinic and was lucky to be assigned to

Dr. Fowler. He immediately diagnosed my symptoms and started me on a treatment protocol that made me feel better. By 6 weeks, I was almost symptom-free and by 6 months, I was **feeling 100% better**. I have continued his regiment and have had very few minor flare-ups over the past 8 years. I feel my flare-ups are always caused when I am lax with following the protocol. Dr. Fowler is an intelligent, kind doctor who truly is a lifesaver." **Chandler, AZ**

"Dr. Fowler is a LIFE SAVER!! Throughout my treatment plan, I was able to be **healed 100%** and now feel terrific!! After years of suffering with horrific pain, I am so blessed and thankful to have found this AMAZING doctor who has t**ruly given me back my life** and, in many ways, **saved my marriage**!!! Thank you so much, Dr. Fowler, for your life-changing help! I can't imagine where I would be without you !" **T. Phoenix, AZ**

‘’I am so grateful I found Dr Fowler. I had been suffering from vulvodynia for the past 10-plus years or so. I have seen so many gynecologists/specialists within this time frame and underwent numerous treatments and procedures including surgeries with no success. I researched my condition online, and luckily, Dr Fowler's services popped up. I first saw Dr Fowler in June of 2015 and it was the best decision I ever made. I can honestly say he has changed my life for the better. In under one year of treatment, I would say I'm about **80% better.** I would definitely recommend Dr Fowler to anyone who is experiencing any conditions relating to the vulvovaginal area. Once again thank you, Dr Fowler!!’’ **F. El Paso, Texas.**

‘’After suffering with severe vaginal burning for over a year and numerous visits with other doctors I found Dr. Fowler through an article written about one of his patients on the internet. She had been suffering without answers for several years and had found some relief early in her treatment and was publicly sharing her story. When this condition started I would suffer through work, go home at lunch to sit in a bathtub, and then struggle through the rest of the day until I could get back home into another bath. Every time I made plans, I would stop to envision myself feeling at my worst and wondering if I would be able to get through that activity if I was having a bad day. I would often times make up lies as to why I couldn't attend an event and even cancel a vacation, forfeiting the cost of a plane ticket. Four months into Dr. Fowler's protocol, I don't feel like my life is completely run by this condition now. I am feeling about **50-60% better** and I have gone on trips again and been able to keep plans. I am confident that as I continue with his protocol, I will continue to get better and better.’’ **W. Richardson, Texas.**

‘’I struggled for a couple of years with what my obgyns would call BV. They would put me on the vaginal antibiotic and it would always come back at some point. The real problem was never treated. To say I became frustrated was an understatement. Not having things right in that area is so uncomfortable and embarrassing. I needed to do something as my regular doctors weren't able to solve the problem. I searched the internet to try whatever I could find product-wise to fix it only to find that so many other women had the same issue!!! I finally came across Dr. Fowler's website three years ago. I made an appointment as I was so fed and embarrassed about this issue. Dr. Fowler figured out that my problem was really Altered Vaginal Micro Flora of Noninflammatory Vaginosis. Who knew?? So many gyns had no idea what to do. I have to say I

was just so impressed with Dr. Fowler after my visit. He put me on the correct regimen and it **has been a life change**r. I highly recommend a visit to him.'' **G. Cave Creek, AZ**

"I was referred to Dr. Fowler by my Nurse Practitioner. I was having vaginal itching and burning for years. Nobody could figure it out. I had used every cream available. Dr. Fowler is the only specialist that I have been to that is truly competent. He has **performed miracles** in helping me get better. I would refer him to anyone having women's issues.'' **N. Scottsdale, AZ**

"I have to start this out by telling you that finding Dr. Fowler was truly a lifesaver for me. I had suffered for approx. 25yrs with intense vaginal burning. It affected every aspect of my life and even contributed to the end of my marriage. I saw many, many doctors over the years and most of them gave up on trying to help me. I couldn't sit comfortably, I couldn't exercise anymore, and wearing pants was excruciating. My last OB/ GYN put me on a nerve medication for neuropathy patients, which put my head in such a fog I nearly killed myself on the freeway. In desperation, I went home and searched (again) online for anyone who shared my problem. For some reason, this time, I found Dr. Fowler's website. He personally returned my call immediately (which was another surprise) and reassured me he could help. I jumped on a plane to Phoenix and saw him within a week. His regimen was easy to follow, and within 2 months, I felt about 80% normal! Within 4 months, I felt **100% pain-free**. I continue to see Dr. Fowler and will continue to follow his advice as he **has been a true lifesaver**. I can't understand why there aren't more doctors out there that aren't learning from him so his knowledge will continue to help all women.'' **C. San Jose, CA**

"I suffered from chronic vaginitis for 8 years before coming across Dr. Fowler's site on the internet. Reading the testimonials from other women made me realize I had to go down to Arizona for his help. I have seen over 10 gynecologists in Canada, spent over $20,000 in private healthcare, and would leave the offices in tears because no one could diagnose the problem. Within 3 months of starting Dr. Fowler's treatments, I would say I am already **80% better**. This has been life-changing! For years, I was in constant pain, living with irritation. It affected my mental health as well as my relationships. I cannot begin to thank him enough for diagnosing the problem and giving me an individualized treatment plan that actually worked! I would gladly recommend him to anyone dealing with chronic vaginal issues. He has been amazing." **K. Vancouver, British Columbia, Canada**

"Dr. Fowler is absolutely amazing. He has done something that several other doctors have not been able to do. Identify what my problem was, and then treat my individual diagnosis. This is what makes the difference: individual diagnosis. I was having a discharge with a horrible odor for 2 years. He also took the time to explain the what and why during my first visit, which made me feel better immediately. I had my follow-up visit today and am so happy because I feel that I am about **75% better.** He's really been amazing." **P. Phoenix, AZ**

"I experienced odor, soreness, and burning pain that felt like a terrible UTI that no doctor properly diagnosed. After seeing multiple OB/GYNs, and a urologist, as well as numerous tests and rounds of antibiotics to treat UTIs and BV, I was simply not getting any better. I was starting

to believe my problem was due to an infection that was resistant to antibiotics. I found Dr. Fowler on the internet, and he was not covered by my insurance. However, I was desperate to get better. He properly diagnosed me with inflammatory vaginitis (IV), a condition that I had never heard of, four months later, following Dr. Fowler's rigorous (but effective!) protocol, my symptoms are **dramatically improved**. I am so glad to put this behind me." **C. Phoenix, AZ**

"I suffered with both vaginal and bladder irritations/burning off and on for the past 30 years. I was told that I had interstitial cystitis (of which there is no cure) and tried to manage it with diet. This was after seeing dozens of doctors who could not find anything wrong with me. I've lived with this for years, but recently had a particularly bad flareup that would not go away. While on an interstitial cystitis help page, I came across someone who had been helped by Dr. Fowler and to my surprise, he was located in my hometown of Scottsdale/Paradise Valley. I reached out to his office, and after filling out the detailed patient application, he contacted me directly to inform me that I was an eligible candidate for his protocol. His initial protocol is projected to take up to 4 months to see results...I, however, began to see/feel improvements within weeks. I am now at my 4-month follow-up appointment and am **95% better...nearly cured!** Do not hesitate to reach out to Dr. Fowler's office if you are experiencing any of the above-mentioned symptoms and have not been able to find relief. Help is out there." **D. Phoenix, AZ**

"Suffered for years with vulvodynia, and Dr. Fowler has a wonderful treatment plan. Have to follow the rules but I am symptom-free now since I started with him. Finally! So many doctors and so much pain. Rarely do I recommend it, but in this instance I do highly. Dr. Fowler is so empathetic and extremely knowledgeable. I am fifty- eight years old and began suffering in my 30s. I'm so happy I came and gave it one last shot. **Having a life again and it's wonderful**. Hope your journey is as successful as mine." **C. Scottsdale, AZ**

"I had been having problems with yeast infections for about two years. By the second year I was getting them every other week. I had gone to more than five different gynecologists who gave me temporary treatments but couldn't solve the problem. I was wasting so much money on monistat and anti-fungal pills. I had just accepted the idea that every time I had sex, it would result in a yeast infection. It was affecting my daily happiness, work, school, and relationships. I became very angry that all of the doctors would tell me to wear cotton underwear, change out of my bathing suit quickly, eat yogurt, and shower immediately after working out. One doctor even just blamed it on the heat in Arizona. I changed my whole diet and completely cut out carbs and sugars, only eating protein and vegetables. It was extremely frustrating changing my entire life and not seeing any results. As an otherwise healthy 23-year-old in college, I couldn't figure out what I was doing wrong for my body to keep attacking me in this way. I was very embarrassed by it and wanted to hide it from friends and boyfriends. I felt dirty. Finally, a gynecologist referred me to Dr. Fowler and I saw it as my last hope. When I came to my appointment and he immediately pinpointed my problem, I was nearly in tears. It felt amazing to finally have someone who believed in me, understood my struggle and could help me. After I started my treatment, I noticed results immediately. The treatment was strict, but it was easy to stick with it once I saw it was helping me so much. It's been 6 months now and **I feel like a normal woman.**

I can have sex, wear thongs, swim, work out, and wear yoga pants, and I never have any problems. I still do my treatment but not as strictly as I had to at first. When I think back to my life in the past two years and how miserable I was my only regret, it makes me want to cry. I wish I had heard about Dr. Fowler sooner. It makes me so sad to think of other women who are going through this and see no way out. I felt like I was at rock bottom. I've already recommended him to two people who have struggled like me." **A. Scottsdale, AZ.**

"I was referred to Dr. Fowler by my gynecologist and he said I had a tough condition to cure. I was having episodes like it was on fire down there. I had tears to go with it. I had this dating back to my teenage years from time to time. The last episode would not go away. It just kept getting worse and worse. We came to Dr. Fowler and after 8 months of treatment, the burning had **nearly totally resolved**. I feel like it is a miracle. I would recommend Dr. Fowler. "**M. Wickenburg, AZ**

"I have had pain with intercourse off and on over the course of 19 years. I have a wonderful OB who has delivered five of the six children that I have and he is well aware of the extreme sensitivity that I have had during OB evaluations, pap smears, and intercourse. He did not ever treat my symptoms so I thought something was just wrong with me. After my sixth child, he referred me to Dr. Fowler. I did Dr. Fowler's complete treatment regimen for six months and it was only 50 percent improved, so I was a little frustrated. But I decided to keep going, as some improvement was better than where I had been previously. After ten months, I would say that I was completely better. **Intercourse was no longer painful**, the sensitivity during a gynecological exam was minimal (mostly just uncomfortable instead of extremely painful) and I felt so much better about myself as I realized that this was not something I was making up or was just too sensitive. I had a physical challenge that had been solved and it was so much better. I appreciate that this challenge for the duration of my marriage is no longer there, as I hope to have many more years in front of me without the pain I experienced so many years before." **S. Gilbert, AZ**

"'I had been suffering for 10+ years with episodic burning, discharge, and the most horrible rash on the vulvar tissues. Plus there was an unusual odor. I could not find a doctor who could help me. I saw at least a dozen doctors. They gave me every excuse in the world why nothing worked because all testing kept coming back negative. Then, I was referred to Dr. Fowler by my gynecologist. In 4 weeks after starting Dr. Fowler's treatment, **I felt like a new person**. I could not believe Dr. Fowler knew what the problem was immediately. Yeah for Dr. Fowler, I would highly recommend him!!" **B. Scottsdale AZ**

"Since 2012, I have been dealing with external urethral, vaginal, and anal irritation. I have seen multiple doctors in my area and surrounding areas, including large, well- known medical facilities. I did not have any luck finding help close to home to remedy my discomfort. After three years of trying to find a doctor to help, my friend recommended that I check out Dr. Fowler to see what he could do for me. I found out about Dr. Fowler from a friend from church who found him through an online support group. My friend flew out from PA to see Dr. Fowler two weeks prior to my flight out for my appointment with Dr. Fowler. I have improved almost **90**

**percent** since seeing Dr. Fowler a year ago. Prior to seeing Dr. Fowler, I was unable to comfortably wear tight-fitting clothing, underwear rubbed me to extreme discomfort, working out was uncomfortable, and everyday activities were uncomfortable overall. My overall quality of life is now 90 percent improved since seeing Dr. Fowler a year ago and my symptoms are very well managed. Thank you, Dr. Fowler!" **J. Harrisburg, Pennsylvania**

"My ObGyn nurse practitioner recommended I see Dr. Fowler as I was diagnosed with Lichen Sclerosis. Seeing Dr Fowler and being treated for LS and noninflammatory vaginosis literally saved me. I wasn't feeling very feminine. The treatment Dr. Fowler recommended and I followed brought **good news as to the healing of this condition**. I am thankful and highly recommend Dr. Fowler for this condition." **J. Surprise, AZ**

"I am so happy to say I am thrilled with how much I have gotten better since seeing Dr. Fowler. Being only 22 years of age, I was mortified with the problems I was having: embarrassing strong odor, heavy discharge, and painful intercourse due to low estrogen levels. This problem persisted for a year and a half until my OBGYN referred me to Dr. Fowler since no other treatments seemed to help in the slightest way. I am 4 months in on my treatment and all the symptoms I was experiencing are **80% gone**. I wish I would have been referred to him much sooner, as I am **on track to living a healthy normal life again**!" **A. Gilbert, AZ.**

"I am grateful to Dr. Fowler and his staff for their kind attention to my condition. I had been experiencing chronic vaginal infections with discharge, burning and itching. I had been to several gynecologists who were unable to help me. Dr. Fowler is highly professional and does fabulous work. I am very pleased that I am **finally cured.** I recommend him enthusiastically!" **K. Scottsdale, AZ**

"I struggled for 3 years with yeast infections and constant burning and irritation. I was prescribed oral antibiotics several times by different doctors to combat these problems. I would feel better for a while and then all the symptoms would come back, sometimes even worse than before. I was frustrated and there were no Doctors in Canada that seemed to know what was wrong. I booked myself into the Mayo Clinic in Scottsdale AZ. They referred me to Dr. Fowler at his private practice, Fowler Gyn International.com. After seeing him once I finally had some answers to these problems. He started me on a treatment play right away. About three months after starting I felt 80 to **90% better**. The burning was gone. There was less discharge, no odor, no redness, no yeast infection. I no longer worried about my condition and could do all my regular activities. I could have **intercourse with no problem.** The products I bought in the clinic were very important in my recovery. My skin is very sensitive and these products were not irritating to my skin at all. My entire family prefers his recommended soap as it is not drying or irritating. So glad to have found Dr. Fowler. He made me feel comfortable talking about these issues and optimistic about my recovery. The staff at his clinic were welcoming as well." **P. Calgary, Alberta, Canada.**

"Before seeing Dr. Fowler, I had symptoms for 5 years of vaginal itching and burning and 2 doctors could not give me a diagnosis or help. I saw Dr. Fowler's name on an IC website as

helping many women with vaginal symptoms like mine. I am happy to report that after 4 months of treatment, I am **98% better!**! Thank you, Dr. Fowler!" **S. New Hope, PA**

"Dr. Fowler has **changed my life!** I have been a patient for about a year now and **I'm about 80% better** since when I started. I have been battling vaginitis for over 4 years. Before I found Dr. Fowler, I kept going to my regular GYN for treatment. I was not being treated properly and kept having reoccurring issues. My symptoms of burning, itching, constant odor and constant pelvic floor muscle spasms were ruining my life. I decided to give up on my GYN and started researching my issues online. This is where I found Dr. Fowler and decided to give it a shot. After 4 months from my first visit with Dr. Fowler, I was already 40% better. He is an amazing doctor and is so knowledgeable about vulvo- vaginal issues. Before finding and seeing Dr. Fowler, I wasn't even aware that issues like this existed and their root causes! I don't know what I would have done if I hadn't found Dr. Fowler because my vaginitis was taking a toll on my life and relationships. I highly recommend seeing Dr. Fowler- Thank you Dr. Fowler for all you have done!" **S. Cincinnati, Ohio**

"After treatment for breast cancer, which involved bilateral mastectomies and chemotherapy, I thought life would return to normal. What did happen was a great deal of discomfort from vaginal dryness and a low level of libido. I was fortunate to find out about Dr. Fowler and was able to start a treatment program that has **relieved all of my symptoms**. I am free from the vaginal dryness and pain with intercourse. **Life is now back to vibrant and free from worries**. I would highly recommend Dr. Fowler and his practice." **J. Scottsdale, AZ**

"Good news first 4 months after initial treatment, I am feeling so much better, about 80% improvement. I can have intercourse with no pain, speculums are no longer my mortal enemy and the itchiness/smell that I would get has disappeared. I dealt with vulvar vestibulitis for 7 years and this is the first time that I can have sex without pain. The first time I was diagnosed, my options were super limited. It was recommended that I only wear white cotton underwear and that I switch my laundry detergent to a no scent baby detergent and use a silicone-based lubricant during sex; it didn't work. The next doctor's recommendations were I try a numbing cream before sex requiring my husband to wear a condom every time, and antidepressants because apparently, my vagina was "depressed" or electroshock therapy. None of those options were exactly appealing. The next doctor recommended pelvic floor therapy and it seemed promising but using vaginal dilators to "restrain" my muscles were not particularly pleasant and unfortunately, I had to continue the therapy on my own when we moved and I didn't continue it. It was painful enough with one finger in there. Adding dilators was even more painful and unpleasant. We moved to Arizona and I set up my appointment with the gyno and they gave me two names. I initially thought that if I continued the PVT with a therapist, that might be the way to go, especially since my old physical therapist had had success with that treatment. Then I looked at Dr. Fowler's website and the way he presented his treatment seemed so simple and scientific that I couldn't not go and give it a try. I'll be honest: his website was a lot less warm and fuzzy than other gynecologists' websites, but the scientific way the treatment was presented and the fact that he had gone to the Mayo Clinic convinced me to try it; it couldn't hurt and I'd been dealing with

this for 7 years. It was one of the best decisions I've made so far, and I couldn't be happier. The treatment at least for me, brought a lot of changes initially, and to be honest it was scary, but once I got home and processed what I needed to do it was better. It's not exactly fun as you need to put medications into your vagina, which as you probably know, is not the most pleasant thing to do if you're dealing with vulvar vestibulitis but in my case, after a month, once I put the medications in there was no more burning or itching pain upon contact. I think the toughest part for me has been washing my hair but everything I've done in the last four months has made me **feel so much better** and is worth every little bit of inconvenience I might have felt. You have nothing left to lose. I doubt it can get worse your appointment and hopefully Dr. Fowler can help you like he helped me!" **C. Phoenix AZ**

"After having to burn upon urination and having to urinate 12-15 times before bed, I found Dr. Fowler's office. I received the product for sensitive genital skin a few days after I ordered it. Right away I had great relief from the burning. I'd say I was already **60% better** even before getting the main treatment! I just followed the protocol that was on the information sheet. I'm so gratful to Dr. Fowler!!" **M. Austin, Texas**

"I had burning and itching, what seemed to be bladder infection symptoms with frequency and urgency for 10 years, but when I went to different Doctors, no bladder infection was found. They tried different meds and no meds. After having a bout of horrible itching, I found Dr. Fowler on the internet and came to his office. It's made a **huge difference!**!" **M. Culver City, CA**

"The last 60 days since first coming to see Dr. Fowler have been a complete turnaround in my lichen sclerosis condition. For over 4 years, I have struggled with the symptoms of chronic itching, dryness, cracking, odor and discharge that were all-consuming and uncomfortable. Since beginning the protocol Dr. Fowler has prescribed, I have seen an over **90% improvement** in my symptoms, including those from inflammatory vaginitis, which he also diagnosed. My urge to scratch has completely gone away. My tissues are healing, and I have full confidence that a condition I once thought was hopeless will no longer be a lifelong struggle. I highly recommend Dr. Fowler's practice and am thankful there is a doctor who is treating these conditions so successfully." **K. Sedona, AZ**

"I had an awesome experience with Dr. Fowler. He was recommended to me by my dermatologist. Within 2 months he had **relieved my burning** pain, itching and distress. I followed his instructions and had great results. He and his staff made me feel comfortable. They were very professional and caring!" **S. Silverton, Oregon**

"I was having continual discharge, itching, burning and soreness that no other doctor was able to diagnose and stop the symptoms after a year of various treatments. I found Dr. Fowler by referral by another gynecologist. After following Dr. Fowler's regimen, I was better in 4 months and completely **symptom-free** after 6 months. Dr. Fowler is awesome!" **J. Surprise, AZ**

"I suffered for nearly 20 years with high discharge, painful sensitivity and feelings of inadequacy because of my condition. Other gynecologists dismissed my symptoms. "Some women just have

more discharge," one told me. I had abnormal pap smears because of my condition, which resulted in a misdiagnosis of pre-cancer and what ultimately proved to be an unnecessary D&C procedure. It got to the point that I couldn't even clean myself after going to the toilet without tearing. I couldn't consider having sex with my husband. Finally, a new gynecologist who tore me during a routine exam and to whom I'd recounted my symptoms yet again recommended Dr. Fowler, who was then at the Mayo Clinic. Even though Mayo didn't take my insurance, I took a risk and made an appointment and went to see him. It was the best decision I'd ever made. He was the first physician to take my problem seriously and to actually know what was wrong with me and have a solution! I have since followed him to his private practice. It took a minimum of 6 months to really start to **feel better,** but after 20 years of misery, what is 6 months? I actually started feeling like a regular woman. I could enjoy sex again. I didn't have to constantly change my underwear or wear pads all day because I wasn't wet and sticky. I didn't tear constantly. I didn't itch uncontrollably. By the time I'd been on Dr. Fowler's regimen for a year, I could hardly believe I'd spent so much of my life in such misery. I am still on his regimen years later because it works! I **can't thank him enough for giving me quality of life again**." **J. Tempe, AZ**

"After suffering for months from what I thought to be recurring yeast infections and being misdiagnosed by multiple doctors, I was feeling very frustrated and hopeless. As a young, healthy female, I couldn't understand what was happening to my body. Why was I experiencing this discharge, itching, burning, and pain during intercourse? I tried over-the-counter medications, herbal remedies, and multiple rounds of antibiotics for both yeast and BV; each ended up making my symptoms clear up for a short time and then they'd come back with a vengeance. I'm so happy I found Dr. Fowler online. I came to see him in November in desperation and left with answers and hope. Not only was I treated with care, but he used methods that no other physician had before. He took various tests and then explained the results in detail to help me understand what was going on. He then put me on a treatment protocol. After 4 months, I have seen significant improvements in my symptoms. I'm 80% better overall and sometimes I have **100% improvement!**" **M. Scottsdale, AZ**

"I've had recurring yeast infections for 9-10 years. I found Dr. Fowler on the internet, and after an examination, he prescribed a protocol that has stabilized my system. I have been on it for about 2 years and have seen **great results.** I would recommend Dr. Fowler to other women who have had recurring yeast infections without long- term relief! **B. North Dakota**

"My symptoms began 10 years ago. I think I went to see about 20 doctors and they diagnosed me with different conditions. I would pray to God every day that I would find the right doctor to treat this condition. Finally, while I was doing my research online, I found Dr. Fowler's website. I made an appointment and I thought well I'm going to give it a try. He was able to diagnose me with a condition called vulvodynia and gave me a treatment that worked very well. Now I'm doing a lot a lot a lot better, I'd say **80% better.** Dr. Fowler is an angel sent from God. My life has changed so much. My sex life has changed to be more enjoyable. The burning was just so bad it made me tired. After work I would just have to come home and lay down. Now the **burning is almost gone**. I love Dr. Fowler, he is the best doctor in the world." **G.El Paso, TX**

"I was very fortunate to have found Dr. Fowler. I had been suffering for years with vaginal infections and very painful irritation. I saw him one time and was put on a treatment plan, and very shortly after starting treatment, I started to feel **so much better. He has changed my life so dramatically.** I recommend him to anyone who suffers from recurring vaginal infections and irritation. He is very knowledgeable and understanding." **S. Tuscon, AZ**

"I've been a patient of Dr. Fowler's for almost 15 years. When I update my yearly information prior to my annual appointment, I often read through the testimonials from other patients. I can relate to so many patients, especially the newest ones, because I was there at one time. I was in so much pain, felt so much anguish, saw so many doctors, and thought I was going crazy for 15 years before finding Dr. Fowler. He was the first doctor who recognized my symptoms--they actually had a name!!! His regimen really works. Stick to it and be patient. It may take a few months, but you will finally **feel like a normal person**. Again. Believe me." **C. Carefree, AZ**

"I had seen several doctors before being referred by Mayo Clinic to Dr. Fowler. Dr. Fowler saw immediately what my problems were, the treatment is working, and I'm **feeling much better.**" **E. Chandler, Arizona**

"I had suffered for years with undiagnosed symptoms and had seen a number of doctors back home in Canada, none of whom could diagnose the issue with one visit to Dr. Fowler, he diagnosed my problem as Lichen Sclerosus. An issue that I had struggled with for years, was diagnosed and treated with on visit and I **100% better** within 4 months of the medicated treatment protocol. I was so impressed with Dr. Folwer that after I learned that he had left the Mayo Clinic (where I had first met him), I searched him up and found him practicing at Fowler Gyn International and have followed him there." **T. Edmonton Alberta, Canada**

"I have been a patient of Dr. Fowlers since his tenure at the Mayo Clinic Scottsdale. I lost track of him when I moved to Europe and have since been reunited with him at the Fowler Gyn International. I live in the Cayman Islands now. My issues with vaginal dryness, odor and discharge were creating major problems. Dr. Fowler's treatment helped **relieve all those symptoms** in a matter of a few months. I am very grateful for his knowledge & treatment of my symptoms. I highly recommend Dr. Fowler to anyone with any type of vaginal issues that most Gyn's overlook as routine." **M. Grand Cayman Islands**

"My story is similar to others in that I had been to 5 different doctors comprising 11 visits and still no relief. In fact I had worse vulvar burning and pain with sitting, tight clothes and could no longer engage in intercourse. It was constant. In searching the internet for someone with experience and knowledge regarding this condition, I found Dr. Fowler. At the first visit, he was so concerned and compassionate and knew exactly what I was going through. Coming to Arizona to see him and start the treatment he recommended has made all the difference in the world. It is truly a journey, as he says. After 13 months, I am **70% better** from vulvodynia and **my life has been restored**. My lichen sclerosis has fully resolved. With a few changes in protocol, I feel that I will be completely better soon. Don't give up, as he can help you!!!" **T. Mountain Ranch, CA**

"I was 69 years old when my vaginal symptoms of severe burning began. After visiting several gyn doctors, I found no relief from my symptoms. It was painful sitting, and I had to keep my legs apart, riding in the car was painful, I couldn't let underwear touch me in certain ways, and I could not wear slacks. Out of desperation, I found Dr. Fowler's website and read many of the testimonials from his previous patients. After 4 months of his prescribed treatment, I have experienced an improvement of **50-60%**. I'm just mid-way through the treatment and look forward to getting 100% better. Based upon my experience, I would recommend Dr. Fowler to anyone who is suffering from vaginal misery." **H. Valley Falls, KS**

"I was referred to Dr. Fowler by my regular OB-GYN. Prior to seeing Dr. Fowler, I have been through numerous urinary tract infections, unusual vaginal discharge, and lots of discomfort from vaginal itching, burning and getting paper cuts on the vulvar tissues. Since 2013, I have been seeing Dr. Fowler, and ever since I have become more aware of my vaginal issues and he has been very informative about the problems that I have been having. Since I started using his routine and have followed it for the past few years, I have had positive results. My vaginal issues have **improved tremendously**, and I only now use maintenance therapy so that I can continue to be comfortable with my daily lifestyle. I would recommend Dr. Fowler without any hesitation." **T. Chandler, Arizona**

"I had been suffering for about 2 years, increasing over the time period, with what I was told were yeast infections and bacterial vaginosis. I was almost always uncomfortable with itching and burning and a terrible discharge. I felt terrible about myself and even when I felt well enough to have intercourse, it was painful. I saw 3 different medical providers who continued to treat me with the same medications that would help temporarily and then the symptoms would come back. Finally, the provider who was trying to help me the most heard about Dr. Fowler and told me she recommended I try going to him. Once I looked Dr. Fowler up on the internet and saw that he had helped many women with similar symptoms and experiences as me, I finally had some hope that maybe someone could help me. I immediately started following the protocols on the website and ordered the products. I use peri- wash bottles to carry the Gordon's Boro-pack rinse with me at all times. I found it difficult to wash my hair in the sink, so I wrapped a towel around my waist and leaned over in the shower with a handheld shower head and that has worked well for me. Overall, I have found the products and vaginal treatment protocols easy to comply with. Since I started seeing Dr. Fowler about one year ago, my issue is about 80% better. I have a little ways to go, but my case has been a bit more difficult to treat. The Lichen Sclerosus is **100% resolved.** Dr. Fowler has been very good at helping me understand what was going on and is comforting and kind. He has **definitely changed my quality of life** for the better." **H. Tucson, AZ**

"I found Dr. Fowler through a referral from my OB/GYN office. I was experiencing a lot of vulvar itching with some cuts/cracks on the lips. Also, the whole area was very intense red. Plus the tissues would bleed and there was an odor with a clear discharge. I saw 2 doctors, including a dermatologist. Then, I was referred to Dr. Fowler. I found the treatment that Dr. Fowler has given me was very easy to do. Now, at my 4-month check-up, I feel back to normal again, with

**symptoms 100% resolved**. I would highly recommend him to anyone who is having this kind of problem. And I have given his name to my doctors. He is wonderful!!" **J. Glendale, AZ**

"My vulvodynia is a lot better. There is no pain with intercourse. I used to have tremendous pain afterward, but now only occasionally and just a little bit. The general burning at the opening is infrequent. I used to get it all the time. No more itching. I have had this pain and itching for the last 28 years. It became worse in the last 5 years when I entered menopause. I was treated by other doctors and had no results. I was told to see a vulva doctor. I goggled in my symptoms and found Dr. Fowler. In 4 months, I am about **70 to 80% better.** I highly recommend Dr. Fowler to anyone who has vulva pain and needs relief." **C. Chandler, AZ**

"I dealt with this condition of vulvodynia for over five years. It was not only compromising my daily lifestyle but it was also affecting my marriage to a great extent. I had great discomfort with most activities. Even walking sometimes was painful. My husband and I had a baby a year ago and I was hoping things would improve after having a child. It actually got much worse from there. I was unable to have intercourse after having my baby. It was extremely painful and I physically could not do that. I went to my ObGyn to try to figure out what was going on. He right away referred me to Dr. Fowler. Dr. Fowler put me on my own personal protocol and I've been doing it for about four months now. I've already seen a **huge difference** in the past few months. I've noticed this in my daily lifestyle. I've had way less pain and discomfort. I feel about **70% better.** He told me that I was ahead of the game compared to most at this point. I feel very positive and hopeful that I will feel 100% better soon. I don't know what I would have done without this amazing doctor." **N. Tempe, AZ**

"The problem started around ten years ago and I was told it was due to menopause and just aging. The itching was terrible and I also had pain with intercourse. It was distracting and causing irritability. I saw about 3 doctors for it. One year ago I was diagnosed with Lichen Sclerosus. Then I was referred to Dr. Fowler 4 months ago. Now I'm doing much better; even the vulvar rinse is very helpful. There is no longer any itching or pain. It's wonderful. I'd say overall, **95% of my previous symptoms are gone.** Even the soap is great. I was so grateful I sent a thank you note to the NP who referred me to Dr. Fowler; that was the best thing that happened to me. It **has changed much of my daily life**. I am delighted with how quickly relief started after Dr. Fowler's prescribed treatment!" **B. SunCity West, Arizona**

"I can remember thinking that the trip across the country to see Dr. Fowler would be the last time I would go to a doctor for this chronic condition I had been dealing with for over three years. I was severely depressed and fed up with the doctors who all seemed to be the same. By this point, I had been to so many different gynecologists that I had lost count, but I decided to give it one last try. Doctors I had seen all said my symptoms were just in my head, but I knew that the discharge and odor that I was experiencing were far from normal. My self-esteem was at rock bottom and the thought of sex gave me anxiety; all the enjoyment was gone from it. I don't remember how I came across Dr. Fowler's practice online - most likely during my hours of research trying to find ways to cure myself, a period of time where I felt extremely lost- but I am

grateful beyond measure that I did. Immediately, I was amazed by Dr. Fowler's intelligence. He knew exactly what he was talking about and was sensitive and caring, something I desperately needed during that vulnerable time. Dr. Fowler diagnosed me with Inflammatory Vaginitis and told me every way in which things down there were not healthy and explained how they should be. I can't explain how much just knowing what to call this condition meant to me, as well as the hope I felt about the future. Dr. Fowler told me that for my case in particular, treatment would be a long road, but in 8 months, I have seen **notable improvement** and have faith that it will continue. I fully trust his expertise and his methods and I can't thank Dr. Fowler enough for what he has done for me." **N. Philadelphia, PA**

"One year ago I was in tears all the time because of my pain when urinating and during sex was so bad. It felt like severe burning and itching. I had been to over 10 doctors in the year before that point. They just kept testing me for STDs and giving me antibiotics and steroids, which not only did not help, but made it worse. Finally, the last ObGyn here in AZ gave up and told me I should go see Dr. Fowler. That was the best advice anyone could have given. Dr. Fowler is a miracle worker. Immediately, in the first week I wasn't crying anymore. Within 4 months, I was 90% better and **felt cured.** I would recommend Dr. Fowler to anyone that is suffering the way I was." **J. Sundance, WY**

"It started almost two years ago. I had never had any vaginal issues prior to this. After getting sick with a cold my doctor prescribed me several bouts of antibiotics. When I had finished them I began to have severe vaginal irritation. It started with a yeast infection that came and went for about 6 months. After seeing several gynecologists and after several prescriptions, nobody seemed to know what was wrong with me. The yeast infection finally dissipated but then I was left with a case of recurrent bacterial vaginosis. This went on for about a year. I tried every possible remedy to no avail. I researched for hours on the internet how to solve this terrible thing so many women seem to suffer from. I began to feel depressed and hopeless, like a part of me was missing and I would never get it back again. That was until I found Dr. Fowler!! I came across his website on the internet and after reading success stories told by women like myself, I thought what have I got to lose? After following his four-month treatment protocol I can say that I am ecstatic. I feel like Dr. Fowler has **given me my life back** and I am forever grateful. In those four months he brought my vaginal health back to normal and I **feel 100% better.** I can't say enough wonderful things about my experience with Dr. Fowler. He is truly my hero." **S. Tucson, Arizona**

"I had Candida glabrata vaginal yeast off and on for 6 years before I saw Dr. Fowler. I felt like there was always a discharge and it was painful at the vaginal opening, plus some itching. It had been treated by my GYN multiple times. However, it never cleared up. My gynecologist finally referred me to Dr. Fowler. Dr. Fowler placed me on medication that has **helped immensely** after only 3 months. The yeast is gone!! **What an improvement in my life!** I would definitely recommend Dr. Fowler." **B. Sun City West, Arizona**

"At the age of 27, I started having inexplicable burning pain. I was unable to exercise, unable to wear jeans or most pants, unable to sit comfortably in a chair for any extended period of time, and unable to be intimate with my husband. The pain affected my work life and personal life, because the pain was all I could think about. I saw several physicians in my hometown, and none of them could explain my symptoms or offer a solution. Then I was so fortunate to find Dr. Fowler. I flew out to Arizona, where he diagnosed me with vulvodynia and gave me a very detailed treatment plan. He was very professional, knowledgeable, genuine, and compassionate toward my condition and my pain. He spent time with me, explaining the diagnosis and the next steps. I have been seeing Dr. Fowler for the past 5 years now, and when I compare what my condition was like then to now, it's a night and day difference. As a result of Dr. Fowler's treatment plan, my burning pain is **almost 100% gone! My life is back to normal**, which is something I never thought would happen. I rarely ever think about my condition. I'm so grateful and thankful for Dr. Fowler and his expertise. He has helped me in a way that no other physician could, and I'd travel any distance for that." **A. Denver, Colorado**

"DON'T GIVE UP! Keep reading the countless testimonials on this page and you will be instilled with hope. I was in a serious place of despair when divine intervention led me to Dr. Fowler. I can genuinely tell you that I have been able to reclaim my health, my self-esteem, and MY LIFE with his help in only 9 months!! The time, money, and energy have been a small price to pay for the immeasurable benefit I have gained. My female problems began at age 45 when I began getting urinary tract infections after intercourse. Peri-menopause can be a time when vaginal tissues thin and make women more susceptible to UTIs. I had 7 in one year, which means I had 7 courses of strong antibiotics. This led to countless months of recurrent yeast infections, which set the stage for the development of vulvodynia- a nerve disorder that impaired me to the point of being unable to have intercourse without extreme discomfort. I saw numerous healers to try to remedy my problems to no avail -homeopathy, naturopathy, spiritual and psychic healings and Western conventional therapies were all unsuccessful. Dr. Fowler's training and experience have made him a rare find in the GYN WORLD. The vaginal fluid analysis enables him to very succinctly diagnose problems and he has very effective remedies to address every piece of the puzzle. I was extremely diligent in following every directive I was given, including meticulously following his skin care regimen. You get out of this experience what you put in! Do not cheat and cut corners because it will only diminish your progress. After 9 months on his program, I have been able to resume **having intercourse without discomfort** or distress and have been free of urinary symptoms and yeast infections. I worried that I may never enjoy intercourse again and I am happy to report that I now look forward to it. And I have no doubt that I will only continue to improve with time. I will never find a way to truly thank Dr. Fowler for everything he has done for me. He is not only exceptionally competent, but he is a kind and caring doctor who truly wants to help women who are suffering." **V. Novato, CA**

"I began to have very uncomfortable pain in my lady parts to the point where I couldn't even sit comfortably. I saw many gynecologists back home in Texas and no one could give me an answer. They would just make me feel super confused and scared. My family knew how bad the pain and confusion I was going through and helped me find Dr. Fowler online and we all came down for a

visit. Right away, Dr. Fowler knew what I had and I felt so much relief that someone actually understood what was going on! I have now been on the protocol Dr. Fowler created for me for about ten months and **I feel normal again.** I can walk around in my day-to-day job and duties and I have no pain and I can even have intercourse again! I began to feel much better after 4-5 months and every month after, I have noticed improvement. Dr. Fowler definitely takes the time to make sure you are comfortable and answers all your questions. Traveling to see Dr. Fowler was definitely a trip worth taking." **N. El Paso, Texas**

"After spending 6 months going to my gynecologist every 3 weeks with the same symptoms of burning, itching, discharge, and pain and never getting relief, she referred me to Dr. Fowler. I was unable to be intimate with my husband and it affected my ability to sit in a chair all day at work and to wear tighter clothes. After 4 months of treatment, I am 100% better with sitting and wearing clothes and **I'm 80% better** with symptoms provoked with intercourse. Also, Dr. Fowler was able to get my hormones under control. I could not be happier with the treatment plan he created for me. Having had a total hysterectomy 9 years ago, it is so wonderful not to have hot flashes and night sweats anymore. I would highly recommend anyone suffering from chronic vaginal symptoms to see Dr. Fowler." **M. Phoenix, AZ**

"I found Dr. Fowler through the Mayo Clinic online researching my symptoms. This came about after I had seen 7 doctors in Las Vegas. Frustrated and in pain, I took a trip to Phoenix, and now I'm up to **80% better! My life is back together.** No more itching and burning for weeks on end! I know how to manage my symptoms on a daily basis and keep on track. Thank you so much, Dr. Fowler!" **R. Las Vegas**

"I had been suffering from vaginal dryness and what I thought was some kind of ulcerations in my vulva area, extreme pain like razor blades and rawness with numbness. I had gone to see everyone from gynecologist, urologist, internal medicine, neurologist, just to name a few. After being misdiagnosed with genital herpes and vulvar shingles, I had had enough and decided to get a referral from my gynecologist and general doctor to go see a vulva specialist. So, four months after walking into Dr. Fowler's office, **I'm perfect! No symptoms whatsoever**. Sex is back to what it was when I was much younger, before I went off of hormones, good lubrication, no irritation and everything works, no sensitivity. It's pretty amazing. I had improvement after two months of being on the protocol with progression until resolution. No more skin outbreaks either. I wish more women could have access to this information. I suffered needlessly (and so did my new husband) for over a year and a half. Hurray Dr. Fowler!!!!! Thank you. " **J. Phoenix, AZ**

"For five years, I experienced incredible burning in my vaginal area. My whole life changed for the worse. I was an avid tennis player, worked out regularly at the gym, and loved to travel and socialize. This all changed when I began to experience these awful symptoms. No gynecologist or a specialist could help me or even had a suggestion or referral. My daughter did research on the internet for me and found Dr. Fowler's website. Much to my surprise, there were others who had experienced the same symptoms as I did. I made an appointment with Dr. Fowler who was empathetic and understanding. Just four months later, I feel so much better. I followed Dr.

Fowler's regime very carefully and am happy to report that I am **feeling fantastic**. I would highly recommend Dr. Fowler to anyone who is experiencing vaginal burning." **L Scottsdale, AZ**

"I was searching the internet for help with symptoms I've been suffering with for several years. I had burning and swelling which was painful, difficult even to do routine activities. Had to stop having intercourse. I found Dr. Fowler on the internet and after I read his website, it made me feel trusting. I had already seen a vulvar specialist and was looking for further improvement. My first visit with Dr. Fowler 3 months ago and I already have **improved tremendously**! In regard to the burning I would say it's better! I definitely feel like I'm healing. It's tons better than before starting the protocol. If you are suffering from these types of symptoms I strongly suggest you make an appointment with Dr. Fowler." **G. Phoenix AZ**

"For three months I suffered from extreme vaginal and rectal itching, along with irritation, day and night. It came on suddenly and I did everything I could think of to improve the situation. After going to two primary care and three specialists with no improvement, I found out about Dr. Fowler being referred by the second gynecologist I went to. Within two weeks of following Dr. Fowler's regimen I was remarkably better. Now, four months into it, my symptoms have reduced by **80-90 percent**. I am so relieved to be feeling better. I would highly recommend Dr. Fowler to anyone who shares my symptoms." **W. Gilbert, AZ**

"When I met Dr. Fowler it was literally like hell. It's night and day. It was ruining my marriage. My daily thought was filled with how much pain I was in. It was affecting my time with my children and my relationships with family and friends. I had been suffering with the most horrific vaginal pain for 9 years. Now I'm **95% bette**r. I rarely have any symptoms. I feel great now. **The only thing I ever think about the problem any longer is if Dr. Fowler is no longer available if it were to come back." T. Phoenix, AZ**

"I'm doing very well, overall 80% better. Some days, I don't even know I have a problem. I'm really, really happy about it. Of note I ran out of estrogen and resorted to my old estrogen preparation, which really caused irritation. Now back to Dr. Fowler's preparations. I've been fighting with this problem for about 4 years and am very happy to find Dr. Fowler. No more bladder irritations, **no burning with intercourse**. Always thought I had UTI, but test results always came back negative. WOW, such a difference now with Dr. Fowler's protocol. **Life is great once again.** Thank you, Dr. Fowler!" **E. Phoenix, AZ**

"Oh gosh. I'm **100% better!!** No burning or itching for a long time. I am thrilled. This is a whole lot better. Can't hardly believe it. Previously, I had nothing that helped; I had symptoms for eight years. It began with the burning of urinating. Every provider knew I had Lichen Sclerosus but when I told them about the burning, all they could say was that they didn't see anything causing that. I was just given the same medicine by all gynecologists I saw and dermatologist and none of it helped until I came to Dr. Fowler, a real blessing for me." **M. Sun City West, AZ**

"I have been a patient of Dr. Fowler for 4 months now. When I came to see him for the first time, this was what I wrote in my patient profile." My pain scale ranges from a 6 to a 9 out of 10 at all

times. I have been unable to work and properly care for my child. My mom is here most days to help. I cry every day. I am frightened by this pain. I am so afraid that this will not end or that I will only experience some pain relief under heavy medication which will also prevent me from living a normal life. I am a single parent and my ability to provide for myself and my child depends on my ability to work. This causes extreme stress as well." Four months later, I am living a full life. I work, I care for my child and I am able to do almost any activity I choose. My pain is **85-90 percent** better and I have not finished my treatment yet. I feel that Dr. Fowler has saved me from a life of tears and constant suffering. The doctors I went to in my city said there was nothing they could do for me. There is an answer to vulvodynia and Dr. Fowler has it. Please do no hesitate to see him. It will change your life! I am so thankful to Dr. Fowler for dedicating his life work to women with problems like mine." **J. Winnipeg, Canada**

"I had vulvodynia for 8 years prior to seeing Dr. Fowler. The vulvodynia was so bad that on some days, I could not wear pants or sit for prolonged periods of time. It interfered with all aspects of my life. I had been to many doctors, in many states before finding Dr. Fowler. Dr. Fowler **gave my my life back**. At my one-year follow-up appointment, **80% of my pain is gone**. I no longer think about it all of the time. I know if I stick with Dr. Fowler's regimen, I will continue to get better!" **K. Cincinnati, Ohio.**

"I am much better. I had recurrent bladder infections and urinary frequency and urgency even without bladder infections for 15-20 years. I had seen multiple doctors, including my PCP, a urologist and a gynecologist. Then my executive physician referred me to Dr. Fowler. Since starting his protocol, the sensation of frequency and urgency have resolved and I have had no more bladder infections. His vaginal treatment really works. The testosterone has corrected my low libido and improved my muscle control which I have difficulties with due to Parkinson's. **I have been able to restart yoga which I thought I would never be able to do again**. I would highly recommend Dr. Fowler for patients with any of these symptoms." **S. Maricopa,**

"I have Lichen Sclerosis. I have had it for years without knowing. I went to 3 different doctors until finally my gynecologist referred me to Dr. Fowler. I was experiencing dry, itchy, cracks, and cuts inside the creases of my vagina. Dr. Fowler is amazing. He knew just the right medicine for me. It has been 5 months and I am **so much better**. It was worth the money and worth the drive for me. I would recommend him to anyone with these symptoms." **R. Buckeye, AZ**

"Dr. Fowler's approach is different. In my case, I consulted multiple Doctors, none of whom came up with a diagnosis or treatment plan that worked. One extremely well-trained, respected specialist in New York explained that vulvodynia is a diagnosis of exclusion. He explained that they rule out things you don't have and then conclude you just have pain, burning and irritation for unknown reasons. If this sounds like you or you are chronically suffering, Dr. Fowler may be your answer. Dr. Fowler had an explanation for the discomfort and treatment for what caused me such pain. Dr. Fowler's lab testing uses more advanced equipment, is more sophisticated than the standard wet mount lab tests and is quantitative. This more sophisticated lab testing in my case revealed my problem. Dr. Fowler saw a floral imbalance that he could treat whereas the other

specialist saw nothing wrong with me. The other specialist who was kind and wanted to help only offered that I "live with the pain" and use antidepressants. Not only is Dr. Fowler's lab testing is more sophisticated. He identifies disease states that the mainstream Textbooks don't yet identify. He has researched this thoroughly while at the Mayo Clinic and published his findings. His approach isn't on the fringes of conventional medicine. Rather it is on the cutting edge of medicine. His credentials are impeccable but most importantly, Dr. Fowler has years and years of successfully treating difficult cases and thus, he knows exactly what works. I had a **complete resolution to my symptoms** as a result of strict adherence to his protocols. Lastly, Dr. Fowler is a caring, sympathetic Doctor who has a kind, gentle way. He is always available to provide advice and answer questions. I highly recommend Dr. Fowler and I am extremely grateful for the solutions he provided to me." **L. Dix Hills, NY**

"I had been suffering from intense vaginal pain, itching and burning for 10 years. I saw multiple gynecologists, but no one was able to correctly diagnose what was causing my vagina to feel like tissue paper during intercourse. routine treatments for bacterial infections or yeast infections did not help and I frequently left the doctors' offices in tears because aside from "a little redness and dryness," I looked OK. I frequently had small tears right above the vaginal opening and one doctor insisted it was herpes. In spite of my insistence, my husband and I had been monogamous (testing for herpes was negative). Eventually, my vaginal "architecture" started "melting," and a biopsy finally confirmed an autoimmune disease called lichen sclerosis. The standard treatment for that is a super-high potent steroid cream that can eventually cause the vaginal tissues to thin even more. A girlfriend mentioned this doctor she found that was able to help her chronic vaginal pain, so I made an appointment to see Dr. Fowler. It took 9 months, but Dr. Fowler was able to restore my vaginal flora to a healthy state and I am finally pain-free and **feel like a normal female again!** The anatomy changes from the FS are permanent, but with a healthy vaginal flora and a much lower dose of cortisone cream, I can **enjoy sex again without any pain** and I am free from the constant discomfort of burning and tearing I had been living with. I highly recommend seeing Dr. Fowler if you have been frustrated with the standard medical treatment for vulvovaginal problems" **T. Phoenix, AZ.**

"After more than 25 years of vaginal and pelvic pain, I developed cuts and tears that only added to the frustration. I was crying each time I had to use the bathroom. I've had numerous surgeries, including a hysterectomy, that were supposed to heal my pelvic pain. I've even been to massage therapists and physical therapy and chiropractic treatments, thinking it was nerve pain from my lower back and each specialist told me the same: they could help me and I had come to the right place. They were all wrong. I was prescribed vaginal estrogen creams by various gynecologists that did nothing but irritate me. I had numerous anti-yeast preparations and the only thing they did was cause more irritation and pain. I was very skeptical when I came to see Dr. Fowler. It took about 6 months following the protocol that I was prescribed before I began to see a great difference. It has now been over a year, and I can honestly say I am relieved and have minimal pain. The urgency to urinate, pelvic **pain, burning, and the cuts and slits that would never heal are gone.** I will continue to see Dr. Fowler and I am thankful to have found his practice." **D. Phoenix, A**

"Having problems with my vagina with burning and itching constantly. I went with four gynecologists in Phoenix, AZ and another two gynecologists in Mexico and nobody found what the problem was. I spent one year with different treatments and nothing worked. Finally, a gynecologist referred me to Doctor Fowler and he found the problem. After 4 months of being on his recommended treatment, I am **80% better. my life has changed!** Thank you Doctor Fowler!!!" **C. Phoenix, AZ**

"I had seen several providers when my symptoms began over a year period, and undergone much testing and treatments with no relief of my symptoms. I had become quite frustrated and disheartened. I found Dr. Fowler on the web and I went to see him. After several months of treatment, my **symptoms were completely gone** and I was finally able to have relief and feel normal again. Due to other health issues, I stopped the treatment regimen several months ago and now my symptoms have returned to some degree. I am very hopeful, though, that restarting the treatment regimen will again control my symptoms and allow me to be pain-free. I would highly recommend Dr. Fowler to anyone suffering from vulvodynia as I have true belief in his treatment regimen and it **made the biggest difference in my life** and health." **E. Anchorage, AK**

"I have suffered over 10 years with vulvodynia and lichen sclerosis that no other doctor has been able to discover. In California I saw two providers and two in Arizona before finding Dr. Fowler. Dr. Fowler was able to diagnose my issues on my first visit. It is now 10 months and the vulvodynia is at least **75% better.** The lichen sclerosis is completely gone. He has helped me and my frustrations tremendously. I would certainly recommend Dr. Fowler to anyone that has vaginal problems. I am so glad I came to him." **J. Buckeye, AZ**

"I am delighted to report that after a very short time of using the products for sensitive skin recommended by Dr. Fowler, that alone eliminated 70% of my chronic vaginal pain, even before starting the vaginal treatment. Much of the burning and itching vanished, and still more importantly, the constant onslaught of yeast, BV, and UTIs ceased. I could sit again quite comfortably, and I was no longer constantly "aware" of my vaginal pain. It's a simple, inexpensive, and easy-to-follow protocol- - and the results in my case were noticeable immediately. I began by using the soap, shaving cream and ointment, and then added the vulvar washes. The last ingredient was quite essential to my progress. I'm currently 51, and I've had fifteen years of almost unremitting pain. During this time, I've been to more doctors than I can name here-- all with no results until I found the Fowler protocol. It's amazing to **feel almost normal** again. I had really lost hope. I'm following up with Dr. Fowler in his office, and I hope to get to the next level of wellness with the vaginal treatment. I hope women--and their partners!- everywhere find Dr. Fowler. His approach is **literally life-changing."** M. Bloomington, IN

"I am currently 22 years old, and I have had my symptoms since I was about 15. My vagina would feel like it was on fire or that someone was lighting a match and just holding it there. I tried everything to make it better using numbing creams and steroids. They temporarily helped, but my symptoms kept coming back. When I would have a flair-up, I could not walk or even get out of bed because I was in so much pain. I lived in Colorado at the time and had gone to many

doctors, even one at the Denver Children's Hospital and the OB/GYN told me to just drink more water and wear sweatpants. That did not help at all. Then when I was 17, I moved to AZ and found a doctor who prescribed me some pain pills. Those helped, but did not cure my problem. Then about two years ago I heard of Dr. Fowler through my gynecologist and came to him right away. I got on the regimen he prescribed me, and it did help, but I didn't fully comply and therefore, all my symptoms came back. I then came back a few months ago and got back on the regimen. I have been on it for 4 months now and I am about **70-75% better**. I have gotten used to all the changes and they really are not a hassle anymore. **My life has completely changed** since I met Dr. Fowler. I am so grateful that he helped me. I would still be in so much pain and only treating my symptoms and not actually curing the problem. If you are considering seeing him, I would definitely do so." **M. Flagstaff AZ**

"It's my 8th month of treatment and the word is I am so much better...the itchy, burning discomfort is **pretty much gone**! The good doctor, Dr. Fowler, told me he could help and boy did he. I have been to various doctors around the country and never could get a correct diagnosis, so their treatment(s) made me worse. Ladies, follow this doctor's orders, follow the plan, and you too will be on the road to recovery." **M. Philadelphia, PA**

"Very early on in my marriage, from day one, I experienced pain with intercourse. It burned, it was uncomfortable and quite honestly I hated sex. I didn't want to have anything to do with it. I would itch constantly and be miserable throughout the day. I started seeing doctors immediately wondering if it was just an allergy to sex...secretly, I hoped that was the case so I would have a good reason not to have to do it. After probably 3-4 different doctors, there was "speculation" that I could have "vulvodynia," "vulvar vestibulitis," and "lichen sclerosis." These were just a few of the diagnoses they threw out at me. We tried pills, creams, ointments, and the list goes on. One of the only creams that actually seemed to work was suddenly taken off the market. I felt like I was at the end of my rope. I had a doctor tell me once that if I had a baby it might help things out. My husband and I are infertile and cannot have children biologically. Another dead end. Another 4 doctors and PAs later, including urologists, and still no answers. Then after 12 years of misery, I started to see an OBGYN who seeded to really do his research and was interested in what I was dealing with. We continued to try new things. Since we cannot have children and I was having multiple periods a month (it seemed) and asked if I could have an ablation, to help maybe relieve the pain of wearing tampons constantly. I was still trying to keep my intimate relationship good and so between trying to heal after sex ( a few days) and wearing tampons (a couple of weeks), I was never getting any relief. As a result I asked if "surgery" would be an option for me. The reason "having a baby" could have helped is because if I tore then the theory was they could remove the "bad tissue" while they were already "down there". But without this reason, it was too risky to do surgery. So, now I had a reason for my doctor to proceed with a "vestibulectomy." After recovery from that (6 weeks), I seemed to be better for about 6 months and back to square one. I hurt, it burned, I itched, all over again. This is when my OBGYN referred me to an out-of-state colleague of his, Dr. Fowler. In the 2 years I have been treated, my lifestyle and intimate relationship with my husband **have improved dramatically**. I no longer burn and itch on a daily basis. Sex is actually enjoyable. I don't have to mentally

prepare myself for days. I don't burn during or after sex **90%** of the time. There are occasional flare-ups due to spotting from menstruation post-ablation, but overall, I have been able to have relief and enjoy daily activities more. I work out a lot, and sometimes that would cause pain, but I no longer worry about that with my workouts. I highly recommend Dr. Fowler and his caring staff to anyone dealing with these issues. It's not easy to talk about and after telling my story to many doctors that didn't understand, it's nice to have someone get it and know how to help." **P. Twin Falls, ID**

"Over the last eight months of treatment with Dr. Fowler, I have had **significant improvement.** No more severe burning, itching and agitation after activities or sitting for longer periods of time. Even going to the movies was out of the question due to being so uncomfortable. If you are having any doubts whether or not it is possible to find a treatment that will work, put your mind at ease and make your appointment. The treatment is "doable" and well worth the effort." **S Scottsdale, AZ**

"Finding Dr. Fowler has changed everything for me! I have been suffering from chronic recurrent yeast infections for the past 4 years. I have seen 5 different doctors who kept putting me on boric acid suppositories for weeks at a time, all to no avail. The infection would clear for a bit and then the symptoms would start creeping back again. Not one doctor could figure out why this was happening to me. I am an otherwise very healthy 42-year-old woman. I was in constant discomfort with burning, itching and discharge and became very depressed. I tried everything on my own, from following an anti-candemic diet, taking probiotics, drinking tons of water, weekly acupuncture, and holistic candida cleanses, but nothing worked. One evening, while I was online doing even more research, I googled excessive discharge and Dr. Fowler's site popped up. I figured I had nothing to lose at this point and decided to fill out his questionnaire and see if he could possibly help. Just speaking to him made me feel better, as he was empathetic, understanding, and compassionate and it made me feel like I wasn't crazy. It's hard to suffer from an invisible illness! It's hard for others to truly understand what you are going through, but Dr. Fowler did understand. I knew right away that I was on the right track. After taking the Vaginal Fluid Test, he was able to come up with a diagnosis of Inflammatory Vaginitis. He immediately put me on a protocol of medications and products that I was to use for a four-month period. Today, I am **90% better**! The constant burning and itching were gone after the first couple of weeks of treatment and now **I'm feeling almost completely back to normal**!!! After 4 years of hell, **I have my life back,** and I can't thank Dr. Fowler enough. He is even easier to reach on the phone than my local doctors. Dr. Fowler is the real deal and he will help you!" **T. Valley Village, CA**

"In late 2013, I started having burning and pain in the vestibule area. In a three- month time frame, I saw 8 doctors, tried numerous creams and even had a painful biopsy. Nothing helped and no one could give me a reason for the pain. It was a very emotionally difficult time - I thought I was incurable and would have to live with this pain for the rest of my life. I read "horror" stories on the internet of women who had been suffering for years and could not find relief. I got more and more depressed. I found a great group of women online who have also

suffered from this horrible condition and one of them recommended Dr. Fowler. I was hesitant to fly to another state to see a doctor, but I was desperate, so I called and made the appointment. It was the best decision I have made! Dr. Fowler understood exactly what I was going through. It took some time, but I can say I am **90% better** than where I was a year ago! **I feel like I have my life back**." **A. Bartlesville, OK**

"I have had vulvodynia for over 25 years. I had seen countless specialists over the years but never received relief from symptoms. I have tried botox injections, interferon injections, physical therapy, acupuncture, tissue removal... vestibulectomy, ineffective hormonal treatments, naturopathic medicine, eastern medicine, psychotropic medications and numerous other treatments to no avail. I had never given up hope and found Dr. Fowler using an internet search. His treatment has provided me with a significant reduction at **about 95%** reduction in symptoms at this point and I feel optimistic to achieve full remission of symptoms. I was initially reluctant to try some of his treatment recommendations, but once I did, I was very happy with the results and **finally felt normal** for the first time in over 25 years. Dr. Fowler is incredibly competent and caring. He is always available by phone for questions and concerns. I am very grateful I found FGI and would highly recommend it to anyone suffering from vulvodynia." **C. Scottsdale, AZ**

"I cannot tell you how frustrating the last three years have been trying to find a gynecologist who could and would help me. I have been to five different gynecologists who told me there was nothing wrong with me-one even called me crazy and said it was "all in my head!" Moreover, I could not have intercourse and I felt very insecure ALL the time because of the odor, discharge and burning sensation. If that wasn't enough, I also spent thousands upon thousands of dollars going to these different gynecologists and taking medicine that was unresponsive. Since first seeing Dr. Fowler four months ago, I have made immense progress with all of my symptoms. In fact, I am **60-80% better**! I can finally have **intercourse again without feeling a burning sensation**; the odor and discharge are almost non-existent and I finally am starting to feel secure with myself again. Ladies, I highly recommend you go to see Dr. Fowler if you are having problems that just cannot seem to be resolved. You will not be disappointed and it will save you a lot of time and money in the long run." **I. Gilbert, AZ**

"I had been suffering from chronic yeast infections and chronic vaginal itching for two years before finding Dr. Fowler. I am so glad I finally found him and got the treatment I needed. I had gone to multiple doctors and had been told the same thing over and over. I had tried different medicines. I was so frustrated with my situation because no one had any answers for me or knew what was going on. I felt like I couldn't live a normal life because the itching and irritation were constantly bothering me. One night, my mom called me and said she found a doctor I should go see. I came to Dr. Fowler's office, and my life changed! He diagnosed me with Vulvar Contact Dermatitis and Lichen Sclerosus. Over the course of the treatment for the past 4 months, I've only had about five times where I felt a little fair for 5 minutes or so. I'm definitely more comfortable. Before, it was constantly itching, with no more cuts or swelling. Life is much better. Overall **90% better**. The discharge is fully resolved. I am so thankful to Dr. Fowler for helping

me resolve my issues. **I feel like I can live a normal life again!** I would highly recommend Dr. Fowler. **He gave me back my life**!" **T. Gilbert, AZ**

"When I first started experiencing burning and pain, I went to my gynecologist and was told that everything tested normal. I went back multiple times and was treated very poorly. Eventually, she found an "answer." She misdiagnosed me for an STD. After being put on medication for 8 months with no improvement, I went to a new gynecologist only to be treated the same way, with no relief. Eventually I found Dr. Fowler on my own. I read his testimonials and was hopeful that I might find the answer. The pain and burning consumed my life. It was all I could think about. I was truly miserable. After being put on my new regime, I found relief. At the moment, I feel a **60-70%** improvement. I feel like **I have my life back**. Please be your own advocate and come to Dr. Fowler. It is worth it!!!" **K. Scottsdale, AZ**

"I had been to my GYN every month for six months prior to seeing Dr. Fowler trying to get rid of itching and chronic discharge. With no results, my gyn finally referred me to Dr. Fowler. Four months after starting the treatment recommended by Dr. Fowler, there are no clinical signs of lichen sclerosis. The itching and discharge have **resolved**. This has **immensely improved my life**. I would highly recommend him for any vulvar concern." **P. Chandler, AZ**

"Ladies, please read my review! In September of 2014, I had just left the office of my Gynecologist for the 6th time in the last 4 months. I was stuck in this never- ending cycle of BV and reoccurring yeast infections. My gyno kept prescribing me the same medicine and I remember sitting in her office for the 6th time begging her to try something else because what we had been trying wasn't working. She then gave me Dr. Fowler's card and said I think you need to see a specialist. I immediately googled Dr. Fowler and started reading all of the other reviews. I felt like many of the women who had written the testimonials were experiencing the exact same situation. I called immediately and scheduled my first appointment with Dr. Fowler. After my first appointment, I was a little nervous that some of Dr. Fowler's instructions were kind of crazy (sorry Dr. Fowler)! But, I was desperate and would have done anything to fix my problems, so I followed his regime exactly like he asked me. And let me tell you, it wasn't easy! I am happy to report that after just a few weeks, I was already BV and yeast infection-free! I still had a little soreness during intercourse, but I was much better. It was only one month after that I was **100% better** with absolutely no problems or pain! IF YOU ARE IN A SIMILAR SITUATION, PLEASE GO SEE DR. FOWLER! The key is to stick to the plan he gives you, exactly! No cheating or you won't get the results! *Quick Funny Story- I was on an airplane headed to a bachelorette party when I looked over a girlfriend's computer screen and asked her how she had heard of the soap that she was about to purchase. She said her doctor had referred her to that soap, and she loves it. I asked her if, by chance, her doctor was Dr. Fowler and her face was in complete shock. We were both seeing the same vaginal doctor, although, for separate problems, both had amazing results!" **J. Gilbert, AZ**

"I had problems with extreme vaginal burning and discharge for 8 years. I could not have sex, limit my outside activities, and could not ride my bike or even walk without it irritating me. I

have been to five different gynecologists with no results. My gynecologist in Montrose, Colorado, referred me to Dr. Fowler and **now I feel much better.** I'm not as stressed about it because it is obvious that I'm getting better. The vaginal burning is nothing compared to what it had been. I still have some burning in the peri-rectal area. I can actually have sex without it burning for 2 days like it did. I think about it less. It has been well worth the time it has taken on the treatment protocols to get better. I would recommend Dr. Fowler to anyone with these symptoms." **T. Montrose, CO**

"I want to thank Dr. Fowler for all that he has done for me. Finding Dr. Fowler was the best thing that has happened to me. He has been so kind and understanding with all of my problems. He has always taken the time and has answered all of my questions. If you follow his suggestions, his protocol will work. I have been seeing Dr. Fowler for two years now, and I can say that I am **100% better.** Working with Dr. Fowler and his staff has been a joy. They are always there to answer any questions that I have had by phone or by e-mail. Thank you Dr. Fowler, for **getting my life back." J. Chandler, AZ**

"I had massive vaginal discomfort for 31/2 years. I had seen 4 docs with no relief. I found out about Dr. Fowler by googling vulvodynia. I'm so glad I did. I think it was divine intervention, quite frankly, that I found him. Now at 4 months on his protocol, in terms of everyday discomfort, I'm 60+% better some days **close to 90%** when I don't even think about the problem. Before, it was a crap shoot. Working out, tight clothing, perspiration, and urination all made much worse. Have been using dilators and could feel the sensitivity was getting less, even to the point I wanted to try intercourse again but with trepidation because it had been so painful, I had not been able to engage for two years prior to beginning this treatment. There was some burning but he was able to fully insert and he is well endowed so that's a big improvement. I have gone from feeling helpless and in despair to regaining my self- esteem and hope for my future. I would highly recommend Dr. Fowler to anybody coping with the problems he addressed." **V. Novato, CA**

"I suffered with incredible pain and discomfort and nonexistent sex life for at least a year before finding my way to Dr. Fowler. Just a few months after I started Dr. Fowler's protocol, my labial i**rritation vanished** and I was **able to resume my active life** and my normal sex life. (Boy is my husband happy.) Prior to that, I wondered if my life was essentially over, as I was so uncomfortable and unable to be intimate with my husband. After I found Dr. Fowler, I realized that my gynecologist had been treating the symptoms of my underlying problem rather than the cause, and her treatments were actually making me worse. Finding Dr. Fowler right in my own town has been a Godsend." **D. Paradise Valley, A**

"A little over a year ago I was misdiagnosed by my regular gyn. A friend (a patient of Dr. Fowler) told me about Dr. Fowler and that I should speak to him. I made an appointment and was extremely pleased when I left his office that day with my new treatment plan in hand. I did his protocol as recommended for 5 months now. I am happy to say I am symptom-free. Overall **99.9% better**. Only every once in a while will I have a slight flare, but it goes away on its own.

Sex was extremely painful, but now it's not painful, and we're good. The sense of urinary frequency and urgency has gone away completely. I am 100% happy about how this treatment is going. I would highly recommend any women to see him with any vulvovaginal problems." **D. Phoenix, AZ**

"I found Dr. Fowler through my gynecologist after having symptoms for one and one-half years. I set up an appointment immediately. I was encouraged when I met with Dr. Fowler that my situation was fixable. I started on the regiment he prescribed. And I am thrilled with my progress. I'm not at the finish line yet, but I will be. At this point in time, after 4 months of treatment, I'm overall **60% better**. I feel like I'm doing really good. I've been in the pool and before, it was too raw inside there, and it burned bad and now I do great in the pool. Now I can sit prolonged and it's not so tender when I wash. I'm definitely encouraged that it's getting better. It was a nightmare... it was horrible pain. Also, there is no more discharge. Thank you Dr. Fowler" **P. Scottsdale, AZ**

"I had this incredible pain, on and off, for about 10 years. I had gone through my regular OB/GYN, with little to no results. I was able to work with the Mayo Clinic, and worked with 3 different doctors there, and they had no answers. About two years previous, I had a partial hysterectomy- the theory being that would help, but 6 months later, the pain was back. At the Mayo Clinic, when the doctor left me sobbing in the office, telling me the next step was yet another laparoscopy, a nurse came and gave me hope. She was the former nurse of Dr. Fowler when he was at Mayo and she gave me his phone number. I went to see him, and within 3 months of following his protocol, I was **pain-free-** and remained pain-free for another year and 3 months. I did fabulous! I recently had a relapse due to going off the protocol. (sorry about that, Doc), and will begin again knowing it will work." **A. Gilbert, AZ**

"I started experiencing severe pains in the vulva region around 6 years ago. After first seeing my regular ObGyn I was directed to 5 different specialists in Phoenix, AZ. None of the treatments were working. Around 3 years ago, I decided to call the Mayo Clinic based on a co-worker's recommendations. Mayo referred me to Dr. Fowler. The treatment might have been at the time, but my condition today has improved, and I am back to a normal, healthy life. I'm doing better, would say about **80% better**. My mind is not always thinking about the problem. It has made my life easier, able to do more things. Before, it was difficult to swim or exercise, but now I can do it without the pain. I'm really doing fine so far. Dr. Fowler is the only one I would recommend. **The day he decides to stop and play golf, we are all in trouble." E. Cave Creek, A**

"After 8 months of extreme discomfort of vaginal itching, burning, discharge, and bad odor. I found Dr. Fowler by referral of a friend. In just two and a half months, my symptoms were **90% better.** I have found going out in public a pleasure, not a chore now. I had threatened to use a wire brush on myself now I'm glad I didn't! I highly recommend it. Dr. Fowler." **J. Slayersville, Kentucky**

"Four years ago, I was fortunate enough to find Dr. Fowler at the Mayo Clinic. Prior to that time, I had seen at least 5 physicians who tried to diagnose my symptoms without success. A hysterectomy and gallbladder removal were not the answer. For over a year and a half I suffered a great deal with vulvar pain no one could seem to alleviate. Dr. Fowler diagnosed vulvodynia and lichen sclerosis. With his protocol, I have been **asymptomatic** and **living a normal, healthy life** for the past 4 years after the initial 6 month treatment. To say I am grateful to Dr. Fowler is an understatement." **S. Seattle, Washington**

"I want to thank Dr. Fowler and the staff for helping me with my condition, which I had for two years. My gynecologist said she could no longer help me and referred me to a specialist, Dr. Fowler. He diagnosed me with Lichen Sclerosus. Now I'm **feeling a lot better**, just after 8 weeks of treatment. I'd say I'm **80-90% better**. The itching is gone, and I no longer scratch. The cuts and cracks have resolved and not reoccured. I am happy! I would highly recommend Dr. Fowler and staff." **R. Peoria, AZ**

"I suffered with itching and burning in my crotch for over 7 years. I saw doctors off and on and used prescriptions, which reduced the discomfort for a very short time - but it never really went away. The last doctor said my condition was so bad that they didn't think they would be able to help me and recommended that I see a specialist. I saw Dr. Fowler about 2 months ago. He accurately diagnosed my condition as Lichen Sclerosus and put me on a treatment regimen that has improved my condition 1000 percent! It is such a blessing to finally be **free of the itching and burning**. I would highly recommend Dr. Fowler." **M. Scottsdale AZ**

"After 4 years and 3 doctors, I had literally lost hope that my vaginal conditions would ever go away. My symptoms began in 2010, a persistent thick, white substance in my vagina that my doctors simply couldn't identify, diagnose or treat. There wasn't any pain, odor, or physical discomfort at all, just a very embarrassing white discharge that wouldn't go away. I would avoid intimacy because I couldn't be spontaneous; I was embarrassed and ashamed and my relationship suffered. Finally! I met the doctor (who still couldn't help my condition) but he did better... he referred me to Dr. Fowler. Dr. Fowler diagnosed my condition at my first appointment and started me on the right path to recovery and **getting my life back**. Within only 3 months, I saw the difference, and at my first follow-up appointment with Dr. Fowler, I was already **80% better. I feel better now**, more confident and hopeful. I'm so glad I met Dr. Fowler and his great team." **M. Scottsdale, Az**

"I had clitoral pain feeling like a deep uncomfortableness for 10 years and vaginal odor and some itching. I saw multiple doctors without relief. I was referred by Dr. Kho at the Mayo Clinic to see Dr. Fowler. The experience has been nothing short of amazing! It took me being on the prescribed regimen 8 months, and I became **100% better.** I continue to use the daily cream, and lye soap and will resume the astringent solution. Very, very pleased. **You saved my life, Dr. Fowler**... and my sanity. Many blessings." **K. Jackson, Michigan.**

"Three years ago, I started getting burning and itching and went to my doctor to find out that I had bacterial vaginosis and yeast. I would be prescribed the usual antibiotics and suppositories,

and it would seem to go away but always came back. I was tired of the cycle. I decided to contact Dr. Fowler and to finally find out what my problem is and why it won't go away. It's worth the trip to find out what's wrong and fix this problem of mine. Even having started on his products recommended for sensitive genital skin, within two days, I felt totally better. The **burning and irritation resolved!** At one look he also diagnosed me with Lichen Sclerosus, which had been overlooked by my local doctors. I'm so glad I made the trip, and that's the truth!" **P. Lancaster, Texas**

"I read countless testimonials on Dr. Fowler's website before I felt confident about making an appointment. I had been to so many doctors with no real answers. I can assure you that I am one of the many patients that Dr. Fowler has treated and helped. He was able to make the correct diagnosis and provide the treatment protocol to finally help **my issues resolve**. I am so thankful to have found Dr. Fowler. His specific knowledge and experience have been invaluable to me. He is also a doctor who truly cares about his patients. Thank you, Dr. Fowler. You have truly been a godsend!" **J. Johns Creek, Georgia**

"Before I was referred to Dr. Fowler, I suffered from daily vulvar itching and burning. It affected my everyday life and I was not able to do the things that I enjoyed. Since being on the treatment regimen, I am so much better. My mood is brighter and I can start living again. Overall, **90%.** I can tolerate sitting better than walking, and I can do some bike riding. I have been able to start wearing pants, in the past I would wear skirts. I would heartily recommend Dr. Fowler to provide expert help to all women suffering from these medical problems." **A. Phoenix, AZ**

"Overall, I'm about **70% better**; things are a lot, lot better. Intercourse is so much better, and not painful if I'm following all the protocols. Afterwards can be a little sensitive for like a day. I'm able to exercise and the friction from my clothing is no longer irritating. The protocol was not hard to do, and the benefits were definitely worth it! I'm excited to **have my life back,** and grateful to Dr. Fowler for finding the causes of my discomfort and healing me when no one else could!" **K. Scottsdale, AZ.**

"I had constant cracks and cuts with burning for 3 years. I couldn't sleep and I WAS IN AGONY." After seeing 3 doctors, my PCP referred me to Dr. Fowler. He diagnosed me with Lichen Sclerosus with one look at me. I am so much better. After 3 months of treatment, I'd say **90% better.** I'm thrilled. Run to Dr. Fowler if you have this condition. He is a miracle worker." **D. Scottsdale, AZ**

"I have been diagnosed with vulvodynia and lichen sclerosis and have been seeking treatment for 3 years. I called Mayo Clinic in Phoenix and was referred to Dr. Fowler in private practice at Fowler Gyn International. I began the Hypocontactant Regimen portion of treatment in December and started Vaginal Rejuvenate Therapy in January. In just two and a half months I am already **85% better**! The tissues seem to be healthier, and dense, as before they were so thin. Rare burning, nothing like before and intercourse is now possible once again **without pain.** It is tremendous to have this kind of results so quickly. The quality of my life has truly changed. It is

amazing! I urge anyone experiencing these problems to follow Dr. Fowler's treatment EXACTLY. It is well worth the effort in order to feel so much better!" **S. West Chester, OH.**

"Thank goodness for Dr. Fowler! When I first met with him, I was burning and itching (with frequent trips to the bathroom) most of the time. It was miserable. Now, I am free of discomfort with only an occasional infrequent flare-up. Life has returned to "normal". I am so grateful!" S. Rock Island, I "Having intercourse with my husband had become so painful it was causing real issues in our marriage since our sex life had been so good. The changes leading up to my getting to the point where we did not even want to have sex any longer had been building for years. Other doctors had believed, as I did, that I was experiencing UTI after intercourse and only prescribed antibiotics. As I aged, the other issues became impossible to deal with. No lubricants worked to provide relief. Since coming to Dr. Fowler, I'm doing amazingly better. **No more pain with intercourse**, which is huge. No more sensations like I have a UTI after intercourse. The dilators also made a big difference. They got things opened up again where before I could tell, I was very shrunken down. No more issues with the dryness. At times I would have cracking and staining and that is not happening any longer. I mean, **everything cleared up.** It's awesome." **M. Paradise Valley, AZ**

"I am a new patient of Dr. Fowler's and have been following his recommended protocol for 4 months. I feel tremendously better! I came to see Dr. Fowler to be treated for chronic swelling, burning, and skin tearing. I have suffered from these symptoms for years. My regular gynecologist did not know what to do for me. These symptoms would often mimic those of vaginal infections even when I didn't have an infection and I would be left untreated and suffering. With a proper diagnosis from Dr. Fowler, I am receiving a targeted treatment. For the first time in years, I am not constantly thinking about how bad I feel all of the time because **I am not feeling bad!" A. Oro Valley, AZ**

"I've been on my protocol for 4 months. I'm much better compared to what I was in the beginning. I cannot complain; it's **80% better**. Fewer symptoms all the time. I **don't have that searing pain any longer**. I complied with the treatment protocol, and the results have been positive. Dr. Fowler and the staff are friendly and efficient in their treatment. Don't wait. Schedule an appointment and start to feel better. There is hope... and treatment." **S. Scottsdale, AZ**

"I spent several years going to doctor appointments where drug after drug was given to me for all of my symptoms. Nothing seemed to help. I was referred to a vulvar specialist in Phoenix who only gave me a prescription for a drug I ended up being allergic to. I was So desperate for help. I saw a different gynecologist who referred me to Dr. Fowler. I was in tears when I arrived for my appointment. I never thought I would feel normal again. He changed my life. I am doing well. Much, much better! I don't think about anything down there. It's not part of my conscious daily life anymore. There is **no burning; in fact, it's 100%** resolved. I'm thrilled. I can't tell you how Dr. Fowler has changed my life. I was miserable. Now I'm really happy; I can smile and I can function! I am engaging in intercourse again. It is the experience that it should be. Please, anyone with any of these symptoms, schedule an appointment. Do not waste your time with doctors who

do not understand what is taking place or how to treat the symptoms. Do not suffer when Dr. Fowler has a way to treat you and make your life enjoyable. Growing older needs to be a positive and wonderful experience." **E. Scottsdale, AZ**

"Before seeing Dr. Fowler, I was in such severe pain that it affected my everyday life. I would barely sit down at a restaurant, at my job or even to use the restroom. I had several tests done, which all came back negative, and then I was referred to Dr. Fowler by my gynecologist. I was diagnosed with vulvodynia and lichen sclerosis. After 3 months of Dr. Fowler's regimen and expertise, I am feeling **100% better.** I have not felt any pain, I can use tampons again, and I can continue to be comfortable with my everyday routine. The problems I had never crossed my mind. All swelling, irritation, and itching are completely gone. I would highly recommend Dr. Fowler to anyone who is concerned with vaginal problems. His staff is amazing and I am so lucky to have been referred to such an amazing physician. I can now continue a healthy, regular and comfortable lifestyle! Thank you, Dr. Fowler!!" **R. Scottsdale, AZ**

"About a year ago, my mother and I came across Dr. Fowler on the internet and started making appointments. Through my overall treatment with Dr. Fowler, I have been feeling healthier and have gotten persistently better. At this point, it's about **80% better**. I had horrible pinching vaginal pain during walking, wearing jeans, and exercising. Now after my treatments, I have been feeling a**lmost totally pain-free** vaginally and can exercise or walk whenever feeling healthy down there." **D. Goodyear, AZ**

"I think I'm doing a lot, lot better. Since the first two weeks of treatment, I have **felt normal again**. The dry, itchy and feeling inflamed resolved. Now intercourse has improved a lot as well, no longer cracking or tearing. Three years ago I was diagnosed with Lichen Sclerosis with itching and painful discomfort, treated by a dermatologist, who did a great job, but not enough to get me well until I met Dr. Fowler. Now my life has turned around for the better. The itching stopped, the irritation stopped, and the color of my skin came back to normal. Thanks, Dr. Fowler." **S, Maricopa, AZ**

"I used to have vaginal infections twice a month for the last 15-18 years. I had been to 4 doctors without anyone telling me what I had. Fortunately, I found Dr. Fowler on the internet while I was looking for treatment for my infections, itching, and burning. Lucky me!! I have been in Dr. Fowler's care for the last 11 months, and my condition has **improved by 80%**, with no more itching, burning or odor just occasional discharge. I used to be very conscious about the odor and my mood was usually low and it was difficult to have intercourse because it hurt. Most of my symptoms are gone now. **I am a changed person!** My confidence is back. I am very thankful to Dr. Fowler and his staff. I received great attention, respect, and understanding for my problems. I would recommend Dr. Fowler and his treatment for anyone with a vaginal condition. Thank you, Dr. Fowler!" **P. Huixquilucan, Mexico**

"After suffering from burning and pain and no desire for close to 10 years and putting up with flare-ups, it finally got so bad that I needed to seek medical help. At my routine visit to my gyn I mentioned it to the Doctor, and her recommendation was for me to see Dr. Fowler. After, 4

months of being on the protocol, I feel I have **improved by 80%**, feel much better. The burning sensation went away and the itching is minimal and corrected by closer adherence to the regimen. I really appreciate Dr. Fowler's expertise and wisdom in helping me become a healthier woman." **Y. Fountain Hills, AZ**

"I suffered from vaginal dryness and burning for many years, thinking this would be forever. I tried different doctors, different estrogen creams, pills, everything and nothing worked. Then I read about Dr. Fowler on the web and going to see him was the best thing I ever did. All the products he recommended for me work great and it is a very easy process each day. I have had no trouble. I have been seeing Dr. Fowler for about 7 months and I am **70-80% better** and much happier. I highly recommend you do the same- he really makes it better- it can get better!" **E, Gilbert, AZ**

"After struggling for about 3 years with recurring yeast/vaginal infections, I finally found Dr. Fowler. He is the only doctor who has been able to treat the underlying cause of these horrible symptoms! I was getting infections once a month and would go to my GYN doctor who would prescribe medications to treat the condition. But the following month, I'd get another infection. So after many months of going through this, it became exhausting, going to the doctor each time and getting the same medications. Sure it would relieve my symptoms, but the whole time I knew that it was just a temporary fix and that this would happen again in another 4 weeks. It was very frustrating how no GYN could figure out why or how this was happening so often. I finally went to a new GYN who couldn't make sense of it either, but fortunately, she had heard of Dr. Fowler and recommended that I make an appointment with him. Dr. Fowler was very thorough. He performed the VFA test and could see exactly what was going on and why I was experiencing these ongoing infections. He set me up with a treatment protocol and explained that it does take a little bit of time for things to **improve 100%**. But honestly, after beginning the protocol, I went for an entire 4 months without a single problem, so to me, that was a major improvement! After having these recurring infections every month for 3 years, to make it 4 months without any issues was a major relief. I could actually trust that the protocol Dr. Fowler placed me on was doing its job!! No more having to wonder if there was a way to overcome this problem. Now I know it's possible." **B. Scottsdale, AZ**

"I experienced a mysterious vaginal burning 10 years ago at the age of 30. For 6 months, I suffered from unusual amounts of discharge and burning coming from higher up inside by the vaginal opening, but results found little to no yeast, no BV, etc. The doctors were stumped. After 6 months it mysteriously subsided on its own, but during this time period, I could not have intercourse, and it pretty much disrupted my whole entire life. I had become depressed and irritable, and my condition eventually forced me to take a break from my studies. Once again, these symptoms have revisited me. At the age of 39, almost 10 years to the month, I am suffering from unusual discharging and higher-up vaginal burning by the opening. Three doctors later, a series of failed creams, regimens and antibiotics, I'm back to square one. Now with a child and even more responsibilities, life with my symptoms was a miserable one. I felt isolated and alone, and no one could understand what was wrong with me. I was beginning to give up all hope. 7

months ago, I met Dr. Fowler after being referred to him by a nurse practitioner who came to know me very well, by my numerous visits to her. She asked me to see Dr. Fowler, and without hesitation, I called him. I was desperate to try and see anyone who could help at this point, after a half hour and a special vaginal fluid analysis done in the office. He said to me, I know what you have, he said my estrogen receptors in my vaginal mucosa were not working well, and he placed me on a very specific vaginal regimen, which has come to **change my life dramatically**. Now **80% better f**or vulvodynia, only about 2-3 days per month. Sexually active and it's good. My natural lubricant is now good and I don't have any burning after intercourse anymore, which is fantastic." **Y. Maricopa, AZ**

"Generalized Vulvodynia destroyed my life at the age of 19. I was in extreme pain with no lasting relief. I only get seconds of relief by applying frozen ice bottles. I couldn't walk, sit, stand, wear underwear, or sleep on my side. It was debilitating in every way for the past two years. Imagine a constant 24/7 burning on the external genitalia region and my less problematic at the entrance as well. That's my daily struggle every single day. I never got a second without my skin on fire. Acid being poured on the skin is truly the most accurate description. As a college student, working in a high-end retail store, active in sports, able to have sex, etc. I never saw this coming. Although, I do have to mention I had issues for 3 years prior to this. I had irritation for a week before my period, every single time I menstruated, regular or irregular periods. It always came before, and disrupted my life for a week. So, I always knew I had hypersensitivity in the vulva area, but I never knew it could build up to a pain-level condition. Regarding the post-menstruating irritation, I put up with it, hoping I"d grow out of it. Once this struck me, I then started seeing doctors, countless doctors. I saw a couple of Vulvodynia specialists in my state, but I always left with no hope. At age 20, I knew Dr. Fowler was my calling to the end of my suffering! I found Dr. Fowler by talking to one of his Vulvodynia clients who live in Arizona. I found her through social networking sites months before he launched his website. The only thing I regret is not seeing him sooner!!! I was even in a wheelchair in the Phoenix airport since I couldn't walk or function on my way to the visit. Fast forward to now, 9 months after seeing him I'm **improving 40-50%**! My in-office visit with Dr. Fowler left me envisioning my pain-free future! I believe I would be at a higher percentage by now, if it wasn't for not prioritizing the regimen to a tee. I started noticing relief and then used lidocaine patches for additional relief. Bad idea! Ladies, follow everything and you too will get a good response to the FGI treatment approach! I'm progressing more as the days go on! I'm able to have peace of mind knowing I'm in good hands! My favorite part about meeting Dr. Fowler is that he was confident that he could relieve my pain. He knew what he was doing... and I knew I was in the right place! I'm 21 now, and I'm not giving up on my dreams. I was given a correct diagnosis, easy-to-follow medication ( that really works!), and my prescriptions, so we are striving for 90% improvement in the next few months! I'm very excited!!! Dr. Fowler cares enough to dedicate his practice to helping women with difficult vulvovaginal conditions. I am grateful for my individualized treatment protocol, and Dr. Fowler's guidance! I'm on my way to **getting my life back!** He's very knowledgeable! I finally found the physician I was looking for, with the expertise in the condition I battle!! Thank you for everything. You're greatly appreciated, Dr. Fowler!! **A. Clio, Michigan**

"I had been to several gynecologists and women's health centers, and no one was able to help me. This went on for about 6 years. It was depressing being constantly dry and irritated in the vaginal area. and forgetting about being intimate... it was just too painful. stung like paper cuts. Lubricants didn't add the moisture that was needed for intercourse. Sitting felt different, and sensitive with wiping. Wearing tight clothing felt prickly, like a heat rash. Dr. Kho from the Mayo Clinic saved me by referring me to Dr. Fowler. He is truly remarkable in healing this kind of condition. Spared me from a life of being depressed and feeling alone. I highly recommend him!! Very gentle and understanding. Stay with the protocol, and **your issues will go away**... have faith and hang in there; that is what I can pass on to other women with this condition. It does get better!" **K. Phoenix, AZ**

"I started with my condition after having trouble with the birth control pill. After having multiple infections and problems, my original ob/gyn referred me to a specialist who was able to greatly improve my condition. At that time, I remember having so much pain that my husband and I would have to stop in the middle of having sex because it hurt too much and have to blow dry (on low, of course, after a shower so as not to irritate the skin in the vulva area. That specialist was able to help a lot, although I did not respond. Well, to some of the methods. Fast forward three kids later, and while I felt good overall, I started having strong pain while standing at certain points throughout the month. This was particularly bad during my period, where it would hurt to wear a tampon, but a pad would irritate my skin so much that the whole time was miserable. The pain would become so bad when I was standing that I remember having to stop making dinner one night because standing at the stove just hurt too much, and I had to go lay down. At this point, I found Dr. Fowler, who has been able to help me **almost completely pain-free.** With three children, I can't spend my time sitting or lying down too often. I no longer dread my periods and only have an occasional day where I have pain, and we are working further to adjust my medicine to the point where I look forward to not having to deal with any pain. Many days, I no longer feel like I even have this condition as it is so far from my mind." **B. Phoenix, AZ**

"I have been dealing with my issue for about 2 years now with burning, itching, discharge, and odor. I have gone to see my normal gynecologist (3 different doctors in the same practice) and 2 emergency room doctors, and no one was able to diagnose the problem. I finally went back to my gynecologist to see a new physician, and she recommended me to go see Dr. Fowler. I called his office to schedule an appointment (left a voicemail) and was very pleasantly surprised when he personally called me back to discuss the problem. I filled out the online form after our conversation and had my first appointment scheduled. I am now 4 months into my treatment and can't explain how much better I am feeling. I am **80%** back to my normal self. Even at the exams, at the first one, it felt like I had to be scraped off the ceiling. At the follow-up, the sensitivity was like a normal pelvic exam. I struggled with my symptoms for 2 years, and it controlled my life. I can't explain how excited I am to get back to all the normal activities a 20-year-old should be getting to experience. With my symptoms in "full force," I was a prisoner to them. I was not able to have a normal day without extreme pain and discomfort. As I stated

earlier, I am 80% **back to my normal self** and can't wait to put this behind me and live a full life." **J. Tempe, AZ**

"Before seeing Dr. Fowler, I was having burning and itching and not sleeping well because I itched so much. I could not have intercourse since it hurt so bad. My gynecologist referred me to Dr. Fowler. I have been under Dr. Fowler's care for the last 6 months. His treatment has been great. I feel like I'm getting back on track. Overall, the burning and itching is **100% totally gone!** I also used to get cracks, but I don't get those anymore. I can't engage in intercourse yet because my vagina is too tight. Now, we are working on correcting that. I'm excited that I'm getting better!" **K. Maricopa, AZ**

"Thank you, Dr. Fowler, **I have my life back!** I saw Dr. R. Stuart Fowler approx. Eight months ago, and am so glad I did. I used to have vaginal itching, swelling, and cracks from lichen sclerosis. **I immediately got relief** from Dr. Fowler's protocol and had my life back, resuming all activities that I had dreaded because I knew it would only irritate my condition. Thank you, thank you!" **M. Atlanta, Georgia**

"My symptoms first began in high school with what I thought were chronic yeast infections. I was treated multiple times by my regular gynecologist for months and saw a reduction in "flare-ups," but I never felt totally better. About 2 years ago, the flare-ups started to come back more frequently, and for about six months, I felt like I had a severe and constant yeast infection with itching and burning that was driving me crazy. I was uncomfortable to pee, exercise, or have intercourse. I was again given multiple treatments by my regular gynecologist without relief. Finally, my gynecologist was convinced there was more going on than yeast infections, and he referred me to Dr. Fowler. I was impressed by Dr. Fowler's knowledge and resources in helping with feminine issues that most women (including myself) don't even know exist. I was grateful that he was able to tell me what was going on with my body and give me a protocol to follow that would help me get well. After discontinuing my synthetic birth control and being on the recommended protocol for just a couple of weeks, I saw a major reduction in my symptoms. Within a few short months, I am free of flare-ups and feeling **100% well!** Without Dr. Fowler, I am sure I would not have found the relief that I have, and I am **grateful to have control over my body and life again." J. Gilbert, AZ**

"I have been a patient of Dr. Fowler for 2 years. Before seeing him, I saw three different gynecologists who misdiagnosed my condition and ran lots of unnecessary tests. I was worried that my condition could not be treated, so I met Dr. Fowler. At my first visit with Dr. Fowler, he immediately identified my medical issue and explained thoroughly what was causing it and, most importantly, how to treat it. The treatment plan that he prescribed was effective. Within a month, things started to improve, and I stopped the treatment because I forgot to pack medication when I went on vacation. I know how critical it was to stay on it. Seeing Dr. Fowler **has extremely changed my life**. I'm like **98% totally better!" E. Scottsdale, AZ**

"Vulvodynia was an incredibly painful, frustrating, and depressing part of my life for the better part of two years. I saw numerous doctors, was subjected to multiple tests, and was prescribed

several different antibiotics and other medications that only seemed to make my condition worse. I probably saw 8 different doctors over the course of those two years, none of whom could help. Without anyone who could identify a problem, I was skeptical that a solution existed and made to feel as though the condition was psychological. When I met with Dr. Fowler for the first time, he knew exactly what was causing the pain. He had a positive approach that, with time and management, **100% resolved** my issue! To date, he is the only doctor I have met who understands this condition and the pain that Vulvodynia causes and has a viable solution. He knows what he is doing, and I would hope that someone with a story similar to mine would be able to find his practice and get the help they need as well. This is not a condition that any doctor, specialist, gynecologist, or naturopath can solve; this is an area that Dr. Fowler has dedicated a substantial amount of time researching, and his solutions are working." **C. Scottsdale, AZ**

"Dr. Fowler is a brilliant gynecologist! After just four months, I am **95% better.** He and his staff will greet you with a smile, assist you, and send you off with confidence and a smile. I am thrilled that another physician in the same field who could not help me referred me to Dr. Fowler." **N. Scottsdale, AZ**

"I had my first yeast infection when I was thirteen years old, and I had no idea what was happening down there. My mother took me to the gynecologist, and he gave me a prescription, which gave me relief within a few days. I had no idea this was going to be the beginning of a very long and grueling process. I had one or two infections a year before I became sexually active when I was 20 years old. After that, they became a constant year-round infection. When I was around 26, I had a severe reaction to an over-the-counter product and had to schedule an emergency visit to my doctor. My body could no longer accept the use of any over-the-counter products, and I started taking fluconazole. My mother was desperately trying to find the new "it" doctor to give me any kind of relief without any luck. She felt my pain through the years and had been through every agonizing detail with me until she found Dr. Fowler. In one visit, I knew that my life would change. Now I'm **70% better**. I had been to dozens of doctors who had no idea what I was going through and continued to prescribe me Fluconozole, which helped but never got to the root of the problem." **S. Chandler, AZ**

"Overall, **at least 85% better**. Almost no symptoms. It is a drastic improvement, nearly insufferable before. She complained of persistent incapacitation, burning, and irritation, which has shown dramatic improvement. Quality of life has improved to the degree that her smile is a frequent aspect of daily life. " Written by husband, **A. Scottsdale, AZ**

"It all started at the lake with a UTI. The burn never went away after taking the RX. The symptoms went on for 5 years, and now, oh my gosh, I don't believe it. After 8 months of using Dr. Fowler's protocol, I'm 70-80% better. There are so many more good days than bad, which is so awesome. I have a life again. I didn't have a life. It was depressing, for sure. I'm happy. There is nothing worse than feeling discomfort every day. Nobody knowing what was wrong with me made me feel crazy. I saw about 10 doctors. It became very depressing. Not one Doc could find

out what was going on with my body. Every test was negative, but with the burn that I had, I knew that something was wrong. I had seen so many doctors, and it is so emotionally draining to hear, "Nothing is wrong with you"! It would keep me up at night, and any form of exercise would be too much. It affected my marriage. I would burn for days after sex. After feeling like there was no other choice, I went to the Mayo Clinic in AZ. It was there I learned of Dr. Fowler. Dr. Magrina at the Mayo Clinic referred me to Dr. Fowler. **He changed my life!!**! With intercourse, I don't burn at all any longer! If you have symptoms that I had of burning, stinging, and pain, go see him. The money I spent was nothing compared to the freedom I felt being **pain-free**. My husband adds, "She's a new woman." **B. Boulder City, Nevada.**

"Following a complete hysterectomy in my 30s, I had been placed on a variety of HRT (both pharmaceutical and bio-identical) over the course of the next ten years, as I was thrown into complete menopause. Some products had no effect, while others had horrible side effects. Through bio-identical hormones, I was finally able to get most of my symptoms under control, except for the vaginal dryness. The doctors in my area were competent and WONDERFUL, but they were unable to grasp exactly why all of the creams and potions they were prescribing me were not absorbing or providing relief. I became desperate, as my normal active life was coming to a halt. I had to stop intercourse and exercise, and even my desk job and performing normal activities were becoming painful. I finally turned to the internet for help, and I came across Dr. Fowler's website. Luckily for me, Dr. Fowler's practice was only a five- hour drive away, although I was at my wit's end and willing to fly across the country for a chance of feeling better. The vaginal dryness eventually consumed EVERY aspect of my life. I was unable to have intercourse. However, after one month of treatment with Dr. Fowler, I was able to resume intercourse. In addition, the dryness had become so bad that I could feel tearing of the vaginal tissue and itching as I walked and moved from a sitting to a standing position. This made even working at my desk horrendously uncomfortable. Again, after just a few weeks, I felt tons and tons and tons better. The itching and dryness were all gone, and the burning with intercourse **100% resolved." H. Las Vegas, NV**

"Had symptoms for 2 years. Now 4 months on treatment. I'm getting better. Overall, **80% better irritation, 70% better burning**, and no discomfort with intercourse. I have to say that I have been to many doctor's apt. for what I thought was a yeast infection over and over again. The doctors would make me come in and act like I was trying to get drugs or something, or it was all in my head because they didn't see yeast. The teraconazole acted like a bandaid and worked for a week or two. I was thinking this is crazy. I have better things to do than worry about my vaginal health. Then, finally, my newest gyn referred me to Doctor Fowler. Thank goodness! Although your insurance can't be used, it was the best way to spend money because I finally got results, and I'm on the road to recovery! Alice was so friendly, and of course, Dr. Fowler always returned my calls and answered questions. Thank you to both of you. This is a life-changing event because if you have ever had these conditions, you know that it really puts a damper on things. I really appreciate all you have done, Dr. Fowler, in **getting me back to myself!" K. Phoenix, AZ.**

"Overall, **80% better.** I feel like the treatment has definitely helped. It's not bothering me as much. Some discharge is still there. Discomfort occurs only when I wear jeans and a little with intercourse, but that has definitely improved. Before treatment, the burning was constant and so was the discharge; intercourse was hardly ever. It was consuming. I was constantly thinking about it. I am very grateful to Dr. Fowler and his staff. They are very professional and took the time to listen to all of my concerns. I feel like they knew exactly what I was going through and were able to give me the answers I was looking for. If you are tired of having the same symptoms and trying different treatments that aren't working, I highly recommend giving Dr Fowler a call!" **M. Glendale, AZ**

"I was miserable for several months due to dryness, severe irritation, and painful intercourse. Dr. Fowler recognized my condition immediately. After 8 weeks of treatment, I am feeling **100% better!" K. Tempe, AZ**

"In January of 2010, I was first diagnosed with BV. Little did I know that it would be a long, painful, and extremely frustrating journey that disrupted my physical and sexual well-being. I was diagnosed with BV again and again, every 2-6 weeks. My gynecologist did little to help me. She prescribed the same antibiotics for me for years every time I came in. Well, some know, that one can develop resistance to antibiotics, so this has always been a concern of mine. Not to mention the ongoing infection that never seemed to go away. The only other treatment tried by my gynecologist was a sort of dye, which she tried once with no luck in making any improvement in my condition. She never suggested anything new or other options, even though over the years and frequent visits, she came to know me very well. It almost seemed to not phase her, as if it were normal for this woman in her 20s. My sex life in my relationships was stressful because of this ongoing problem. I felt guilt for not being able to do things with my body that I wanted to and should be able to at my age. My relationship suffered. I feared having sex because I feared being in pain and having to tell my partner to stop. What should be something for a couple to enjoy together became something that I feared and put off, or even suffered through the pain. Even at work, I would be in pain, walking around sometimes to the point of tears. Well, I lost my insurance coverage for a while and went to Planned Parenthood to get my medications. It got to the point in 2013 that I went through 12-14 rounds of antibiotics by October. I had had enough. There had to be someone out there who knew more than the other doctors I had seen. I started looking up specialists in Women's vaginal health online. I then found Dr. Fowler's website and watched a video. Finally, maybe someone who could help me. I'm like a billion times better. It was like a constant infection, and I had used 14 rounds of antibiotics. I'm very pleased; it has been much more pleasant these past 6 months. Also, the pain with intercourse has **resolved** so it's **nice to have a regular sex life again." D. Phoenix, AZ**

"I used to have this condition for 10 years. I went to a lot of doctors, and some of them thought I was crazy. I used to cry myself to sleep almost every night. I wasted a lot of time and energy searching for a cure that was elusive.I tried every snake oil treatment there was and then some. My lowest point was when I didn't want to live with this condition anymore. I cried out to God and he answered my prayers and I found Dr. Fowler. It's been only 3 months and I'm doing a lot

better and feeling a lot better. There are days I don't even think about it, which used to be every day all day long, oh my goodness. Overall **40% better**. Notice discharge once per day but not all day like it used to be. Odor does not notice it very often. I ride the city bus and now have the confidence to get on without an anxiety attack. **I'm feeling almost normal.** I thought I would never feel normal again. I'm getting there." **L. Phoenix, AZ**

"In August 2013, I woke up one morning feeling like acid had been poured on my outer genitals. Thinking I had a UTI, I went to my family doctor, who prescribed an antibiotic. After I finished the medication, I still had burning sensations in my vulva that were not going away. The burning was constant 24/7. It was all I could think about. Any pressure made the pain increase, so I couldn't wear jeans or have sex. I stopped playing tennis and stopped socializing. I saw a gynecologist at MUMC who prescribed Zoloft. One pill, and I was sick for 10 days. I realized I needed a different approach, and started researching specialists. I spent months researching Vulvodynia on the internet, trying to figure out how to get better without taking antidepressants or anticonvulsants. I found Dr. Fowler's website and was very impressed with his background. He offered a free talk, so I called and spoke with him. He assured me that he thought he could help me. I flew from SC to Phoenix, AZ, to see him in February 2014. Based on my VFA test results, he came up with a protocol for me to follow. It has been 4 months since I started the protocol and I have improved about **80 percent**. The burning sensations have decreased significantly, I am able to have sex again and I am back to playing tennis. I am so thankful I found Dr. Fowler and I would highly recommend him to anyone suffering from this condition." **L. Murrells Inlet, South Carolina**

"Thank you, Dr. Fowler, **I HAVE MY LIFE BACK!** I saw Dr. R. Stuart Fowler approx. 8 months ago, and I am so glad I did. I used to have such vaginal itching, swelling, and cracks from Lichen Sclerosus. I immediately **got relief** from Dr. Fowler's protocol and had my life back, resuming all activities that I had once dreaded because I knew it would only irritate my condition. Thank you, thank you! " **M. Atlanta, Georgia**

"After I gave birth and when I started intercourse, it was very painful, felt like burning acid. It was so bad as soon as my husband started just to touch me a little bit. Even when I would sit down, it caused some burning. I waited 6 months with no improvement, and my gynecologist referred me to Dr. Fowler. I was happy he could recognize the problem. His treatment protocol has been very effective. It took just 4 months, and I am **90% better**. I completely recommend Dr. Fowler." **A. Glendale, Arizona.**

"Due to my vaginal problems of burning, itching, and unable to have intercourse, I took to the web to find help. I had problems for 2 years and two other physicians could not help me. Thank goodness I found Dr. Fowler. After 4 months of treatment, I am **80% better.** Dr. Fowler is a kind, gentle spirit who is here to help us women. His assistant is also a very sweet and gentle person, which made my situation not feel so hopeless. Dr. Fowler also makes it affordable." **R. Phoenix, Arizona**

"I first started having the symptoms about 2 years ago. I saw a few gynecologists and none of them could find out what was wrong. They all diagnosed me with recurrent yeast bacterial infection and put me on antibiotics, but my condition did not improve. Tired of not feeling like myself, I decided to give it another try and went to see another gynecologist referred to me by a friend. Thanks to Dr. Richards, I found out about Dr. Fowler. I flew to Arizona to see Dr. Fowler. From my first visit, I could tell I had finally found a doctor who knew what he was talking about. Dr. Fowler diagnosed me with a case of Vulvodynia and put me on a strict regimen for 4 months. Right away I started to feel better. **No more itching, burning or yeast infection. I finally feel like myself again**. What a relief! All I can say is: Dr. Fowler you are a genius, and your magic works! Thank you so very much for all your help." **C. Glenwood, New Jersey**

"I had symptoms of vulvodynia and lichen sclerosis for 6 months with no relief. After seeing my family doctor and a gynecologist with no relief of symptoms, I was fortunately referred to Dr. Fowler. With his treatment for lichen sclerosis and a plan for returning my vaginal flora to normal, my symptoms have gradually and **almost totally disappeared.** I am thankful to Dr. Fower, who specializes in these female problems for helping me to recover from these symptoms." **M. Scottsdale, Arizona**

"I called Dr. Fowler's office to schedule an appointment (left a voicemail) and was very pleasantly surprised when he personally called me back to discuss the problem. I filled out the online form after our conversation and had my first appointment scheduled. I am now 4 months into my treatment and can't explain how much better I am feeling. Even at the exams, although Dr. Fowler is very gentle, at the first one, I was so sensitive it felt like I had to be scraped off the ceiling. At the follow-up, the sensitivity was like a normal pelvic exam. I struggled with my symptoms for 2 years, and it controlled my life. I can't explain how excited I am to get back to all the normal activities that a 20-year-old should be getting to experience. With my symptoms in "full force," I was a prisoner to them. I was not able to have a normal day without extreme pain and discomfort. I am **80% back.to my normal self** and can't wait to put this behind me and live a full life." **J. Tempe, Arizona**

"I have had a yeast problem for the past 10 years, giving me burning and itching and normal doctor visits did not cure the problems. I was disappointed with all the continuing symptoms, and my husband started looking for some type of specialist to address this situation. He was fortunate to find Dr. Fowler's website and got excited that it addressed the same type of problems I was having. We called and made an appointment. Dr. Fowler examined me and immediately placed me on a protocol for treatment. I adhered strictly to his protocol and saw immediate results... with **100% relief** after 2 months. I highly recommend Dr. Fowler as he has cured my problem." **M. Las Vegas, Nevada.**

"Overall, I'm 80% better. This is great! I had been having excessive burning and itching for the past year. After seeing four gynecologists plus my PCP with no resolution to my problem, I lost all hope. I kept thinking maybe it was me but it wasn't. Fortunately, the last gynecologist I saw gave me Dr. Fowler's information. I decided to come in. It was the best decision! I can wear pants. I can actually exercise; I could not do that at all... the sweating was a killer. Don't have

itching in the vaginal area anymore either; we are still working on resolving some in the perirectal area. **All burning has been resolved**. Dr. Fowler's expertise **has given me back my life.** I would highly recommend any woman suffering from severe itching and burning to consult with Dr. Fowler." **R. Phoenix, Arizona**

"When I first came to Dr. Fowler, I was experiencing symptoms similar to that of a urinary tract infection. It turned out that an overdose of antibiotics I was taking for the urinary tract infection, which in fact I did not have, destroyed the good flora in my vagina. I then chose to take an overseas trip that set me further back. I went through great trauma: unable to sit due to discomfort, could not wear underwear, could not exercise, or have intercourse. After 4 months of the treatment prescribed by Dr. Fowler, I am now able to do almost everything I could do in the past. I am **well on the way to recovery** and am confident that the symptoms will resolve 100%." **P. Scottsdale, Arizona**

"Dr. Fowler gave me a miraculous recovery and **my life back**. I began having vulvodynia symptoms in my early twenties. I just didn't know what it was. The vaginal burning, irritation, and itching felt like an infection. The many doctors I consulted with told me, "There's nothing wrong with you. It's all in your head. You need to seek counseling." So, for years, I suffered with this condition in silence, with no relief. In my mid-thirties, my condition worsened to the point that I could not wear underwear or pants without severe pain. I met Dr. Fowler, who quickly diagnosed my condition. Vulvodynia! Finally, I not only found out what was wrong but was given treatment for it! I followed Dr. Fowler's protocol and, over a short period of time, had a **COMPLETE recovery**. This treatment not only saved my health but my relationship with my husband, as well. I continue to see Dr. Fowler to maintain my flare-up-free vulvodynia treatment...and it works!" ***E. - Prescott, AZ ****

"I had vaginal burning, itching, and pain for over 4 years. I went to multiple GYN doctors to be diagnosed with a yeast infection or bacterial vaginosis. None of these doctors listened when I asked about what was causing these to recur. I did countless hours of research online, searching for someone who would provide an answer to my question. I was thankful to find Dr. Fowler, who took the time to listen. I followed his treatment plan and after a couple of weeks, I was beginning to feel relief. After 4 months, I was 70% better. With a small adjustment in my treatment, I am now **90% better. I am ENJOYING LIFE AGAIN!** Thank you, Dr. Fowler. You are truly a God send." ***K. - Clearwater, FL***

"Before seeing Dr. Fowler, I had seen 5 different doctors over the course of two years. The symptoms changed my whole lifestyle; I was depressed and lost the joy of living. I had to curtail activities like prolonged sitting for performances and at the office working. It turned my life upside down. Now, after treatment with Dr. Fowler, the symptoms of BURNING have diminished significantly. I'd say I'm **85% better at this point.** I am very grateful. It's no longer on my mind every breathing second." ***L. - Las Vegas, NV***

"After almost TWO YEARS of having the same issue and not receiving relief from treatments prescribed by my regular gynecologist, I was referred to Dr. Fowler. After just one visit with Dr.

Fowler, he was able to determine the issue and suggest some easy lifestyle changes (e.g., types of lotions and detergents, etc, used) and prescribe vaginal medication to treat the issue. Six months later, I am feeling **70% better** and am on the road to recovery!" ***J. - Chandler, AZ***

"In the last year, I have had 4-5 bacterial and yeast infections that would clear up for a while and then come back. My gynecologist referred me to Dr. Fowler when he realized that he could no longer help me. What a BLESSING Dr. Fowler has become! I have been a Telemedicine/Virtual client since March of 2014. All of my communication with Dr. Fowler has been over the phone. Of course, I wondered how that would work!!! Well, **it has worked beautifully.** Dr. Fowler has always taken my calls or called me back the same day. His step-by-step instructions, which I received in the mail for my 4-month treatment cycle, have been extremely easy to follow. All of my questions were answered in his thorough paper description of my ailment... "Inflammatory Vaginitis." I am happy to report that after my 4-month treatment cycle, I am feeling **80% better**!!! I am relieved to know that I am on the road to feeling better, and I am so happy to share this with others who may also suffer. Thank you, Dr. Fowler, for your expertise!!!!!" ***C.-Truckee, CA***

"If I were to put it into one sentence, it would be **"Dr. Fowler SAVED MY LIFE."** I mean that, literally. Every day, I had wished myself dead. Every day, I dwelled on how to end this horrible, all-consuming pain I was experiencing. My only option was dwindling down to ending my life in the two years of hell I experienced before finally getting Dr. Fowler's help. I had seen my general practitioner, 3 gynecologists, a urologist, and a pain clinic totaling over 80 medical appointments. I was a guinea pig and prescribed 28 different medications, costing more than $6000.00, none of which eased the endless suffering. I tried acupuncture, a herbalist, a naturopathic doctor, and a physiotherapist, costing me over $3300.00, all to no avail. My last hope was Dr. Fowler, so I took a leap of faith and made the 1300-mile trek. It has been 5 months since I first saw Dr. Fowler, and **I am IMPROVING**!!! This journey is not over, but I am seeing the light at the end of this dark long tunnel. If you are wondering, "I've already tried so many different things and spent so much money, and nothing has helped, why would Dr. Fowler be any different?" STOP wondering. **He is different. His testing is different. His regimen is different.** He is worth every penny. Get your life back. Let Dr. Fowler help you. I am so glad I did. Thank you, Dr. Fowler!!!" ***G. - Manitoba, Canada***

"I was diagnosed with bacterial vaginosis 9 months ago by my nurse practitioner. I was given antibiotics and thought it would be resolved fairly quickly. Unfortunately, I was in for the roller coaster of my life and was brought to my knees by this condition. I sought further help from a gynecologist who affirmed the original diagnosis with a renewal of the antibiotic prescription. I was in extreme pain with no relief and managed only by taking ibuprofen, which only dulled my pain for short periods. I sought the help of a naturopathic doctor who could not help me, followed by a female gynecologist who was quick to prescribe more antibiotics without a lab sample, which I refused to take. I was desperate for help. My husband and I found Dr. Fowler's website while researching the internet. My appointment with Dr. Fowler was the beginning of my recovery from the most difficult and frustrating physical condition that I have ever

experienced. I am SO THANKFUL to have met Dr. Fowler and to finally get an accurate diagnosis with a protocol for recovery, which I am dedicated to using as it really works. I have taken the recommendations of Dr. Fowler to heart, and they are now just a regular part of my daily life. My pain has diminished, and MOST DAYS are **COMPLETELY GONE. I am living a normal life**. Who could ask for more than that? My husband and I thank you again, Dr. Fowler, and wish you the best." **P. Medford, OR**

"I have dealt with vulvar pain since the day I got married. Unfortunately, intimacy on my honeymoon was a horrible experience for me, and it had been that way for 13 years. I saw a handful of doctors with multiple diagnoses many different treatments, including surgery to try to get rid of the bad tissue, and no relief. What a miserable lifestyle. It affected my relationship with my spouse intimately and even daily activities such as going to the bathroom. After surgery, I had slight relief for a couple of months, and then the pain came back. My doctor, who did the surgery, then referred me to Fowler Gyn International, and **I am amazed at how different my life is.** I didn't know I could actually enjoy intimacy and have a good sexual relationship. I AM GRATEFUL for the treatment plan and the care the FGI staff has given me." ***P. - Twin Falls, ID***

"I had lived with chronic infections for many years. Had seen several gynecologists who treated me for bacterial and/ or yeast infections with medications that worked temporarily. The problem always came back and disrupted my life and my lifestyle. I had to quit many things that made me happy. I was truly miserable and discouraged, thinking I had Vulvodynia and it would last forever. Then, I found out about Dr. Fowler. His scientific solutions to this chronic problem really do work. I started the protocol about six months ago. I got relief from the outer vulvar area within a week or two, and the rest of the problems went away while I was still on the suppository treatment. I have been **SYMPTOM-FREE** for more than four months. If you have this problem, do not waste any time getting your appointment with Dr. Fowler. He is sensitive, kind, understanding, and knows how to make your condition better. He spent a lot of years figuring out why this condition is chronic and reoccurring and has found the solution. The tests are easy, and so is the protocol. **I have my lifestyle back** and am confident that the condition will not return. It is wonderful that Dr. Fowler cared enough about those of us suffering from this condition to find out why and how to treat it." ***S. - Scottsdale, AZ***

"Vulvodynia was an incredibly painful, frustrating, and depressing part of my life for the better part of two years. I saw numerous doctors, was subjected to multiple tests, and was prescribed several different antibiotics and other medications that only seemed to make my condition worse. I probably saw 8 different doctors over the course of those two years, none of whom could help. Without anyone who could identify a problem, I was skeptical that a solution existed, and made to feel as though the condition was psychological. When I met with Dr. Fowler the first time, he knew exactly what was causing the pain. He had a positive approach that, with time and management, **100% RESOLVED MY ISSUE**! To date, he is the only doctor I have met who understands this condition and the pain that Vulvodynia causes and has a viable solution. He knows what he is doing, and I would hope that someone with a story similar to mine would be able to find his practice and get the help they need as well. This is not a condition that any

doctor, specialist, gynecologist, or naturopath can solve; this is an area that Dr. Fowler has dedicated a substantial amount of time researching, and his solutions are working." ***C. Scottsdale, AZ***

"I have been a patient of Dr. Fowler for 2 years. Before seeing him, I saw 3 different gynecologists who diagnosed my condition and ran lots of unnecessary tests. I was worried that my condition could not be treated, so I met Dr. Fowler. At my first visit with Dr Fowler, he immediately identified my medical issue and explained thoroughly what was causing it and, most importantly, how to treat it. The treatment plan that he prescribed was effective. Within a month, things started to improve, and I stopped the treatment because I forgot to pack my medication when I went on vacation. I knew how critical it was to stay on it. Seeing Dr Fowler has **EXTREMELY CHANGED MY LIFE. I'm like 98% totally better!**" ***E. - Scottsdale, AZ***

"My symptoms first began in high school with what I thought were chronic yeast infections. I was treated multiple times by my regular gynecologist for months and saw a reduction in "flare-ups," but I never felt totally better. About 2 years ago, the flare-ups started to come back more frequently, and for about six months, I felt like I had a severe and constant yeast infection with itching and burning that was driving me crazy. Was comfortable to pee, exercise or have intercourse. I was again given multiple treatments by my regular gynecologist without relief. Finally, my gynecologist was convinced there was more going on than yeast infections and he referred me to Dr. Fowler. I was impressed by Dr. Fowler's knowledge and resources in helping with feminine issues that most women (including myself) don't even know exist. I was GRATEFUL that he was able to tell me what was going on with my body and give me a protocol to follow that would help me get well. After discontinuing my synthetic birth control and being on the recommended protocol for just a couple of weeks, I saw a major reduction in my symptoms. Within a few short months, I am free of flare-ups and FEELING **100% WELL**! Without Dr. Fowler, I am sure I would not have found the relief that I have, and **I am grateful to have control over my body and life again.**" ***J. - Gilbert, AZ***

"Before seeing Dr. Fowler, I was having burning and itching and not sleeping well because I itched so much. Could not have intercourse since it hurt so bad. My gynecologist referred me to Dr. Fowler. I have been under Dr. Fowler's care for the last 6 months. His treatment has been great. I feel like I'm getting back on track. Overall, the burning and itching is **100% TOTALLY GONE**! I also used to get cracks, but I don't get those anymore. I can't engage in intercourse yet because my vagina is too tight. Now, we are working on correcting that. I'm excited that I'm getting better!" ***K. - Maricopa, AZ***

"I was having symptoms of urinary frequency and urgency. I have had UTIs in the past and this seemed similar. I went to a local urgent care because it was the weekend. I gave them a urine sample, and they gave me antibiotics. Three weeks later, the symptoms had not gone away. I decided to go back to the same urgent care. I gave them a second urine sample, and they ordered a pelvic ultrasound. Two and a half weeks later, the symptoms persisted and nothing came out of the ultrasound. I made an appointment and saw Dr. Fowler. He took a vaginal secretion sample

and noted that I had the altered vaginal micro-flora pattern of "inflammatory vaginitis." Then he treated me, and I was **BACK TO NORMAL**. I am also in the medical field, and it is quite common to see patients have unnecessary tests done because of a lack of knowledge. I want to thank Dr. Fowler for educating me about vaginitis. As common as the term "UTI" is. Hopefully, the medical community can also integrate the variations of vaginitis in their day-to-day vocabulary so that more people are aware of these conditions." ***S. - Scottsdale, AZ***

"My gynecologic condition was greatly affecting the quality of my life. I had intense burning and stinging whenever I urinated or had something wet against my vulva. I had pain when standing or sitting in certain ways most of the time. I would often have to shift my weight while standing or walking to avoid the pain I experienced. I could not wear jeans because they aggravated my symptoms of rawness on my vulva. Other constricting types of clothing also made my symptoms worse. I gave up athletic pursuits that I enjoyed, such as attending a cycling class at the gym or using a particular piece of weight-lifting equipment because sitting on it exacerbated the pain. Now, after being treated by Dr. Fowler, my symptoms of Vulvodynia are **100% IMPROVED.** I have **returned to activities I previously enjoyed** and can wear any type of clothing without pain. I am SO THANKFUL for the help which Dr. Fowler's treatment has provided me." ***M. - Gilbert, AZ***

"I've had pain with intercourse for the last 4 years, which has been very frustrating. I've seen 3 different doctors trying to resolve the problem with no success. In fact, surgery was suggested as a possibility for steroid injections in the vagina. Neither was a choice I wanted. Finally, one of my doctors suggested I seek help from a specialist in the lower.48. I went online to research doctors and found Dr. Stuart Fowler. I first saw him in November of 2012, again for a follow-up in June 2013, and now, in November 2013, **I have no pain!**!! It took a while and a lot of dedication to the protocol I was put on, but it was well worth the result. Thank you, Dr. Fowler, from both my husband and myself. ***L. - Eagle River, Alaska***

"About 18 months ago, I developed persistent itching in my vulvar area. My internist referred me to Dr. Stuart Fowler, who specializes in conditions of the vulva. At my first visit with Dr. Fowler, he diagnosed me with Lichen Sclerosus and first put me on a twice-daily ointment. My **itching stopped** immediately. Yesterday, at my one- year follow-up with Dr. Fowler, I was greatly pleased to report that I'm still doing well on his treatment regimen. I am greatly indebted to Dr. Fowler for his passion, expertise, knowledge, continuing education, and commitment to the conditions of the vulva. His proficiency in vulvar conditions is an incomparable asset to the medical community." ***D. - Prescott, Arizona***

“I came to see Dr. Stuart Fowler due to difficulties I had during intercourse. I would bleed and feel very uncomfortable. I was diagnosed with Lichen Sclerosus and Essential Vulvodynia and put on a treatment. After six weeks, I felt much more comfortable having intercourse. The cream prescribed for Lichen Sclerosus has been very effective and I still use it. I had been to numerous gynecologists over a number of years, which, for the most part, did very little to help me. Dr.

Fowler was a God sent to help me overcome my difficulties and now I am able to have sexual intercourse **without pain.**" ***R. - Toronto,*** Canada

“I have had vaginal pain for 3-4 years and questioned medical doctors who told me that I needed to take HRT or just admit I was getting older and intercourse was no longer in the picture. I saw a couple of therapists and then another nurse practitioner. I would get yeast and bacterial infections and it seemed never really to clear up. The NP suggested that I see Dr. Stuart Fowler. After following his protocol faithfully, I have made remarkable progress. I no longer have any discharge or infections and the tenderness is slowly getting less. At this time, after 8 weeks, I'm **80% better!**"***K. - Maricopa, Arizona***

“About a year ago, I developed a vaginal condition that came out of nowhere and was very debilitating. The pain I suffered was agonizing and constant. I sought treatment from at least 9 doctors, including some well-known specialists in the state of Arizona. I spent hours each day researching how to help my condition, and through my vast internet searches, I found Dr. Stuart Fowler's website. His demeanor, compassion, and expertise are unmatched. Thanks to his treatment protocol, I have **gained my life back** in less than a year! It's been **nothing short of miraculous**! For anyone that has difficulty with difficult-to-treat vaginal conditions, I urge you to make an appointment with Dr. Fowler. My only regret is that I didn't find him sooner! Thanks, Dr. Fowler! You have been a lifesaver!" ***A. - Phoenix, Arizona.***

“I had been suffering with vaginal dryness, vulvar pain, itching, and burning for over 20 years. Every doctor I went to told me it was a yeast infection until I saw Dr. Stuart Fowler. When he gave me my diagnosis and told me that he could clear up my symptoms, I almost cried. I had been so depressed from my symptoms overtaking my life. Finally, I received the correct diagnosis and treatment and am feeling **100% better** today!" ***C.* - Carefree, Arizona**

“After suffering with constant external and internal vaginal pain, made worse during intercourse for over three years, and having sought treatment by many supposed experts in the area of Vulvodynia, I finally found Dr. Stuart Fowler. Within a month of treatment, my symptoms improved by 60% and within 8 months, they were **90% improved.** Doctor Fowler has been such a **benefit to my quality of life and marriage**. He is a true expert in his field looking for the root cause of the pain and treating that." ***I. - St. Louis, Missouri***

“When my symptoms began, I thought my life was over at 25. After months of unbearable vaginal burning I came to the realization that I was going to have to give up my career and I was planning to quit working. The pain and burning was so intense that I couldn't concentrate at work. I woke up crying every single morning when I realized that I would once again have to make it through another day with this excruciating feeling. I tried topical remedies, supplements and prescriptions given by my gyno..., but none of it worked. After 3 months of searching I found Dr. Fowler's website and read testimony from other women. Before even meeting Dr. Fowler, he gave me instructions over the phone that instantly improved my pain. He quickly got me in for an appointment and within the first two weeks, my symptoms were 50% improved. I was no longer bed ridden during my free time and I stopped counting down the hours until the

day was over and I could go back to sleep. Within 1 month **I got my life back.** I started wearing clothing other than baggy dresses, I was able to have some sexual activity and finally, I felt happy again. I have seen countless doctors and I can tell you that Dr. Fowler is one of the most competent MDs you will ever meet. He is the miracle that I am so lucky I found." ***K. - Phoenix,* Arizona**

"I presented to Dr. Fowler three years ago with severe vaginal symptoms, including vaginal itching, burning, dryness, and pain, along with frequent urinary tract infections and bladder pressure. Prior to Dr. Fowler, I was given the impression from other health care providers that my symptoms could not be due to vaginal health since 'I was too young' but that they were primarily due to Interstitial Cystitis of the bladder and would remain a chronic part of my life. Dr. Fowler was instantly able to recognize my problem as more than cystitis and started me on my individualized regimen that **has ultimately saved my life**. I went from almost dropping out of graduate school and being in such misery and now **feeling the best I have ever felt,** newly married and enjoying life as it should be. Dr. Fowler provides the most up- to-date science-based practice within his profession and is so well versed as a physician, but even more importantly is that Dr. Fowler provides individualized care; he even has called me on the phone where I live in Texas to answer any of my questions or concerns."***S. - Lubbock, Texas***

"It all began for me with the onset of a yeast infection. It never seemed to go away... there was terrible burning and itching. The burning was unbearable. I went to my gynecologist. I must have gone back to see her 6 or 7 times. Each time it was trying something new. Then came the news from the doctor, "I have no idea what is wrong with you." I was beside myself. I tried another gynecologist. After several more months of going through all the testing, medications, etc. no relief...and it actually got worse. It was everything I could do to get through the day. Sitting was terribly painful; wearing Underwear was a death sentence. I had to wear skirts. An ice pack became my best friend. And this doctor came to the same conclusion... "I have no idea what is wrong with you." I hit rock bottom. I felt like my life had been taken from me. I was a very active person. I exercised two times per day, loved to hike, and was always on the go.... and boom, it was all gone! I went from an extremely happy, bubbly person to basically a numb individual with no life left in me. The doctor who basically saved my life is Dr. R. Stuart Fowler. This man is the most amazing doctor I have EVER met in my life! Aside from being intelligent, he possesses a bedside manner that is absolutely the best. He was sympathetic and understood what I was dealing with. He ran several very specific tests. It was then when I heard the words for the first time..."You have a condition which is called Vulvodynia." Today I have a **90% improvement** from following Dr. Fowler's protocol. I am **getting my life back!** I am no longer spending every waking moment thinking about my vagina. I know there are a lot of women out there who have this condition, but they don't even know what it is or where to get help. I am writing this letter to give other women hope and knowledge that they CAN recover from this condition. Dr. Fowler can help you." ***D. - Scottsdale, Arizona***

Dear Doctor Fowler, I have been a patient of yours for many years and have found you to be a wonderful doctor; thorough, lucid and caring. As you know, I am a pharmacy technician and in

that capacity, have spoken with many of your patients as they come to fill their prescriptions. Inevitably, the stories they tell me are all the same. 'I have been suffering with my vaginal problem for 5, 10, 15 years. All my other doctors told me I was imagining the problem. I have been to 3,4,6,8 doctors before I found Dr. Fowler. He was **the only one that was able to help me.**' I wish you all the best and want you to know that you have been wonderful to me." ***A. - Scottsdale, Arizona***

"Three months ago, I began to have a yellow vaginal discharge. Dr. Fowler diagnosed and prescribed medicine for me. After using it for three months, my condition has **improved 90%.**" **M. - Scottsdale Arizona**

"Upon having burning, my doctor treated me for yeast infection...twice. Then, I waited to be seen by Dr. R. Stuart Fowler. He diagnosed vulvar lichen sclerosus and treatment was begun. At the end of this initial treatment period **I was beginning to have some natural feeling in the area!**" **L. - Las Vegas, Nevada**

"To all women who might not be having sex with their partner because of pain and burning during sex. I highly recommend that you see Doctor Fowler. **He gave me my sex life back**! Don't give up, there is hope and Dr. Fowler can also help you with your vulvar problems." ***L. - Case Grande, Arizona***

"When I was in my late 50s, I got something that caused my vagina and anal area to itch profoundly. Dr. Fowler told me that I have Lichen Sclerosus. He even went so far as to show me what it looked like during the examination. I looked at the screen and I could see it for myself. He was so nice and kind and at last, I had a doctor that told me everything. Dr. Fowler gave me a cream. After about a week, maybe a week and a half, I was like **100% better**. I want to highly recommend Dr. Fowler. He reassured me through the whole process that I didn't need to be afraid of this disease. You cannot believe how good it feels to know you have a doctor you can be open with and tell your problems to." ***B.- Laveen, Arizona***

"Doctor Fowler not only listens to his patient but has the knowledge, confidence, integrity and compassion to gain the confidence and respect of his patient. I had been to several well-respected GYN physicians in California and no one had been able to provide a lot of relief, but certainly a lot of dedication and interest. This was a period of ten uncomfortable years, and much discomfort and a changed life. When we moved to Arizona, I went to several GYN doctors that provided miscellaneous treatment and drugs, even injections in the vaginal area that provided temporary relief but no permanent help. Then, I heard of Dr. Fowler from several nurses. I had reached a point where I could not make any engagement as I was too uncomfortable to be around anyone or make any kind of commitment. After his patient listened and understanding of the problem, he started treatment for Vulvodynia. What a difference... November 2009 to April 2010, six months. The last appointment was in April 2010. **He said to call IF I have any more difficulty (Ten years, six months). Talk about miracles!!!!"** ***E. - Scottsdale Arizona***

“I suffered with the symptoms of Vulvodynia for almost 2 years before I was diagnosed correctly. I had seen my gynecologist on countless occasions, complaining of searing vulvar pain, itching, and burning. I was unable to sit comfortably, ride a bike, use a tampon, endure a gynecological exam or have a healthy sexual relationship with my husband without major discomfort. The pain was indescribable. For a year, my gynecologist treated my pain as a symptom of a typical yeast infection, as they presented similarly. After several months of unsuccessful treatment, she intimated that there could be emotional-related relationship issues between me and my husband or high-stress levels, which might be the root cause of my problem. I wanted a second opinion. Fortunately, I was able to see Dr. R. Stuart Fowler, M.D., in Phoenix, Arizona. Dr. Fowler examined me, ran some diagnostic tests, and, in about 30 minutes, dismissed the possibility of vulvar leukoplakia and the pre-cancerous potential associated with it. He put me on a broad-spectrum regimen. While feeling a bit overwhelmed by such an intensive approach, I was willing to try anything to relieve my discomfort and lead a normal life again. Let me go on record by saying that my symptoms improved in 3 days. As I began taking the medications, my pain level decreased quickly and dramatically. ! I understand that response usually begins after 4-6 months of treatment. However, my response to Dr. Fowler’s regimen was more rapid. In fact, **90%** of my pain was gone in 3 months” ***L. - Edwards, Colorado***

“Dr. Fowler, I am writing this note to express my gratitude to you for helping me with my vaginal condition. I can’t tell you how much it meant to me to **have things under control**. I had prayed for **a miracle** and God answered my prayer with your wisdom. Thank you for all you have done for me and that you continue to do for others. God bless you and your work.” ***B. - Scottsdale, Arizona***

“In the last four years I have seen four different physicians before seeking treatment with R. Stuart Fowler, M.D. My experience has been that physicians take cultures and biopsies but, do not have an answer when everything comes back. They hardly address any of the “quality of life symptoms” such as burning when clothes (slacks) are rubbing against the area, and you tell them you already only use cotton underwear, or when sexual intercourse irritates continually! In fact, I had been told, “You’ll have to use XXX cream for the rest of your life, or it happens this time of year because of the heat. A lot of my patients are coming in for the same thing!” So I lived with the constant problem and symptoms not knowing that there was a better treatment. Finally, an internist told me she had a colleague who specializes in this area. However, I waited another 14 months because she prefaced her comment with, “If you don’t find any relief with what I give you,” and my prior interpretation of that was I needed to ‘wait it out’ again! After I finally got referred to Dr. Fowler, I especially liked the fact that Dr. Fowler gave me a detailed sheet on how to care for the vulvar area daily. After two months of following his treatment plan, I received significant improvement, which after four months is about **85% better** than when I first visited his office. His treatment has allowed me to wear slacks again. Before I could only wear slacks for only a few hours each WEEK without significant pain and discomfort returning, I can also pursue my normal married sexual life without worrying about the pain the next day!” ***D. - Chico, California***

“Vulvodynia has severely impacted my life and my enjoyment of life. In general, it affects my ability to work, to socialize, my marriage and my ability to just relax. In addition to the physical aspects of the condition, just thinking about the pain as I write today remains a very emotional event. In July 2011, I went to a dermatologist for help, who took a biopsy and diagnosed it with no lichen sclerosis but eczema only. Desperate, I then visited a GYN clinic and was told that the area was not lichen sclerosis and that my condition was nothing more than slight irritations. I asked to be referred to a vulva specialist, which was not granted as the doctor felt that my condition “did not warrant a specialist.” I found Dr. Fowler who efficaciously treated me for lichen sclerosis. Following just a few months of treatment by Dr. Fowler, I am happy to report that I am now **90% symptom-free.**” ***C. - Scottsdale, Arizona***

“I consulted Dr. R. Stuart Fowler in Phoenix in 2001. I had been suffering from chronic vulvar pain for months after a yeast infection that developed from antibiotic treatment for UTI. I had terrible burning symptoms and vulvar pain. My gynecologist was unable to provide relief from my symptoms. She referred me to a dermatologist who gave me a two-week course of a super-potent steroid but this did not provide relief. I finally consulted Dr. Fowler and I began following his regimen. After five months, my symptoms were under control. I have continued to follow his program for the past ten years and my **pain has not returned**! I would highly recommend Dr. Fowler to any patients having vaginal problems.” ***K. - Sedona, Arizona***

“I am writing to thank the NVA for referring me to a local physician knowledgeable about Vulvodynia (Dr. R. Stuart Fowler). I have had the condition for approximately 7-10 years and have seen four other physicians who could not help me. When I first saw Dr. Fowler in February of 2010, I was unable to perform simple daily activities. Example: sitting at my work desk, wearing jeans or pants, walking distances of jogging, intimacy with my husband. I experienced a daily ongoing pain level of 2, with pain episodes reaching a 7 on a 1-10 scale. After a year of following Dr. Fowler’s protocol, I am now much improved. I can sit for long periods of time, wear jeans or pants for several hours, play tennis and enjoy intimacy. When I do have a pain episode, it is much less painful and it does not last. I consider myself at least **80% better** and feel **I am now able to live a ‘normal’ life.”** ***B. - Phoenix, Arizona***

“Here’s a question for you... is it a good thing or a bad thing when your gynecological condition gets discussed on Dr. Oz’ show? I know from experience you can go about treating it the wrong way! I have been treated for vulvodynia symptoms since 1993, though I did not realize that was what I had until 1997. At that point, I switched doctors to Dr. R. Stuart Fowler. My prior vulvar specialist wanted to put me on Interferon for it, and as I was hesitating to accept this regimen, I ran across a nurse who recommended Dr. Fowler to me. Dr. Fowler got my symptoms under control within the first 6 months. More importantly, he has helped me with later flare-ups caused by changes in my body related to long-term birth control pill use and aging in general. At various times in the past 14 years, I have gone to in-network physicians for flare-ups when I didn’t have insurance coverage for Dr. Fowler. Every time, I ended up going back to Dr. Fowler out-of-network. **It was always worth the investment!** As a result I did not listen to the crazy ideas other physicians presented to me, ranging from inserting dissolved acidophilus capsules in olive

oil in my vagina to one doctor's insistence that I must have contracted something from my spouse." ***L.- Carefree, Arizona***

"Starting in the year 2005 and until the year 2008, I was treated by five different doctors. Instead of getting better I kept getting worse and worse. Finally, I went to the emergency room because of intense pain. They said, "We can find nothing wrong with you." My pain kept getting worse. I spent my retirement days lying in bed doubled up in a knot. I didn't get out of bed and I got fat. In the summer of 2008, I had the good fortune of being a patient of Doctor R. Stuart Fowler. He diagnosed me with Essential Vulvodynia and within four months' time, I had a **100% resolution**!" ***J. - Tempe, Arizona***

"Throughout my early 20s, I had endured bouts of what doctors thought were chronic vaginal yeast infections. I visited approximately 12 doctors between 3 states. The "chronic yeast infections" seemed to get far worse. I was on hormone replacement therapy, but doctor after doctor (another 5 or so) also prescribed a full gamut of cures from yeast medication, combined with special "yeast-free" and "sugar-free" diets, to vinegar couches and boric acid. No one was helping me and the pain I was in was unbearable. I resorted to wearing loose-fitting dresses, walking as little as possible, abstaining from intercourse and enduring bouts of severe depression. In 2002, I visited yet another doctor in Scottsdale and she told me that she could not help me but knew who could: Dr. R. Stuart Fowler, Assistant Professor. So, I made the appointment, but with little expectation for a cure, let alone a diagnosis. Immediately during the examination, Dr. Fowler knew exactly what I had. I was stunned. I actually had a named condition and this doctor had dealt with it before! When I returned home, I cried. I had been suffering for at least 12 years, and no one could ever help me. And now, there was even medication and a regimen to follow that would relieve my symptoms. I started to improve right away and after a couple of years under Dr. Fowler's care, I was finally **symptom-free!**" ***C. - Carefree, Arizona***

"As a two-time breast cancer survivor, I was not able to take estrogen. Having lacked this estrogen protection in the vagina, I was continually picking up urinary tract infections over the years. I was treated with standard antibiotics by MDs and OBGYNs. I was always sent home with nothing more than, "Take the prescribed antibiotics and Diflucan for yeast." Over and over again. The story never changed. I was referred to Dr. Fowler. Instantly, Dr. Fowler identified the symptoms and, without hesitation, knew exactly what to do and how to treat this condition. This was the first time I heard this diagnosis. **Dr. Fowler saved me from a life of living agony**, for without his expertise in this subject, I don't know where I would be today." ***S. - Scottsdale, Arizona***

"I had been suffering for almost two years. There were several visits to my Ob-Gyn, but nothing was working. I decided to get a few extra opinions from another 3 gynecologists. Same story every single visit, antibiotics for 10 days, and once finished the symptoms returned. So, finally, I found Dr. R. Stuart Fowler. He set me with an extensive treatment of different medications that lasted around 8 weeks. It's been over a month since I completed the protocol he gave me. And I am very excited to report that the **symptoms are gone,** the irritation is gone, and **my life is back**

to normal. I would say that my vaginal flora is back to normal. I can not thank Dr. Fowler enough!" ***A. - Phoenix, Arizona***

"Following treatment with antibiotics during the summer of 2010, I developed what I thought was a yeast infection, but standard over-the-counter medications did not improve the situation. Symptoms included itching, burning, and extreme sensitivity to clothing, such that I could only wear pants at least one size too large. I saw Dr. Fowler in October 2010. He diagnosed my condition. I carefully followed his instructions, resulting in a gradual lessening of symptoms. When I again saw Dr. Fowler in February 2011, I had improved by **90 percent.** I am now able to wear the correct size pants without discomfort and have been able to have intercourse for the first time in months." ***N. - Sedona, Arizona***

"I am a 63-year-old woman who visited Dr. Fowler due to a complaint of vulvar burning during voiding and I also had pain during intercourse. After 1 month of Dr. Fowler's treatment, I felt better. Now, after 1 year I feel 80% improved. Dr. Stuart Fowler was a God sent to me after 5 doctors in Toronto couldn't help me with my problem. He came up with a plan that managed my symptoms and enabled me to have **pain-free intercourse** with my husband. I am very thankful to him!" ***R. - Toronto, Ontario Canada***

"I was diagnosed by Dr. R. Stuart Fowler, a specialist in Phoenix. My symptoms began in June of 2009 practically overnight and I took several doctor visits to both gynecologists and urologists before I was diagnosed. Actually, I was watching a broadcast of Dr. Oz, who had a segment on his show about Vulvodynia, and when I heard the symptoms, I spoke to my doctor about it at my next visit. She sent me immediately to Dr. Fowler to see if I had Vulvodynia. As I said, I saw many doctors in that one-year period of time and some made me feel like I was nuts. Only after I started my treatment with Dr. Fowler did I feel some relief. It is now almost a year later and **I am back to my old self again.** I started feeling much better in June 2010 and **feel absolute relief now**!" ***L. - Anthem, Arizona***

"From May 2010 until November 2010, I was treated by another physician for a vulva issue. I began seeing Dr. R. Stuart Fowler in November 2010. After following his treatment plan for the last six months, I am now 7**0% improved**. Obviously, I'm well on the way to having this problem completely resolved." ***S. - Surprise, Arizona***

"I am a 66-year-old woman patient of Dr. R. Stuart Fowler. I am writing to commend him for the successful treatment of my "complicated case." I was referred to Dr. Fowler by my family physician. After a thorough assessment, he prescribed an intensive...actually, I think I'd call it aggressive protocol, which he assured me that to achieve relief from my symptoms, I should follow assiduously. I did so and within two to three months many of the symptoms had subsided, and with attention to the remaining protocol, I was pretty much symptom-free within six months. I am happy and relieved to report that I remain **symptom-free** by continuing the still relevant parts of the protocol he prescribed!" ***J. - Sedona, Arizona***

“I fought with finding a diagnosis for my vaginal pain for 3 years and misdiagnosed and treated for a couple of things from different doctors during this time that turned out to be the wrong answers. It got to the point that I was SO frustrated with pain and not sure that I would ever get over it! Then came the answer to my prayers: Dr. R. Stuart Fowler in Scottsdale, AZ. Within 30 minutes of my first visit with him he gave me the diagnosis in October of 2009. He assured me that if I promised to stick to his regimen of a strict list of requirements, I would have relief. Along the way, I went back to see him around every 4 to 6 months, and he admitted to me that I was one of his more difficult patients to clear up because of my body not responding to a few of the medications. After 18 months, I now have complete relief!! **I now have my life back,** and I owe it all to Dr.Fowler! I feel it cannot go without saying that not only did **he cure me** and finally bring an end to my long-endured pain and frustration, but he also was a true supporter and a truly great doctor through the whole ordeal!” ***P. - Lebanon, Missouri***

“I was having difficulty doing my job, I stopped working out and hiking, I was lucky to get 2 hours of uninterrupted sleep because of the pain, my marriage was impacted and my quality of life was diminishing. Unless you live through it, you cannot imagine living like this. I saw an OBGYN-Urology specialist – was treated for urinary problems, but the pain was a constant and did not diminish. In early winter 2010, I found an OBGYN in Las Vegas, NV who was able to help me sleep with a pain pill and a topical gel. But the respite was short-lived. Luckily, he had heard of and recommended I contact Dr. Fowler in Phoenix, AZ. I had a consultation and exam with Dr. Fowler in late April 2010. He immediately put me on a treatment regimen. At the time of my follow-up in August 2010, my **pain had stopped. I now have my life bac**k. I cannot say enough how much Dr. Fowler helped me, and what I owe him for his help.” ***J. - Weehawken, New Jersey***

“I was mired in a so-called “purgatory of misery,” having suffered pain, burning, swelling and a host of despair. I just wanted to crawl into a hole and vegetate in my wretchedness. My daily routine and pleasurable activities had become non-existent. Over a period of three months, I saw numerous Atlanta specialists, all of whom had different prognoses and proposed treatments. Prescribed medications offered little relief, if any, and several further aggravated the “mystery disorder.” At the peak of my distress, I was fortunate to cross paths with Dr. Stuart Fowler. From my perspective, Dr. Fowler is truly a miracle worker! Within weeks after following Dr. Fowler’s regimen of treatment, my symptoms rapidly improved, and my outlook became hopeful. I began to feel once again like an outgoing person I had forgotten existed. I cannot sing this doctor's praises enough! Thanks to DR. Fowler, I think that my long **ordeal is coming to an end**.” ***C. - Tucson, Arizona***

“After stopping HRT 5 years ago, I started to have vaginal burning and repeat yeast infections. I even had a perineoplasty in March of 2011, which still didn’t help, and I was sent to a vaginal therapist, which didn’t help either. So five doctors later, with much frustration, pain, and not being able to have any relations with my spouse, I asked my family doctor if he knew anyone in Las Vegas who could treat me. That’s when he told me to Arizona. I first saw Dr. Fowler in August of 2010. My vulvar pain at that time, on a scale of 1-10 was a solid 10. I could hardly sit

in the chair while I was talking to him. He diagnosed me with "Vulvodynia." That was the first time I had anyone tell me what I had. He started treatment with that first visit. On my next visit I had improved by 30%. On my March 2011 visit, I was happy to be 50% better, and in June 2011, I was at 60% improvement. By July 2011, I was jumping for joy at **70% improvement!** I am so thankful for finding Dr. Fowler before I went totally crazy from the pain and burning and not knowing what was causing it. I totally recommend Dr. Fowler." ***L. - Las Vegas, Nevada***

"I had been seeing a doctor in Charlotte, NC. All the signs were prominent for diagnosing Vulvar Dermatitis. However, because the studies were not well known, I was misdiagnosed as having a yeast infection. At the time of my annual physical at Women's Health Clinic in Scottsdale, Arizona, my primary provider referred me to R. Stuart Fowler, M.D. who has the expertise with Vulvar Dermatitis. This was a very positive, informative and educational experience given the facts of Dr. Fowler's expertise in treating Vulvar Dermatitis. It is a very difficult health issue to diagnose and I feel passionate that it would be beneficial to other women to know of the treatment available." ***K. - Charlotte, North Carolina***

"I have found my story is not uncommon. I suffer from Generalized Mixed Vulvodynia. It began around age 29. I saw several Gynecologists in my hometown of Kansas City, MO. Diagnosis and recommendations were all over the board, incorrect and unhelpful. Where my story takes a great turn, is when I discovered, through my own research, Dr. R. Stuart Fowler. At age 38, I have been a client of Dr. Fowler's for 2 years. My condition has **improved significantly. His approach has been nothing short of spectacular!** No woman should have to suffer for the 7 years I did." ***A. - Kansas City, Missouri***

"I would like to share with you my success story. I was treated by Dr. R. Stuart Fowler, MD in Phoenix, Arizona. Prior to becoming his patient I had been treated for three years with no success. Six weeks after my first visit to Dr. Fowler, I had a 90% resolution of my symptoms and now, two years later, **I am symptom-free!**" ***R. - Scottsdale, Arizona***

**"I have my life back** thanks to Dr. R. Stuart Fowler. For nearly three years, I have been in constant pain. My lifestyle was significantly compromised. I couldn't exercise anymore, because it increased the pain. Prolonged sitting and driving were painful, and friction from clothing was also an issue. I couldn't even go out to eat with my family often – most restaurant seats were too hard for my condition. I went to my local general practitioner who sent me to an Arkansas Urologist. They were unable to diagnose my condition and even told me I "needed to learn to live with the pain." Over all these months, I had a number of serious flare-ups that sent me to the Emergency Room. Once, the doctors over-sedated me, and I stopped breathing. It was an incredibly scary experience. Finally, I was referred to Dr. Fowler. I'm happy to say after 18 months of treatment **90% of my pain is gone**! I am so grateful to Dr. Fowler. I recommend seeing him to anyone." ***D. - Northwest Arkansas***

"I started having discharge in 2005. Over the course of the 5 years that followed, I saw several gynecologists, a nutritional therapist, and a Chinese Medicine specialist. Each gynecologist diagnosed me with chronic yeast infections and treated me for yeast. I was put on rounds of

antibiotics and over-the-counter treatments for my symptoms, but my condition did not improve. Even though I wasn't improving, the doctors couldn't come up with any other diagnosis for my itching, burning, and discharge. In January 2011, I met with Dr. R. Stuart Fowler and knew that he understood my condition. After looking at the slides under a microscope, he allowed me to come and see the slide under the microscope for myself. He pointed out the numerous white cells that shouldn't be there, and he also showed me the low amount of lactobacilli that I had. One thing that was missing was yeast. In fact, prior to the physical exam, we reviewed my medical records from the previous 5 years and noted that none of my cultures tested positive for yeast. I now know that I most likely never had yeast to begin with. I appreciate Dr. Fowler. He has **greatly helped me**, and I know he will help other women in the future." ***L. - Phoenix, Arizona***

"I just have to say how incredibly thankful I am to Dr. R. Stuart Fowler. I had been to a few gynecologists for over three years to get help with what I thought to be reoccurring/ chronic yeast infections. After wiping the counter free of Monistat and also taking my fair share of Diflucan, I ended up at Dr. Fowler's office following a great recommendation from a co-worker. Dr. Fowler really worked with me and was extremely patient. I followed all of his suggestions with some apprehension at first but it truly paid off. It did take a while for it to **fully resolve** but of right now I could not be happier!" ***J. - Scottsdale, Arizona***

"This letter is being sent to express my deepest appreciation to Dr. R. Stuart Fowler for solving a vaginal condition I suffered with for a number of ears because no doctor could diagnose the problem to recommend a cure. I had gone to three gynecologists in my home state with the symptoms of burning, itching and tearing of my vaginal area. After many tests and even a biopsy, they came up with no label or treatment for what I had. My search through the internet provided me with a doctor. My appointment with Dr. Fowler was in April 2009. Within hours he diagnosed me as having Vulvodynia and vulvar lichen sclerosis. I was prescribed medication by Dr. Fowler and saw a very **significant improvement** in 2 1/2 months. I am on maintenance medication and **again living a normal life.** Thank you, Dr. Fowler!" ***L. - Bismarck, North Dakota***

"The constant burning, frequent urination, and discomfort caused me to discontinue many of my activities. In fact, it was difficult to even enjoy lunch with a friend, when all you can think about is the burning and pain in the vaginal area. To describe the pain as "uncomfortable" is an "understatement"! Then, there were the many doctor appointments. My GP recommended a local urologist. Then, I saw two more urologists. From the urologists, I went to a gynecologist. For five years, I tried every medication and remedy that was recommended. And, although my gynecologist diagnosed the problem correctly, she suggested that I see a vulvar specialist. Dr. R. Stuart Fowler has been terrific. I am pleased beyond words to say that **I improved by 75%**." ***S. - Rock Island, Illinois***

"I would like to express to you how much I appreciate you, your help and your great understanding. You are a blessing from God!" ***T. - Phoenix, Arizona***

“I began noticing symptoms as to what I thought at the time were yeast infections. I began experiencing pain with intercourse. I tried at-home yeast treatments, and that didn’t help. I finally went to my gynecologist. I was prescribed a treatment for a yeast infection. This also did not work. I went back again. They took a sample to determine what kind of yeast was causing the infection and I was prescribed a different treatment for a yeast infection. By this time, my “yeast infection” was not improving and pain had been getting more intense with intercourse. I had a biopsy performed. The results of the biopsy came back as Lichen Simplex Chronicus. My gynecologist prescribed medications to treat the skin condition. The medications prescribed appeared to make some of the symptoms less intense, but the pain with intercourse was still very apparent. After two months of this treatment and still no resolution, my gynecologist recommended I find a specialist. After some hours of searching on the internet, I managed to find Dr. R. Stuart Fowler in Phoenix Arizona. As I reviewed his specialties, I was positive that this was the doctor I needed to see. I was able to schedule an appointment. I was nervous, scared, and worried. My previous gynecologist had just told me that there was nothing more they could do. Any information online regarding my symptoms was mainly from women on message boards panicking because no doctor had been able to help with or diagnose their issue, some dealing with this for years. At the time of my appointment, Dr. Fowler listened intently to my story regarding how I finally ended there. He performed his exam and determined that I had Vulvar Vestibulitis. Although I had never heard of Vulvodynia or Vulvar Vestibulitis, it began making sense why my previous treatments were not working! Dr. Fowler was able to put me at ease and prescribed a treatment plan for me. I recently had a follow-up appointment with Dr. Fowler. As of the date of my appointment, my symptoms have practically disappeared. I am having intercourse **virtually pain-free!**” ***B. - Cincinnati, Ohio***

“It's amazing how much better my Vulvodynia is. And since I don't hurt all the time, I've gotten off Zoloft! **I am 90% better** and able to go back to the gym, before seeing Dr. Fowler, I had seen three other specialists and they thought I was crazy."!” ***S. - Jonesboro, Arkansas***

“I was diagnosed with Inflammatory Vaginitis and went to two other physicians, one in California and one in Phoenix, Arizona. This went on for almost a year with no relief. I was on different medications and suppositories and nothing worked. Nothing was done until I went to R. Stuart Fowler, M.D. Assistant Professor. After going to Dr. Fowler, I was so pleased that after 5 months, I was 80% better and **in 7 months, 100%.** I will continue with Dr. Fowler. I am very pleased with the outcome!” ***R. - Yuma, Arizona***

“My nightmare began in early 2011 when I developed pelvic and vaginal problems. I first sought medical attention with a local gynecologist in June. For the same condition, I saw him again in December, still with no relief or understandable diagnosis other than being told it was menopausal symptoms. In February 2012, I returned to the same local doctor and left the office feeling lost, confused, in misery and very depressed with the feeling he did not want me to return to him again. I really had the feeling he could not diagnose my problem. My state of being had progressively gotten worse, to the point where I could hardly sleep. I was in constant pain, cried often and was severely depressed and very scared. I had become an absolute nervous wreck. My

entire vaginal area felt like it was a hamburger that had been submerged in acid and then set on fire. The constant burning, itching and swelling left me unable to concentrate on anything other than misery. I was in a very desperate state. I called to schedule an appointment. When I told the schedule representative that I needed to see a gynecologist, he asked if I would prefer to see a male or female doctor. I told him emphatically that I wanted to see the best doctor who could help me with the specific symptoms I had just described. He told me, "It will definitely be Dr. Fowler". In March of 2012. I met with Dr. R. Stuart Fowler. Upon completion of the examination. He explained what my condition was and how "we" were going to remedy it. I was so relieved to hear that there was hope and there was a name for my cruel affliction ~it was called Vulvodynia. My treatment was to begin immediately. In August, I returned to see Dr. Fowler. I felt **75% to 80% better.** The itching was gone, the burning had lessened considerably and my pain was no longer constant and greatly reduced. I cannot express how grateful I am to Dr. Fowler. His experience in exactly what my condition is has been a major breakthrough in my well-being and my overall improved health. I hope the work and knowledge of Dr. Fowler will encourage spreading the word to other women in my situation so they may receive the kind and comprehensive attention and care that I have received from Dr. Fowler. I commend and thank Dr. Fowler for the interest, time, and effort he has extended in the pursuit of conquering the horrid and cruel condition of Vulvodynia." ***P. - Kingman, Arizona***

"After suffering for at least four years with burning and itching, and after repeated visits to at least four different doctors, I finally sought treatment from Dr. R. Stuart Fowler in Phoenix. He diagnosed me and put me on a regimen of medications that has given me great relief. After four months of treatment, the itching and burning are **95% improved,** and **so is my life**! I am so thankful to have found Dr. Fowler." ***L. - Star Valley, Arizona***

"I have been a patient of Dr. Fowlers for 4 years. I first began to see him in the summer of 2008. I had been to several different gynecologists for an ongoing problem I had been having for over 7 years. My symptoms were severe. I was having itching, burning while urinating, discharge, and severe pain while having intercourse. It always felt like deep cuts on my vaginal walls. I was having discomfort all day every day. The specialists that I saw treated me for yeast infections but the medications were not helping at all. I had a biopsy taken of my labia but the results came back with no significant diagnosis. I felt like I was at my wit's end. I finally decided to see Dr. Fowler. It felt like my last hope. After meeting and examining me, he told me that he had come up with a regimen for my symptoms. I was over the moon with hope. He was very kind gentle and so sympathetic. I knew I was in good hands. After seeing several specialists with no avail I felt like he completely understood my problems. On my second appointment, he explained in detail what he had come to diagnose: lichen sclerosis and Vulvodynia. He gave me a sheet of paper explaining what lifestyle choices I needed to make in my daily life. He also had several prescriptions that he said would start to help within a month's time. He was 100% accurate about everything. I started on my medications and started changing my daily habits. Within 8 weeks I felt almost completely cured of my discomfort and pain. I was weary at first, because it was hard for me to trust another Dr., but I knew I could count on Dr. Fowler. Since that summer **I feel that I have done a complete 180.** I no longer feel the deep cuts. I began to **have intercourse**

**regularly with no discomfort.** Because I had such pain while inserting a tampon and it expanding, he put me on a special type of birth control and it feels as though not having my period anymore is just an added bonus. I don't feel like the changes to my daily lifestyle have been a burden because doing those small things has made a huge amount of difference. I continue to see Dr. Fowler each year for my yearly exam. My symptoms have subsided greatly. I will forever be in debt to Dr. Fowler for **changing my life**. I believe he is the most caring Dr. I have ever seen. I actually look forward to my yearly exam to let him know each time that I see him, and his team that they have benefited my life immensely." ***J. - Chandler, Arizona***

"I am a patient who was diagnosed with Vulvodynia in early 2010. I am being treated for this condition in Scottsdale, Arizona by Dr. R. S. Fowler. The first time I saw Dr. Fowler for this condition was in early 2010. I saw him again in May 2010 and I had improved at least 50%. In September 2010, I was 70% better than my previous visit. In June 2011, I was 90% better and maintained the 90% in December 2011. At my recent visit in June 2012, **I am at 90%** and am encouraged that my condition will continue to improve with the care I am receiving." ***S. - El Paso, Texas***

"I am the father of K. I have been the sad recipient of watching my young daughter grow up in pain and suffering from Vulvodynia. It always seemed like there was an answer and the next doctor would come into our lives and without fail, she did not ever receive relief. I at one time personally admitted her to the emergency room and hospital asking for all the tests possible to run. I have been completely saddened by her diminishing health and hope of having a normal life until meeting R. Stuart Fowler, M.D. His persistence and positive outlook on my young daughter have truly been an answer to my prayers. I so hope others might seek his help and find relief and comfort in their lives. I look to my daughter's future now with the utmost happiness and hope. She is **definitely healing** and her positive outlook on life makes Dad the happiest he can be. Doctor Fowler, thank you!" **K's Father.- Orem Utah**

"I am 30 years old and I have suffered from Vulvodynia since I was 10 years old. I did not know that is what I was suffering from till October 2012, almost 20 years later, when I met with R. Stuart Fowler in Scottsdale, Arizona. I had been to countless doctors and specialists and seven hospitals with no relief. Every doctor told me nothing was wrong. I was beginning to think everyone felt the way I did, and I was being a baby about it or that I was honestly crazy. I was in pain and discomfort day in and day out with no reason for the pain. It was my urologist who referred me to Doctor Fowler. I walked into Doctor Fowler's office with tears in my eyes, explaining to him that I was so sick of living my life bathtub to bathtub because that was the only place I truly felt relief. He looked at me and told me it was not okay that I was in so much pain and he was going to help me get to the bottom of where my discomfort stemmed from. I felt listened to and understood for the first time in 20 years of agony. Within a few weeks, the regimen he put me on had already relieved my discomfort by about 40 percent, which was unbelievable to me. My last check-up with Doctor Fowler included tears, but tears of joy this time. I am so grateful for what he has done for me. **It is unbelievable the difference** I feel and

how much my quality of life has gone up. Thank you Doctor Fowler for all you have done for me. I am eternally grateful to you." **K - Orem, Utah**

"Dr. Fowler I want to thank you for the excellent care you gave me. **What you did worked**." **A. - Mesa, Arizona**

"Doctor Fowler has shown me the utmost respect, dignity and professionalism, which I will never forget. The most important thing I will always remember is how he took the time to talk to me; he listened to me and genuinely cared about me. He made me feel like I was his most important patient. His bedside manner was and is extraordinary." ***K. - Phoenix, Arizona***

"**Doctor Fowler saved my life** as I was suffering from a severe case of lichen sclerosis. I am still following his instructions and prescription to the letter and it is **working perfectly**." ***C. - Sedona, Arizona***

"Doctor Fowler is an amazing doctor with great knowledge, expertise and patient care skills." **B. – Phoenix, Arizona**

"Thank you Doctor Fowler for giving me excellent care and for being wonderful. Stay fabulous!!!" **J. - Paradise Valley, Arizona**

"Dr. Fowler, I will never forget what you did to diagnose me while every test came back normal. I feel with the help of God, **you saved my life**." **V.- Phoenix, Arizona**

"Thank you for helping me the last 4 years get through the pain and return to a normal life without lichen sclerosus and vestibulitis. You truly g**ave me my life back**. I don't know what I would have done had I not seen you. Most doctors don't know what those things are." **R. - Surprise Arizona**

"Dr Fowler, I am a very grateful patient for your expert and efficient care as well as your comfortable bedside manner." **C. - Carefree, Arizona**

"Please accept my deepest thanks and appreciation for the wonderful care you have given me. Your kindness and patience have been remarkable." **N. - Phoenix, Arizona**

"When I first met Doctor Fowler, I was a very confused and frightened woman, and that was unusual for me. But, within ten minutes I understood what was going on and confidence in the medical profession had been restored. I had no doubt that I had found the right person to treat me. Doctor Fowler always made me feel comfortable and at ease which is rather unusual given the position I was in most of the visit. Ha! Doctor Fowler, you are a gem!" **N. - Mesa, Arizona**

"I was in search of an answer for unexplained vaginal and vulvar burning that had plagued me for almost three years. I am a 62-year-old woman with no previous issues. I had seen gynecologists, urologists, dermatologists, regular primary care physicians, naturopathic practitioners. I had been misdiagnosed with bacterial vaginosis, heavy metal poisoning, systemic

shingles, yeast infections, neurological disorders, possible Vitamin D deficiency, and Estrogen deficiency, just to name a few. I had my house tested for environmental concerns; I went for months journaling everything I put into my mouth. I had so many side effects from the multitude of pills I was given for various reasons. I finally quit taking everything to see if I could get my head to stop spinning. Every gynecologist I saw told me that whatever was wrong with me was NOT a gynecology issue. A few months ago, I went locally to a new gynecologist, who said she was sure I had Vulvodynia. She put me on a low oxalate diet and told me to start taking Zoloft. I did try the diet, but given my history with so many side effects of drugs, I did not start taking the pills. I finally went to see Dr. Fowler in January. He immediately confirmed the diagnosis of Vulvodynia and started me on a different treatment protocol. I am finally going to regain my life. I am now back to eating all the foods I have missed with the low oxalate diet. I am not taking any medications (other than the treatment protocol Dr. Fowler has recommended), and I see light at the end of the tunnel. I wanted to share my positive experience with Dr. Fowler. His ability to diagnose this condition and treat it according to my specific needs was **just amazing.** I am very happy to have found him and wanted to pass this information along." **S. – Eagle, Idaho**

"Dr. Fowler seemed to understand my symptoms and told me I had a severe case of vulvar vestibulitis and vulvar lichen sclerosis and that it would take several months to get better. His treatment has been an **absolute miracle.** Dr. Fowler, you seemed to have come straight from Heaven. Thank you so much for your many years of study, for your gentleness and understanding and for helping me and I'm sure, countless other women in a time of great personal agony and need. Thank you so much for your dedication!" **S. - Yuma, Arizona**

"I am writing this letter in the hopes that others will not have to needlessly go through the pain I did. About 10 years ago, I started having the symptoms of Lichen Sclerosus (I did not know what was wrong with me). I made many visits to my gynecologist complaining of itching, burning and a rash on my genitals. Over the first 5 year period, I got to the point that I could not wear pants or shorts and could not have sex (it was too painful). I compare it to the pain of having a migraine headache between hour legs and it never goes away. During this time my doctor diagnosed me with yeast infections and bacterial infections and tested me for herpes and other STDs. I was given many different antibiotics that eventually made me feel really sick. It was a very frustrating and painful time for me. Finally, my gynecologist said to me, "I honestly don't know what is wrong with you, so I'm going to take a biopsy and send it into the lab." The biopsy did prove to be Lichen Sclerosus, and I began searching for a Dr. who specialized in skin diseases of the vulva. I eventually found an amazing doctor, Dr. Stuart Fowler. After my first appointment, my symptoms decreased rapidly for 6 weeks and **virtually disappeared** after 6 months of the treatment. For 5 years now my condition has been manageable and has improved to the point that **I'm living pain-free**. My frustration is that regular gynecologists seem to have no clue about Lichen Sclerosus. It should be a disease that they are familiar with and can either give the proper treatments or referrals to knowledgeable doctors. The word needs to be spread about this disease so others do not need to unnecessarily suffer." **D. - Phoenix, Arizona**

"Last year, I turned 24 years old. The year started off to be the worst year of my life. I did not want to live anymore. I am not exaggerating; I had extreme vulvar pain twenty-four hours a day, five days a week for over four months. I went to 12 different doctors in those four long months: gynecologists, urologists, and family physicians; not one of them could tell me what was wrong with me or how to fix it. I went through almost one hundred prescriptions and one surgery. Nothing helped. One of the doctors gave me eight shots a day in my vagina to try and numb the pain; it did not help. I gave up on doctors and on my life. I graduated from college and worked as a waitress until I could find a teaching job. When I became sick I would go to work and to make it through my shift, I had to take around 10 painkillers a day. After work, I would come home around 3 p.m. and go to sleep until morning. This was my only escape from the pain. My life was ruined and I did not want to live in pain anymore. My boyfriend's (now fiance) mother told me to go see Dr. R. Stuart Fowler, a vulvar specialist. I met Dr. Fowler and he told me I had Vulvodynia. Finally, a name to my pain! Dr. Fowler gave me a regimen to start healing my vulva pain. Within four short weeks, I had **my life back** again. I kept going back every four months to make sure my progress was still on the up and up, and it was. Now a year later, I am almost **100% better** and I can enjoy my life again. I am now getting married to a wonderful man this year, and I am in no pain. I am a teacher now and working on my master's, and I do not think I could have done any of this if it wasn't for Dr. Fowler helping me **get my life back** to normal. Nobody should ever have to live in pain and Dr. Fowler has helped me love my life again. I feel like I am living life to my full potential. I am truly grateful for all he has done for me." **A. - Phoenix, Arizona.**

"I was experiencing very difficult urinary pain that was not a UTI. The urology department performed various tests and found nothing wrong with any of the urinary system. I was referred to see Dr. Fowler. After an examination involving viewing specimens under a microscope, I was diagnosed with urethral burning associated with inflammatory vaginitis. I began a treatment plan, which ultimately led to **complete recovery.** I am very grateful for this experience, for the pain I endured was very difficult and life-altering. I am thrilled with the care I received from Dr. Fowler." ***C. - Phoenix, Arizona***

"A recent misdiagnosis of genital herpes had caused me tremendous stress and concern for 2 years. After several months of taking Valtrex and no relief from my symptoms, my gynecologist recommended I see Dr. Stuart Fowler. He quickly diagnosed my condition as "Lichen Sclerosus." Since then, my **symptoms have disappeared**, and I am thrilled!!! Dr. Fowler is a very knowledgeable, thorough and caring physician. I commend him to you!!" **G. - Paradise Valley, Arizona**

**Arizona Medical Board**
1740 W. Adams, Suite 4000 • Phoenix, AZ 85007
Telephone: 480- 551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2702
Website: www.azmd.gov

June 12, 2025

Governor's Regulatory Review Council
100 N. 15th Ave., Ste. 305
Phoenix, AZ 85007

Via email: grrc@azdoa.gov

**RE: AMB Response to GRRC Petition filed by Dr. Fowler**

Dear GRRC Members,

The Arizona Medical Board (Board) is in receipt of Dr. Fowler's Petition for GRRC to review. It appears that Dr. Fowler is objecting to factual and unprofessional conduct findings in the Board's Order for Probation; and Consent to Same dated February 7, 2024. The Board requests that GRRC deny the petition for review. Dr. Fowler signed a consent agreement for Probation based on the sustained violations as identified by a Medical Consultant and Board investigator. During the Board's investigation, and at the time he entered into the agreement, Dr. Fowler was represented by an attorney with prior experience in Board matters. Dr. Fowler was notified in writing of his right to contest the Board's factual findings and sustained professional conduct violations through a Formal Interview with the Board or a Formal Hearing at the Office of Administrative Hearings if he disagreed with the recommended discipline. The consent agreement that Dr. Fowler signed contains clear language acknowledging his right to consult with counsel, relinquishing his right to judicial review and waiving any other cause of action related the order. Dr. Fowler's probation was terminated on October 16, 2024 after he successfully completed the requirements of the agreement.

Dr. Fowler's current disagreement with the Board's decision to impose probation in this case does not constitute an appropriate challenge under A.R.S. § 41-1033(G) as he has failed to identify a substantive policy statement, final rule or licensing requirement as required by this provision. The Board's actions were specifically authorized by statute. The sustained violations are identified in the Arizona Medical Practice Act and the Board was operating within its authority to investigate complaints alleging unprofessional conduct. *See* A.R.S. §§ 32-1401(27)(c), (n), (r) and (u), 1403(A). The consent agreement for a disciplinary outcome that Dr. Fowler agreed to consists of probationary terms also identified in the Medical Practice Act. *See* A.R.S. §§ 32-1451(F) and (I)(7).

As the Board was acting within its authority and Dr. Fowler knowingly waived his rights to challenge the underlying findings and professional conduct violations through the administrative process, he should not now be allowed to do so in a collateral proceeding.

For these reasons, the Board respectfully requests that GRRC deny review in this matter. I have attached the Board's Orders, a visual aid of the Board's Investigation Process, and our Guidelines for Complaint Resolution for your review in consideration of Dr. Fowler's petition.

Sincerely,

Raquel Rivera
Interim Executive Director

**BEFORE THE ARIZONA MEDICAL BOARD**

| | |
|---|---|
| In the Matter of<br>**ROBERT S. FOWLER, M.D.**<br>Holder of License No. 20406<br>For the Practice of Allopathic Medicine<br>In the State of Arizona. | **Case No. MD-23-0278A**<br>**ORDER FOR PROBATION; AND CONSENT TO THE SAME** |

Robert S. Fowler, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Probation; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

## FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 20406 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-23-0278A after receiving a complaint regarding an email Respondent sent to his patients advertising a medical manual for sale ("Patient 1"). The Board subsequently received an additional complaint from another of Respondent's patients who had received the solicitation via email and text message ("Patient 2"). Both complaints expressed concern regarding the tone of the email and the implication that no other medical professional would be able to treat their medical condition.

4. On March 8, 2023, Respondent sent an email to his patients offering to sell them the Fowler Gyn Manual for treatment of vulvodynia and other gynecological conditions at a starting price of $1500.00. Respondent asserted that he had discovered the underlying etiology for vulvodynia. The email described incremental price increases over time and stated that the manual would be available upon Respondent's retirement

from the practice of medicine. Respondent's email further described the risk of relapse for vulvodynia and asserted that without the manual, patients would not be able to treat their symptoms after his retirement.

5. On March 25, 2023, Respondent sent a text message to his patients offering the Fowler Gyn Manual for sale.

6. On April 30, 2023, Respondent sent an additional email to his patients, apologizing for the statements made in his original solicitation.

7. Board staff requested Medical Consultant ("MC") review of Respondent's solicitation as well as the care and treatment provided to Patients 1 and 2.[1]

8. Patient 2 established care with Respondent in July, 2019 and was treated by Respondent through March, 2023 for treatment of vulvodynia and other vaginal conditions. Respondent utilized proprietary "VFA" testing at each of Patient 2's visit to manage pharmacological treatment of her symptoms.

9. The standard of care for treatment of vulvodynia requires a physician to offer adjunctive treatments such as pelvic floor therapy, if available. Respondent deviated from this standard of care by failing to offer adjunctive therapy or other treatment options for vulvodynia.

10. The MC also noted that there are several medical practitioners in the Phoenix metro area who are qualified to treat vulvodynia. Furthermore, the MC commented that the underlying etiology for vulvodynia has not been proven.

11. There was the potential for patient harm in that Respondent's patients were at risk of misleading information regarding vulvodynia treatment options.

---

[1] Respondent's treatment for Patient 1 exceeded the statute of limitations. A.R.S. § 32-1451.03(A).

## CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(c)(" False, fraudulent, deceptive or misleading advertising by a doctor of medicine or the doctor's staff, employer or representative.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(n) ("Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact.").

d. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r)("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

e. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(u) ("Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.").

## ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is placed on Probation for a period of six months with the following terms and conditions:

**a. Civil Penalty**

Respondent is assessed a $1500.00 Civil Penalty. The Civil Penalty shall be paid, by certified funds, within 90 days of the effective date of this Order.

**b. Continuing Medical Education**

Respondent shall within 6 months of the effective date of this Order obtain no less than 15 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person or virtual course regarding ethics. Respondent shall within **thirty days** of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure

**c. Obey All Laws**

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

**d. Tolling**

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

**e. Probation Termination**

Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent's request for

release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

2. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s)

DATED AND EFFECTIVE this 7th day of February, 2024.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

**CONSENT TO ENTRY OF ORDER**

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent in this Order are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Notwithstanding any language in this Order, this Order does not preclude in any way any other State agency or officer or political subdivision of this state from instituting proceedings, investigating claims, or taking legal action as may be appropriate now or in the future relating to this matter or other matters concerning Respondent, including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent acknowledges that, other than with respect to the Board, this Order makes no representations, implied or otherwise, about the views or intended actions of any other state agency or officer or political subdivisions of the State relating to this matter or other matters concerning Respondent.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

9. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

10. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

11. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(s) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.") and 32-1451.

12. ***Respondent has read and understands the conditions of probation.***

ROBERT S. FOWLER, M.D. DATED: 1-8-24

EXECUTED COPY of the foregoing mailed this 8th day of February, 2024 to:

Scott A. Holden, Esq.
Holden & Armer, P.C.
4505 East Chandler Boulevard, Suite 210
Phoenix, Arizona 85048
Attorney for Respondent.

ORIGINAL of the foregoing filed this 7th day of February, 2024 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Board staff

**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of

**ROBERT S. FOWLER, M.D.**

Holder of License No. 20406
For the Practice of Allopathic Medicine
In the State of Arizona

Case No. MD-23-0278A

**ORDER TERMINATING PROBATION**

At its public meeting on October 9, 2024, the Arizona Medical Board ("Board") considered Robert S. Fowler, M.D. ("Respondent"), request to terminate Probation as previously ordered by the Board in case number MD-23-0278A. After considering all of the evidence, the Board voted to grant Respondent's request to terminate his February 7, 2024 Board Order.

**ORDER**

**IT IS HEREBY ORDERED:**

1. Respondent's Board Order for Probation dated February 7, 2024 is terminated.

DATED AND EFFECTIVE this 16th day of October, 2024.

ARIZONA MEDICAL BOARD

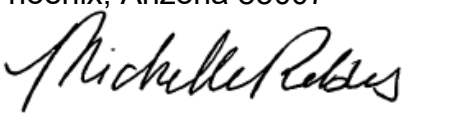
By _____
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 16th day of October, 2024 to:

Robert S. Fowler, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 16th day of October, 2024 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007



Board staff

# Arizona Medical Board
# Guidelines for Complaint Resolution

All Board resolutions, except for dismissals and confidential PHP Agreements are public record. The Board's case resolution options are established in statute (A.R.S. § 32-1451). If no violations of rule or statute are found, the Board may dismiss a complaint. If the Board finds that the case does not rise to the level of discipline, then the statute allows for the Board to consider non-disciplinary options including Advisory Letters and non-disciplinary orders for Continuing Medical Education (CME). Advisory Letters can be issued for cases that do not rise to the level of discipline, or for minor or technical violations of Board statute. Additionally, the Board may issue an Advisory Letter in cases where the Board recognizes that a licensee has demonstrated substantial compliance through rehabilitation or remediation that mitigates the need for disciplinary action. See A.R.S. § 32-1401(3). The Board also utilizes non-disciplinary confidential Stipulated Rehabilitation Agreements (SRA) and Stipulated Health Agreements (SHA) to allow for Physician Health Program (PHP) monitoring for licensees with substance use or other health issues when there is not associated unprofessional conduct identified during an investigation, or in cases where there has been unprofessional conduct unrelated to patient care concerns that does not rise to the level of discipline (such as a failure to timely report a criminal charge as required by A.R.S. § 32-3208).

The Board may consider several factors when adjudicating complaints based on an individualized evaluation of the facts and circumstances of each case, in light of the sustained violations and any prior Board history that the licensee may have. The Board's decision to issue non-disciplinary or disciplinary action can be based on various factors which take into consideration the violations identified, prior Board history of the licensee, and any mitigating and aggravating factors as identified in A.A.C R4-16-604 and R4-16-605 as noted below:

> R4-16-604. Aggravating Factors Considered in Disciplinary Actions
>
> When determining the degree of discipline, the Board may consider certain factors including, but not limited to, the following:
>
> 1. Prior disciplinary offenses;
>
> 2. Dishonest or selfish motive;
>
> 3. Pattern of misconduct; multiple offenses;
>
> 4. Bad faith obstruction of the disciplinary proceeding by intentionally failing to comply with rules or orders of the Board;
>
> 5. Submission of false evidence, false statements, or other deceptive practices during the investigative or disciplinary process;
>
> 6. Refusal to acknowledge wrongful nature of conduct; and
>
> 7. Vulnerability of the victim.

R4-16-605. Mitigating Factors Considered in Disciplinary Actions

When determining the degree of discipline, the Board may consider certain factors including, but not limited to, the following:

1. Absence of prior disciplinary record;

2. Absence of dishonest or selfish motive;

3. Timely good faith effort to rectify consequences of misconduct;

4. Interim rehabilitation;

5. Remoteness of prior offenses; and

6. How much control the physician has of processes in the specific practice setting.

The Board is not limited by these guidelines and may select any one or a combination of resolutions found in this chart. **IN THE EVENT OF A CONFLICT BETWEEN THIS DOCUMENT AND THE ACTION BY THE BOARD, THE ACTION IMPOSED BY THE BOARD SHALL PREVAIL.**

| Level | Errors or Violations of Law/Rule and/or Community Standards of Care | Resolution |
|---|---|---|
| Non-Disciplinary | ***3 Rationales for Advisory Letters pursuant to A.R.S. 32-1401(3):***<br>(a) There is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.<br>• Examples may include failure to timely release records to patient; failure to provide adequate informed consent, inadequate records and/or documentation.<br><br>(b) The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.<br>• Examples may include non-compliance with CSPMP mandatory use requirements; failure to update change of address with the Board, failure to maintain adequate records.<br><br>(c) While the licensee has demonstrated substantial compliance through rehabilitation or remediation that has mitigated the need for disciplinary action, the board believes that repetition of the activities that led to the investigation may result in further board action against the licensee.<br>• Examples may include failing to complete CME during the relevant time period; violation of law or deviation from standard of care identified and CME in relevant area provided during investigation; charging a fee for a service not rendered and provides evidence of refund or repayment during investigation; complaints of health issue and request to limit license until health status changes. | ● Advisory Letter<br>● Order for Continuing Education (Non-Disciplinary)<br>● Practice Limitation (Reportable) |
| Disciplinary | Violations of law or community standards of medicine have occurred that do not warrant revocation or suspension of a license.<br>• Examples may include ethical violations, violations of any federal or state law/rules relating to the practice of medicine; sexual misconduct with a patient; records violations; prescribing controlled substances without proper indications; misrepresentation of board certification.<br>• Licensee who were under a previous PHP agreement and relapsed are offered an Inactivation with Cause while they undergo treatment.<br><br>Violations of law or community standard of medicine have occurred and include egregious acts of unprofessional conduct that warrant suspension or revocation.<br>• Examples include being mentally or physically unable to safely engage in the practice of medicine; repetitive non-compliance with Board Orders; sexual misconduct with multiple patients, practicing medicine while impaired or incapacitated; or commission of a felony or misdemeanor involving moral turpitude or directly related to the practice of medicine. | ● Letter of Reprimand<br>● Order for CME<br>● Civil penalty<br>● Probation<br>● Suspension<br>● Practice Restriction<br>● Inactivation with Cause<br>● Decree of Censure<br>● Revocation |

| | | |
|---|---|---|
| Interim Actions | During an open investigation, staff have identified violations of law or community standards of medicine that warrant immediate evaluation, suspension, or restriction prior to the adjudication of the case. Examples include practicing medicine while impaired or incapacitated; being mentally or physically unable to safely engage in the practice of medicine, felony charges related to sexual misconduct; violating a Board order, consent agreement, or term of probation.<br><br>• Interim Orders – Licensees may be ordered to complete evaluations such as PHP assessment; psychosexual evaluation; neuropsychological evaluation; competency evaluations. These are confidential orders utilized during an investigation.<br><br>• Interim Practice Restrictions – The Board may offer a consent agreement to restrict a portion or all of the licensee's ability to practice medicine. Examples include prohibiting a licensee from prescribing controlled substances, or treating female patients without a chaperone. If a licensee refuses to enter into an Interim Practice Restriction, the Board will be convened to consider summary action against the licensee. This is a public, disciplinary action.<br><br>• Summary Suspension –If the Board finds that the public health, safety or welfare imperatively requires emergency action, the Board may restrict a license or order a summary suspension of a license pending proceedings for revocation or other action. This is a public, disciplinary action. | ● Interim Orders<br>● Interim Practice Restriction<br>● Summary Suspension |

Complaint and Investigation Process Summary

**Complaint Received**

Within 5 days the Intake process is completed (*See Intake Process*)

**Intake Process**

Within 5 days of receipt of a complaint, the Intake Officer reviews the complaint to determine if it falls within the Board's jurisdiction, if so the complaint is referred to an investigator who assigns priority to the case based on the seriousness of the allegations.

**Complaint Investigated**

**Complaint Investigation**

The investigator assesses whether the complaint is about quality of care or professional conduct then contacts the complainant to confirm the allegations. The physician is notified that a response to the complaint is required and the investigator gathers relevant information including medical records.

Professional conduct allegations are reviewed by the investigator. Quality of care complaints are reviewed by a Medical Consultant. The investigator/consultant writes a report opining on whether the investigation indicated violations of law or deviation from the standard of care.

**Investigation Reviewed**

Investigation findings are reviewed by a Supervisor who can request dismissal of complaint (*See Outcome 1*), request further investigation, or send to SIRC if violations are sustained

**Investigation Review**

The Chief Medical Consultant reviews quality of care complaints and the Investigations Manager reviews professional conduct complaints to ensure the adequacy and completeness of investigations. These reviewers may recommend Executive Director dismissal or forward the complaint to SIRC

**SIRC Review and Recommendation**

SIRC reviews cases with sustained deviations and/or professional conduct violations and can request further investigation as needed

SIRC recommends one of three outcomes (*See outcomes below*) and notifies the licensee of their recommendations.

**Sanction Options for Licensees**

For disciplinary recommendations, other than license revocations and suspensions longer than 12 months, the licensee is notified that they may opt to sign a consent agreement for the recommended action, participate in a formal interview before the Board, or request that the complaint be heard by OAH.

**Outcome 1:**

**Dismissal**

The Executive Director received a majority of dismissal recommendations and reviews the investigation materials to determine whether dismissal of the complaint is appropriate. Licensees and complainants are notified of the dismissal decision. Complainants may request that the Board review the Executive Director's decision to dismiss the complaint.

**Outcome 2:**

**The Board considers the following:**

Some dismissal recommendations

Non-disciplinary recommendations, i.e., advisory letters and CME orders

Consent Agreements for discipline, i.e., Letters of Reprimand, Decrees of Censure, and/or probation, restrictions, suspensions, etc., signed by the physicians

Formal interviews after which the Board may do the following:

a. Dismiss
b. Issue an advisory letter or non-disciplinary order for CME
c. Enter an order for discipline
d. Refer to formal hearing if requesting revocation or suspension of more than 12 months

The Board can also review, approve, reject, or modify SIRC's recommendations, and/or return the case for further investigation.

**Outcome 3:**

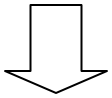
**Recommendation for Executive Director Referral to formal hearing**

All cases for which the ED or Board recommend license revocation or suspension for longer than 12 months are referred to formal hearing. The process is as follows:

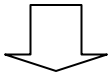
1. Formal Complaint filed by AAG with OAH
2. Full evidentiary hearing before an ALJ
3. ALJ issues a recommended Decision (may include dismissal, non-discipline, or discipline)
4. Board may adopt, modify and adopt, or reject the ALJ's recommendation

If the Board enters an order for discipline after a formal interview or formal hearing, the physician may appeal. The process is as follows:

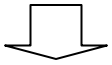
1. Request for Rehearing or Review (Board hears this request) – if the physician does not prevail



2. Judicial Review Action (Superior Court) – if the physician does not prevail



3. Notice of Appeal and briefing before the Court of Appeals – if the physician does not prevail



4. Petition for Review before the Arizona Supreme Court. (this court can choose whether or not to hear the appeal)