

NORTH CAROLINA



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Office of Administrative Hearings
Rules Division
424 North Blount Street (27601)
6714 Mail Service Center
Raleigh, NC 27699-6714
(919) 733-2678
FAX (919) 733-3462

Julian Mann III, Director
Camille Winston, Deputy Director
Molly Masich, Director of APA Services
Ruby Creech, Publications Coordinator
Linda Dupree, Editorial Assistant
Dana Sholes, Editorial Assistant
Rhonda Wright, Editorial Assistant

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NORTH CAROLINA ADMINISTRATIVE CODE CLASSIFICATION SYSTEM

The North Carolina Administrative Code (NCAC) has four major subdivisions of rules. Two of these, titles and chapters, are mandatory. The major subdivision of the NCAC is the title. Each major department in the North Carolina executive branch of government has been assigned a title number. Titles are further broken down into chapters which shall be numerical in order. The other two, subchapters and sections are optional subdivisions to be used by agencies when appropriate.

TITLE/MAJOR DIVISIONS OF THE NORTH CAROLINA ADMINISTRATIVE CODE

TITLE	DEPARTMENT	LICENSING BOARDS	CHAPTER
1	Administration	Acupuncture	1
2	Agriculture	Architecture	2
3	Auditor	Athletic Trainer Examiners	3
4	Commerce	Auctioneers	4
5	Correction	Barber Examiners	6
6	Council of State	Certified Public Accountant Examiners	8
7	Cultural Resources	Chiropractic Examiners	10
8	Elections	Employee Assistance Professionals	11
9	Governor	General Contractors	12
10	Health and Human Services	Cosmetic Art Examiners	14
11	Insurance	Dental Examiners	16
12	Justice	Dietetics/Nutrition	17
13	Labor	Electrical Contractors	18
14A	Crime Control & Public Safety	Electrolysis	19
15A	Environment and Natural Resources	Foresters	20
16	Public Education	Geologists	21
17	Revenue	Hearing Aid Dealers and Fitters	22
18	Secretary of State	Landscape Architects	26
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20	Treasurer	Massage & Bodywork Therapy	30
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Note: Title 21 contains the chapters of the various occupational licensing boards.

NORTH CAROLINA REGISTER
 Publication Schedule for January 2002 – December 2002

Filing Deadlines			Notice of Rule-Making Proceedings	Notice of Text								Temporary Rule
volume & issue number	issue date	last day for filing	earliest register issue for publication of text	earliest date for public hearing	non-substantial economic impact			substantial economic impact			270 th day from issue date	
					end of required comment period	deadline to submit to RRC for review at next meeting	first legislative day of the next regular session	end of required comment period	deadline to submit to RRC for review at next meeting	first legislative day of the next regular session		
16:13	01/02/02	12/06/01	03/15/02	01/17/02	02/01/02	02/20/02	05/28/02	03/04/02	03/20/02	05/28/02	09/29/02	
16:14	01/15/02	12/19/01	04/01/02	01/30/02	02/14/02	02/20/02	05/28/02	03/18/02	03/20/02	05/28/02	10/12/02	
16:15	02/01/02	01/10/02	04/15/02	02/16/02	03/04/02	03/20/02	05/28/02	04/02/02	04/22/02	01/29/03	10/29/02	
16:16	02/15/02	01/25/02	05/01/02	03/02/02	03/18/02	03/20/02	05/28/02	04/16/02	04/22/02	01/29/03	11/12/02	
16:17	03/01/02	02/08/02	05/01/02	03/16/02	04/01/02	04/22/02	01/29/03	04/30/02	05/20/02	01/29/03	11/26/02	
16:18	03/15/02	02/22/02	05/15/02	03/30/02	04/15/02	04/22/02	01/29/03	05/14/02	05/20/02	01/29/03	12/10/02	
16:19	04/01/02	03/08/02	06/03/02	04/16/02	05/01/02	05/20/02	01/29/03	05/31/02	06/20/02	01/29/03	12/27/02	
16:20	04/15/02	03/22/02	06/17/02	04/30/02	05/15/02	05/20/02	01/29/03	06/14/02	06/20/02	01/29/03	01/10/03	
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16:22	05/15/02	04/24/02	07/15/02	05/30/02	06/14/02	06/20/02	01/29/03	07/15/02	07/22/02	01/29/03	02/09/03	
16:23	06/03/02	05/10/02	08/15/02	06/18/02	07/03/02	07/22/02	01/29/03	08/02/02	08/20/02	01/29/03	02/28/03	
16:24	06/17/02	05/24/02	09/03/02	07/02/02	07/17/02	07/22/02	01/29/03	08/16/02	08/20/02	01/29/03	03/14/03	
17:01	07/01/02	06/10/02	09/03/02	07/16/02	07/31/02	08/20/02	01/29/03	08/30/02	09/20/02	01/29/03	03/28/03	
17:02	07/15/02	06/21/02	09/16/02	07/30/02	08/14/02	08/20/02	01/29/03	09/13/02	09/20/02	01/29/03	04/11/03	
17:03	08/01/02	07/11/02	10/01/02	08/16/02	09/03/02	09/20/02	01/29/03	09/30/02	10/21/02	01/29/03	04/28/03	
17:04	08/15/02	07/25/02	10/15/02	08/30/02	09/16/02	09/20/02	01/29/03	10/14/02	10/21/02	01/29/03	05/12/03	
17:05	09/03/02	08/12/02	11/15/02	09/18/02	10/03/02	10/21/02	01/29/03	11/04/02	11/20/02	01/29/03	05/31/03	
17:06	09/16/02	08/30/02	11/15/02	10/01/02	10/16/02	10/21/02	01/29/03	11/15/02	11/20/02	01/29/03	06/13/03	
17:07	10/01/02	09/10/02	12/02/02	10/16/02	10/31/02	11/20/02	01/29/03	12/02/02	12/20/02	05/00/04	06/28/03	
17:08	10/15/02	09/24/02	12/16/02	10/30/02	11/14/02	11/20/02	01/29/03	12/16/02	12/20/02	05/00/04	07/12/03	
17:09	11/01/02	10/11/02	01/02/03	11/16/02	12/02/02	12/20/02	05/00/04	12/31/02	01/21/03	05/00/04	07/29/03	
17:10	11/15/02	10/25/02	01/15/03	11/30/02	12/16/02	12/20/02	05/00/04	01/14/03	01/21/03	05/00/04	08/12/03	
17:11	12/02/02	11/06/02	02/03/03	12/17/02	01/02/03	01/21/03	05/00/04	01/31/03	02/20/03	05/00/04	08/29/03	
17:12	12/16/02	11/21/02	02/17/03	12/31/02	01/15/03	01/21/03	05/00/04	02/14/03	02/20/03	05/00/04	09/12/03	

EXPLANATION OF THE PUBLICATION SCHEDULE

This Publication Schedule is prepared by the Office of Administrative Hearings as a public service and the computation of time periods are not to be deemed binding or controlling. Time is computed according to 26 NCAC 2C .0302 and the Rules of Civil Procedure, Rule 6.

GENERAL

The North Carolina Register shall be published twice a month and contains the following information submitted for publication by a state agency:

- (1) temporary rules;
- (2) notices of rule-making proceedings;
- (3) text of proposed rules;
- (4) text of permanent rules approved by the Rules Review Commission;
- (5) notices of receipt of a petition for municipal incorporation, as required by G.S. 120-165;
- (6) Executive Orders of the Governor;
- (7) final decision letters from the U.S. Attorney General concerning changes in laws affecting voting in a jurisdiction subject of Section 5 of the Voting Rights Act of 1965, as required by G.S. 120-30.9H;
- (8) orders of the Tax Review Board issued under G.S. 105-241.2; and
- (9) other information the Codifier of Rules determines to be helpful to the public.

COMPUTING TIME: In computing time in the schedule, the day of publication of the North Carolina Register is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday, or State holiday, in which event the period runs until the preceding day which is not a Saturday, Sunday, or State holiday.

FILING DEADLINES

ISSUE DATE: The Register is published on the first and fifteen of each month if the first or fifteenth of the month is not a Saturday, Sunday, or State holiday for employees mandated by the State Personnel Commission. If the first or fifteenth of any month is a Saturday, Sunday, or a holiday for State employees, the North Carolina Register issue for that day will be published on the day of that month after the first or fifteenth that is not a Saturday, Sunday, or holiday for State employees.

LAST DAY FOR FILING: The last day for filing for any issue is 15 days before the issue date excluding Saturdays, Sundays, and holidays for State employees.

NOTICE OF RULE-MAKING PROCEEDINGS

END OF COMMENT PERIOD TO A NOTICE OF RULE-MAKING PROCEEDINGS: This date is 60 days from the issue date. An agency shall accept comments on the notice of rule-making proceeding until the text of the proposed rules is published, and the text of the proposed rule shall not be published until at least 60 days after the notice of rule-making proceedings was published.

EARLIEST REGISTER ISSUE FOR PUBLICATION OF TEXT: The date of the next issue following the end of the comment period.

NOTICE OF TEXT

EARLIEST DATE FOR PUBLIC HEARING: The hearing date shall be at least 15 days after the date a notice of the hearing is published.

END OF REQUIRED COMMENT PERIOD

(1) RULE WITH NON-SUBSTANTIAL ECONOMIC IMPACT: An agency shall accept comments on the text of a proposed rule for at least 30 days after the text is published or until the date of any public hearings held on the proposed rule, whichever is longer.

(2) RULE WITH SUBSTANTIAL ECONOMIC IMPACT: An agency shall accept comments on the text of a proposed rule published in the Register and that has a substantial economic impact requiring a fiscal note under G.S. 150B-21.4(b1) for at least 60 days after publication or until the date of any public hearing held on the rule, whichever is longer.

DEADLINE TO SUBMIT TO THE RULES REVIEW COMMISSION: The Commission shall review a rule submitted to it on or before the twentieth of a month by the last day of the next month.

FIRST LEGISLATIVE DAY OF THE NEXT REGULAR SESSION OF THE GENERAL ASSEMBLY: This date is the first legislative day of the next regular session of the General Assembly following approval of the rule by the Rules Review Commission. See G.S. 150B-21.3, Effective date of rules.

**EXECUTIVE ORDER NO. 20
AMENDING EXECUTIVE ORDER NO. 84
ISSUED BY GOVERNOR JAMES B. HUNT, JR.
WHICH ESTABLISHED THE NORTH
CAROLINA HOME FURNISHING EXPORT COUNCIL**

By the Power vested in me as Governor by the Constitution and laws of the State of North Carolina, IT IS ORDERED:

Executive Order 84, issued by Governor James B. Hunt, Jr. on August 24, 1995, is hereby amended such that the Executive Order regarding the North Carolina Home Furnishing Export Council now reads:

WHEREAS, an advisory body is needed to develop plans and programs to increase home furnishings exports from North Carolina companies into the global market; and

WHEREAS, North Carolina furniture companies and crafts workers create some of the finest furniture in the world; and

WHEREAS, the home furnishings market is becoming more globally-oriented;

Section 1. Establishment.

The North Carolina Home Furnishings Export Council ("Council") is hereby established.

Section 2. Membership.

The Council shall consist of not more than 30 voting members, with the Governor and the Secretary of Commerce serving as ex-officio members. All voting members shall be from either the public or private sector. All candidates shall have an established connection to a genuine interest in the export of home furnishing products produced in North Carolina. The Governor shall appoint a Chair from among the voting membership. All members serve at the pleasure of the Governor. The Council shall meet at least twice a year at the call of the Chair.

Section 3. Duties of the Council.

The Council shall have the following duties:

- (a) Advise the Division of International Trade of the Department of Commerce on matters related to the exportation of home furnishings;
- (b) Serve as a liaison between the North Carolina export office and industry manufacturers; and

- (c) Discover and explore ways to increase the level of exportation of North Carolina's home furnishing products.

Section 4. Administration.

The Department of Commerce shall provide administrative and financial support for the Council. Members shall receive a per diem allowance for their service and reimbursement for travel and other expenses in accordance with state law, subject to the availability of funds.

Section 5. Special Membership Provisions for Furniture Industry Firms.

When a private sector member employed by a furniture industry firm is appointed to the Council, the international management official of that same firm shall also serve as a member of the Council. The furniture industry firm shall identify the individual within its operation that performs the function of international management official.

The international management official shall serve in an ex-officio, nonvoting capacity, except when the specifically appointed private sector member is absent from a meeting. When the specifically appointed private sector member is absent from a meeting, the international management official shall serve as the proxy for that member and shall have the right to vote on matters coming before the Council at that meeting. When two individuals are members as a result of this arrangement, only the specifically appointed private sector member may claim the per diem allowed under this Order.

When a specifically appointed private sector member employed by a furniture industry firm ceases employment with that furniture industry firm, a vacancy shall be created on the Council and that firm's international management official shall cease to serve as an ex-officio nonvoting member.

This Executive Order is effective immediately.

Done in Raleigh, this the 5th day of April, 2002.

Michael F. Easley
Governor

ATTEST:

Elaine F. Marshall
Secretary of State

U.S. Department of Justice

Civil Rights Division

JDR:MJP:SLL:baw
DJ 166-012-3
2002-0589

*Voting Section – NWB.
950 Pennsylvania Ave., N.W.
Washington, D.C. 20530*

April 3, 2002

Susan C. Patterson, Esq.
City Attorney
P.O. Box 3729
Sanford, NC 27331-37329

Jimmy L. Love, Sr., Esq.
Town Attorney, Town of Broadway
P.O. Box 309
Sanford, NC 27331-0309

Kenneth R. Hoyle, Sr., Esq.
County Attorney
P.O. Box 1968
Sanford, NC 27331-1968

Dear Ms. Patterson, and Messrs. Love and Hoyle:

This refers to the use of a touch voting system for all elections administered by Lee County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act, 42 U.S.C. 1973c. We received your submission on February 4, 2002.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. See the Procedures for the Administration of Section 5 (28 C.F.R. 51.41).

Sincerely,

Joseph D. Rich
Acting Chief
Voting Section

A Notice of Rule-making Proceedings is a statement of subject matter of the agency's proposed rule making. The agency must publish a notice of the subject matter for public comment at least 60 days prior to publishing the proposed text of a rule. Publication of a temporary rule serves as a Notice of Rule-making Proceedings and can be found in the Register under the section heading of Temporary Rules. A Rule-making Agenda published by an agency serves as Rule-making Proceedings and can be found in the Register under the section heading of Rule-making Agendas. Statutory reference: G.S. 150B-21.2.

TITLE 10 – DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAPTER 03 – FACILITY SERVICES

Notice of Rule-making Proceedings is hereby given by NC Medical Care Commission in accordance with G.S. 150B-21.2. The agency shall subsequently publish in the Register the text of the rule(s) it proposes to adopt as a result of this notice of rule-making proceedings and any comments received on this notice.

Citation to Existing Rule Affected by this Rule-making: 10 NCAC 03C. Other rules may be proposed in the course of the rule-making process.

Authority for the Rule-making: G.S. 131E-76; 131E-77; 131E-79; 131E96; 131E-117; 131E-126;

Statement of the Subject Matter: This Subchapter deals with the licensure of hospitals.

Reason for Proposed Action: The NC Medical Care Commission proposes to adopt rules regarding the licensure of hospitals.

Comment Procedures: Written comments concerning this rule-making action must be submitted to Mark Benton, Chief of Budget & Planning/Rule-making Coordinator, NC Division of Facility Services, 2701 Mail Service Center, Raleigh, NC 27699-2701

TITLE 11 – DEPARTMENT OF INSURANCE

CHAPTER 08 – ENGINEERING AND BUILDING CODES

Notice of Rule-making Proceedings is hereby given by NC Department of Insurance/Home Inspector Licensure Board in accordance with G.S. 150B-21.2. The agency shall subsequently publish in the Register the text of the rule(s) it proposes to adopt as a result of this notice of rule-making proceedings and any comments received on this notice.

Citation to Existing Rule Affected by this Rule-making: 11 NCAC 08 .1100. Other rules may be proposed in the course of the rule-making process.

Authority for the Rule-making: 143-151.49

Statement of the Subject Matter: Home Inspector standards of practice.

Reason for Proposed Action: The amendments will make technical corrections to the standards of practice.

Comment Procedures: Written comments may be sent to Ken Giovanni, c/o NC Department of Insurance, Home Inspector Licensure Board, 410 N. Boylan Avenue, Raleigh, NC 27603.

TITLE 15A – DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

CHAPTER 10 – WILDLIFE RESOURCES AND WATER SAFETY

Notice of Rule-making Proceedings is hereby given by NC Wildlife Resources Commission in accordance with G.S. 150B-21.2. The agency shall subsequently publish in the Register the text of the rule(s) it proposes to adopt as a result of this notice of rule-making proceedings and any comments received on this notice.

Citation to Existing Rule Affected by this Rule-making: 15A NCAC 10F. Other rules may be proposed in the course of the rule-making process.

Authority for the Rule-making: G.S. 75A-3; 75A-15

Statement of the Subject Matter: NO WAKE ZONES and proposed establishment of exclusionary zones (to prohibit boating, swimming and fishing) at specific locations around ALCOA facilities along the Yadkin River.

Reason for Proposed Action: Rulemaking for No-Wake Zones and Exclusionary Zones in the waterways of the state is pursued in the interest of public safety.

Comment Procedures: The record will be open for receipt of written comments. Such written comments must be mailed to the NC Wildlife Resources Commission, 1701 Mail Service Center, Raleigh, NC 27699-1701.

TITLE 19A – DEPARTMENT OF TRANSPORTATION

CHAPTER 02 – DIVISION OF HIGHWAYS

Notice of Rule-making Proceedings is hereby given by NC Department of Transportation – Ferry Division in accordance with G.S. 150B-21.2. The agency shall subsequently publish in the Register the text of the rule(s) it proposes to adopt as a result of this notice of rule-making proceedings and any comments received on this notice.

RULE-MAKING PROCEEDINGS

Citation to Existing Rule Affected by this Rule-making: 19A NCAC 02D .0532. Other rules may be proposed in the course of the rule-making process.

Authority for the Rule-making: G.S. 136-82; 143B-10(j)

Statement of the Subject Matter: Rule sets out fees charged to ride North Carolina's ferries.

Reason for Proposed Action: The Ferry Division is proposing amendments to this Rule to set out the toll for motorcycles to be transported on the state's ferries. Pursuant to G.S. 20-

4.01(27)d, motorcycles are included in the definition of passenger vehicles and could be eligible for the same ferry toll as automobiles. However, the Ferry Division acknowledges that motorcycles do not take up the same amount of space as passenger vehicles. The toll for motorcycles is not increasing. The amendments clarify the difference between the toll for automobiles and motorcycles.

Comment Procedures: Any interested person may comment on the proposed rule change by mailing written comments to Emily Lee, NC Dot, 1501 Mail Service Center, Raleigh, NC 27699-1501 by September 2, 2002.

This Section contains the text of proposed rules. At least 60 days prior to the publication of text, the agency published a Notice of Rule-making Proceedings. The agency must accept comments on the proposed rule for at least 30 days from the publication date, or until the public hearing, or a later date if specified in the notice by the agency. The required comment period is 60 days for a rule that has a substantial economic impact of at least five million dollars (\$5,000,000). Statutory reference: G.S. 150B-21.2.

TITLE 01 – DEPARTMENT OF ADMINISTRATION

Notice is hereby given in accordance with G.S. 150B-21.2 that the Department of Administration intends to amend the rules cited as 01 NCAC 35 .0101, .0103, .0201-.0205, .0301-.0302, .0304-.0306, .0308-.0309. Notice of Rule-making Proceedings was published in the Register on February 15, 2002.

Proposed Effective Date: April 1, 2003

Public Hearing:

Date: May 31, 2002

Time: 1:00 – 4:00 p.m.

Location: Governor's Press Conference Rm. 1st floor, Administration Building, 216 W. Jones Street, Raleigh, NC

Reason for Proposed Action: The SECC has grown significantly in recent years with more charitable organizations applying to participate every year. More detailed application procedures have become necessary as have clarification of local responsibilities and tightening of pledge processing procedures. The new rules are designed to provide more flexibility in providing financial information for small organizations. There are several technical changes included as well.

Comment Procedures: Public comment, before and at the public hearing, is welcomed and encouraged within the following parameters. Individuals may sign up to speak on the day of the public hearing beginning at 12:30 p.m. All comments MUST be submitted in writing prior to being delivered orally. Oral comments will be strictly limited to a maximum of five minutes in duration. Additional comments may be included in the written version. There will be no response or rebuttal to comments during the hearing. Any person interested in making written comments to these proposed amended rules prior to the public hearing should submit such comments to T. Brooks Skinner, Jr. General Counsel, NC Department of Administration, 1301 Mail Service Center, Raleigh, NC 27699-1301. Comments will be received through May 31, 2002.

Fiscal Impact

- State
- Local
- Substantive ($\geq \$5,000,000$)
- None

CHAPTER 35 – STATE EMPLOYEES COMBINED CAMPAIGN

SECTION .0100 – PURPOSE AND ORGANIZATION

01 NCAC 35 .0101 DEFINITIONS

For purposes of this Chapter, the following definitions apply:

- (1) "Charitable organization." A non-partisan organization that is tax-exempt for both the IRS and N.C. tax purposes. The organization must receive contributions that are tax deductible by the donor.
- (2) "Audit" or "audited financial statement." An examination of financial statements of an organization by a CPA, conducted in accordance with generally accepted auditing standards, to determine whether, in the CPA's opinion, the statements conform with generally accepted accounting principles or, if applicable, with another comprehensive basis of accounting.
- (3) "State Employees Combined Campaign" or "SECC." The official name of the state employees charitable fund-raising drive.
- (4) "Federation" or "Federated Group" means a group of voluntary charitable human health and welfare agencies organized for purposes of supplying common fund-raising, administrative, and management services to its constituent members.
- (5) "Fund-raising expenses" (supporting activities) means expenses of all activities that constitute, or are an integral and inseparable part of, an appeal for financial support. Fund-raising expenses represent the total expenses incurred in soliciting contributions, gifts, grants, etc.; participating in federated fund-raising campaigns; maintaining donor mailing lists; preparing and distributing fund-raising manuals, instructions and other materials; and conducting other activities involved with soliciting contributions.
- (6) "Administrative expenses" (supporting activities) means expenses for reporting and informational activities related to business management and administrative activities which are neither educational, nor direct conduct of program services, nor fund-raising services.
- (7) "Program service expenses" means expenses for those activities that the reporting organization was created to conduct which fulfill the purpose or mission for which the organization exists, exclusive of fund-raising and administrative expenses, and which, along with any activities commenced subsequently, form the basis of the organization's current exemption from tax.
- (8) "Fund-raising consultant" means any person who meets all of the following:

PROPOSED RULES

<p>(a) Is retained by a charitable organization or sponsor for a fixed fee or rate under a written agreement to plan, manage, conduct, consult, or prepare material for the solicitation of contributions in this State;</p> <p>(b) Does not solicit contributions or employ, procure, or engage any person to solicit contributions; and</p> <p>(c) Does not at any time have custody or control of contributions.</p> <p>(9) "Fund-raising solicitor" means any person who is not a fund-raising consultant and does either of the following for compensation:</p> <p>(a) Performs any service, including the employment or engagement of other persons or services, to solicit contributions for a charitable organization or sponsor; or</p> <p>(b) Plans, conducts, manages, consults, whether directly or indirectly, in connection with the solicitation of contributions for a charitable organization or sponsor.</p> <p>(10) <u>"Review" or "reviewed financial statement."</u> <u>An examination of financial statements of an organization by a CPA. The CPA performs inquiry and analytical procedures that provide the CPA with a reasonable basis for expressing limited assurance that there are no material modifications that should be made to the statements in order for them to be in conformity with generally accepted accounting principles or, if applicable, with another comprehensive basis of accounting.</u></p>	<p>Organization, the Statewide Combined Campaign Chair will consider the following criteria:</p> <p>(a) The organization must have demonstrated ability to manage large-scale fund-raising campaigns.</p> <p>(b) The organization must have the ability and willingness to work with a statewide system of local organizations capable of effectively managing local combined campaigns and relating to the Statewide Campaign Organization.</p> <p>(c) The organization must have an audit to demonstrate acceptable financial accountability.</p> <p>(d) The organization must be a tax-exempt organization under the Internal Revenue Code.</p> <p>(e) The organization must be willing and able, if required, to provide a bond in an amount satisfactory to the SECC Advisory Committee to protect the participant organizations and <u>donors</u><u>contributors</u>.</p> <p>(2) SECC Advisory Committee. This ongoing committee serves as a central application point for all charitable organizations applying to participate in the SECC.</p> <p>(a) The committee recommends overall policy for the campaign to the Governor, the Statewide Campaign Chair, and necessary state agencies and recommends the criteria for participation by charitable organizations. The committee reviews the recommendations made by the Statewide Campaign Organization and accepts or rejects its recommendations. <u>Prior to each year's campaign, the SECC Advisory Committee shall approve a budget to cover all of its costs related to the campaign and shall develop an annual work plan.</u> The committee may, in its discretion, require the Statewide Campaign Organization to provide a bond, as provided in Item (1)(e) of this Rule.</p> <p>(b) The committee is composed of at least 10 20 state employee members appointed by the Statewide Campaign Chair. Members serve three year four-year staggered terms at the pleasure of the Statewide Campaign Chair. If a vacancy occurs, the Statewide Campaign Chair shall appoint a replacement to fill the unexpired term. <u>Any member may be reappointed at the end of his or her term.</u> <u>No member shall serve more</u></p>
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Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0103 ORGANIZATION OF THE CAMPAIGN

The State Employees Combined Campaign is organized as follows:

(1) Chair. Each year the Governor may appoint a Statewide Combined Campaign Chair from one of the Executive Cabinet, Council of State, System of Community Colleges, or University Administration agencies. The Campaign Chair ~~or the Campaign Chair's designee~~ shall serve as director of the campaign. The responsibilities of the Chair include enlisting the support and cooperation of the head of each state department and university in coordinating an effective campaign, promoting the participation of all employees at all levels of campaign policy and operation, setting the dates and approving the published materials for the Combined Campaign, contracting for the Statewide Campaign Organization, and appointing members to and serving as chair of the SECC Advisory Committee. For the purposes of selecting a Statewide Campaign

than two consecutive terms of four years.

(c) The SECC Advisory Committee will meet at the discretion of the Statewide Campaign Chair; however, no fewer than four meetings per year will be held. The SECC Advisory Committee shall conduct business only when a quorum of one-third of the committee membership, including the Statewide Campaign Chair or a designee is present.

(d) Any State employee who serves on the SECC Advisory Committee shall not participate in any decision where that employee may have a conflict of interest or the appearance of a conflict of interest, either of a personal nature or with regard to the agency in which the employee works. Any SECC Advisory Committee member who is also a member or a charitable organization's board or serves in a significant leadership role shall recuse himself from taking part in deliberation or voting on matters by which that charitable organization may be impacted.

(3) Statewide Campaign Organization. The Statewide Campaign Organization shall be selected by the Statewide Campaign Chair. The entity selected to manage the campaign shall conduct its own organization operations separately from duties performed as the Statewide Campaign Organization. The duties of the Statewide Campaign Organization include, but are not limited to, the following:

- (a) serving as the financial administrator of the SECC;
- (b) determining if the applicant agencies meet the requirements of Rule .0202 of this Chapter;
- (c) submitting to the Statewide Campaign Chair the name of an organization to serve as Local Campaign Organization;
- (d) providing the necessary supervision of data centralized pledge processing services in order to process all payroll deduction pledge forms of state employees;
- (e) compiling receiving reports from the for the Local Campaign Organization SECC Advisory Committee and notifying federations and independent agencies no later than March 1 following the close of the campaign on December 1 of the amounts designated to them and their member agencies and of the amounts

(f) of the undesignated funds allocated to them; transmitting quarterly to each federation and independent agency Local Campaign Organization its share of the state employees payroll deduction funds. Interest earnings will be disbursed to each participating federation and independent agency based on its proportionate share of the campaign's total gross contributions if an interest bearing account is established. Undesignated funds shall be distributed in accordance with the rules in this Chapter;

(g) printing and distributing the pledge form, the campaign report form and collection envelopes to the Local Campaign Organization;

(h) maintaining an accounting of all funds raised and submitting an interim unaudited end-of-campaign report of the following:

- (i) amounts contributed and pledged;
- (ii) number of contributions; and
- (iii) amounts distributed to each participating agency;

(i) Once once applications for acceptance into the campaign have been recommended to the SECC Advisory Committee by the Statewide Campaign Organization, preparing a list of all accepted organizations and distributing them to all applicants, applicants;

(j) coordinating an annual statewide or regional training session for Local Campaign Organizations and state employee volunteers;

(k) serving as liaison to participating charitable organizations;

(l) providing staff to administer the SECC in consultation with SECC Advisory Committee;

(m) preparing an itemized budget of anticipated campaign and administrative expenses for the SECC;

(n) preparing a suggested annual work plan of goals and objectives for the SECC;

(o) educating state employees in the services provided through their support;

(p) overseeing the operations of the Local Campaign Organizations to ensure that they are performing their duties;

(q) deducting before disbursements are made, direct costs of operating the

campaign from the gross contributions and charging each federation or independent agency its proportionate share of the campaign's operational cost. The Statewide Campaign Organization and Local Campaign Organizations shall justify the actual costs of the campaign, which should not exceed 10% respectively of gross contributions;

(r) maintaining records related to campaign activities; and

(s) providing such other central management functions as may be agreed upon as essential in its contract with the State Campaign Chair.

(4) Local Campaign Chair. The Governor, if asked by the local charitable organizations accepted into the Combined Campaign, may appoint an area representative from either state government or the University of North Carolina system to serve as the Local Chair. This person will be responsible for forming a Local Advisory Committee for recruitment of volunteer state employees, employees, enlisting and confirming top management support, communicating to area state employees the Chair's support for and participation in the campaign, and providing that the campaign is conducted using the knowledge and expertise of the SECC to insure success.

(5) Local Advisory Committee. The Local Advisory Committee. This committee is responsible for the approval of local campaign literature, review of past performance, the establishment of local goals as needed, and the distribution of any undesignated funds made available for distribution, distribution, the development of a budget and campaign plan, the approval of local publicity materials, the conduct of the campaign, and the recognition of volunteers and contributors.

(a) The committee is composed of at least 10 state employee members appointed by the Local Campaign Chair. Members serve four-year staggered terms. If a vacancy occurs, the Local Campaign Chair shall appoint a replacement to fill the unexpired term. No member shall serve more than two consecutive terms of four years.

(b) The Local Advisory Committee will meet at the discretion of the Local Campaign Chair. The Local Advisory Committee shall conduct business only when a quorum of one-third of the committee membership, including the Local Campaign Chair or a designee is present.

(5)(6) The Campaign Chair shall approve or reject the State Campaign Organization's recommendation for Local Campaign Organization and name an agency as the Local Campaign Organization. The Local Campaign Organization must identify itself on all printed materials as the local SECC organization.

(a) Any SECC charitable organization wishing to be selected as a Local Campaign Organization must submit a timely application in accordance with the deadline set by the Statewide Campaign Organization that includes:

(i) A written campaign plan sufficient in detail to allow the SCO to determine if the applicant could administer an efficient and effective SECC. The campaign plan must include a proposed SECC budget that details all estimated costs required to operate the SECC. The budget may not be based on the percentage of funds raised in the local campaign;

(ii) A statement signed by the applicant's director or equivalent pledging to:

(A) administer the SECC fairly and equitably;

(B) conduct campaign operations (such as training, kick-off and other events) separate from the applicant's non-SECC operations; and

(C) abide by the directions, decisions and supervision of the Statewide Campaign Organization, State Advisory Committee and the Local Campaign Advisory Committee; and

(iii) A statement signed by the applicant's director or equivalent acknowledging that applicant is subject to the provisions of 1 NCAC 35, State Employees Combined Campaign.

(a)(b) For the purpose of selecting a Local Campaign Organization, the

Statewide Campaign Chair and Statewide Campaign Organization will consider the following criteria:

- (i) whether the local organization is willing to conduct a local SECC;
- (ii) whether the organization agrees to comply with the terms of the State/Local Organizations contract;
- (iii) whether the organization has community and state employee support and volunteer involvement;
- (iv) whether the organization has a demonstrated ability and successful history of managing fund-raising campaigns that include:
 - (A) development of campaign strategy;
 - (B) development of campaign materials;
 - (C) development of volunteer campaign structures;
 - (D) training of volunteer solicitors;
 - (E) a financial structure and resources that can efficiently manage, account for, and disburse funds;
 - (F) being a participant organization of the campaign;
 - (G) ability to develop financial relationships with a network of statewide organizations so as to ensure the orderly transmittal, disbursement, accounting of, and reporting of donations and pledges;
- (v) whether the organization is willing and able to provide a bond, if required, in an amount satisfactory to the SECC Advisory Committee to protect the participant organizations and donors contributors.

(b)(c) The Local Campaign Organization shall assist the Local Campaign Chair and Local Campaign Advisory Committee in the training of volunteers, the ordering and distribution of campaign literature, and the collection of pledge reports and envelopes from the state agency volunteers, volunteers, the development of campaign reports, and the forwarding of one copy of each payroll deduction pledge to the Statewide Campaign Organization. In addition, an end of campaign report shall be sent to the Statewide Campaign Organization by February 1 following the close of the campaign on December 31 for inclusion in the required fiscal reports.

(c) The Local Campaign Organization shall:

- (i) establish an interest bearing account with a bank in order to receive deposits of collected funds. Interest earnings shall be disbursed to each participating federation and independent agency based on its proportionate share of the campaign's total gross contributions if an interest bearing account is established;
- (ii) distribute the funds from the contributions in accordance with designations made by state employees. Undesignated funds shall be distributed in accordance with the rules in this Chapter. Each Local Campaign Organization shall disburse contributions quarterly to participating federations and independent agencies;
- (iii) be permitted to deduct, before any disbursements are made, direct costs of operating the campaign from the gross contributions, and shall charge each federation or independent agency its proportionate share of the campaign's operational cost. The Local Campaign Organization shall justify the actual costs of the campaign, which should not exceed 10% of gross receipts; and
- (iv) notify the federations and independent agencies no later than March 1 following

the close of the campaign on December 31 of the amounts designated them and their member agencies and of the amounts of the undesignated funds allocated to them.	<p>(a) State Department Head and University Chancellor. The director or chancellor of each state department and university sets the tone and provides leadership for the campaign. This person shall ensure that voluntary fundraising within the department or university is conducted in accordance with these policies and procedures, communicate support for the campaign to all employees, and appoint Department Executives within the agency's or university's central office;</p>
<p>(6)(7) A <u>three-year</u> contract between the state and the Statewide Campaign Organization, and the Statewide and Local Campaign Organizations, will be executed in order to develop an acceptable audit trail. The contracts will allow a reasonable charge for campaign expenses to be claimed by the Statewide Campaign Organization and the Local Organization. All terms and conditions of these contracts are subject to review and approval by the Statewide Campaign Chair.</p>	<p>(b) Department Executives. Department Executives manage the campaign at the agency or university level. The Department Executives undertake the official statewide campaign within their agencies or university providing active and essential support. The Department Executives ensure that personal solicitations are organized and conducted in accordance with the procedures set forth in these regulations and appoint local agency coordinators at agency institutions or local offices and provide direction and guidance to the local coordinators;</p>
<p>(a) The Statewide Campaign Organization and Local Campaign Organizations shall recover from gross receipts of the campaign their expenses which should reflect the actual costs of administering the campaign. Actual costs of the campaign must be justified and should not exceed 10% of gross receipts. The campaign expenses shall be shared proportionately by all the recipient organizations reflecting their percentage share of gross campaign receipts. <u>The SECC Advisory Committee reserves the right to waive the 10% annual fee. No direct costs associated with the campaign will be borne by the State. All costs shall be borne by the proceeds from the campaign.</u></p>	<p>(c) Local Agency Coordinators. Local agency coordinators are appointed by their respective Department Executives and manage the campaign in agency institutions or local offices. The local agency coordinators undertake the official campaign within their institution or local office assisting in setting campaign goals and providing active and essential support. The local agency coordinators ensure that personal solicitations are organized and in accordance with the procedures set forth in these regulations and work with solicitors to achieve a successful campaign; and</p>
<p>(b) The failure of the Statewide Campaign Organization or the Local Campaign Organization to perform any of its respective responsibilities listed in this Section may be grounds for removal and disqualification by the Chair to serve in its capacity for one year. Before deciding on removing or disqualifying an organization, the Chair shall give the organization an opportunity to respond to any allegations of failure to perform its responsibilities. The organization must submit its response to the Chair within 10 days from notification postmark date. The Chair shall issue a written determination based on a review of all of the information submitted.</p>	<p>(d) Local Agency Solicitors. Solicitors work with local agency coordinators to promote the campaign. Solicitors communicate the importance of the campaign to their fellow workers, encourage participation by payroll deduction, explain how to designate gifts and answer questions regarding the campaign. Solicitors personally solicit employees in their assigned area, report all pledges and contributions to the local agency coordinator and ensure that pledge forms are properly distributed,</p>
<p>(8) <u>Solicitation Campaign Organization.</u> The campaign shall be divided into no more than 15 local administrative regions, and managed within each state department and university according to the following structure:</p>	

completed and collected. Solicitors also assist in planning campaign strategies and events.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

SECTION .0200 - APPLICATION PROCESS AND SCHEDULE

01 NCAC 35 .0201 APPLICATIONS

(a) To be eligible to participate in the State Employees Combined Campaign, an organization must apply annually for consideration, either as an independent organization or as a federation.

(b) Independent organizations and federations wishing to receive an application can do so by making a request in writing to the Statewide Campaign Organization. Such written requests may be made by letter, facsimile or email communication; however, oral, telephone or verbal requests shall not be honored.

(c) Any independent organization or federation which was eligible to participate in the State Employees Combined Campaign immediately preceding the campaign for which application is currently made shall be required only to submit to the Statewide Campaign Organization its most recent information, which shall specifically update the requirements of 01 NCAC 35 .0202 and include a completed Certificate of Compliance.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0202 CONTENT OF APPLICATIONS

(a) All organizations seeking inclusion in the State Employees Combined Campaign must submit an application to the state campaign. The application must include a completed State Employees Combined Campaign Certificate of Compliance, provided by the Statewide Campaign Organization. Included in or attached to the Certificate of Compliance must be:

- (1) A letter from the board of directors requesting inclusion in the campaign.
- (2) A complete description of services provided, the service area of the organization, and the percentage of its total support and revenue that is allocated to administration and fund-raising, fund-raising or copies of its annual report, newsletters, brochures and fact sheets as long as they include the required information.
- (3) The most recent audited financial statement prepared by a CPA within the past two years. The SECC Advisory Committee shall permit organizations with annual budgets of less than three hundred thousand dollars (\$300,000) total support and revenue to submit an audited financial statement or review prepared by a CPA. Total support and revenue is determined by the IRS Form 990 covering the organization's most recent fiscal year ending not more than two years prior to the current year's campaign date. The CPA opinion rendered on the financial statement must be unqualified. The year end of such audited financial statement or review must be no

earlier than two years prior to the current year's campaign date. The SECC Advisory Committee may grant an exception to this requirement if an organization has filed its Articles of Incorporation with the Secretary of State's Office since March 1 of the preceding year of the current campaign.

(4) A completed and signed copy of the organization's IRS 990 form exclusive of other IRS schedules or sufficient documentation regardless of whether or not the IRS requires the organization to file the form, to indicate program services, administrative and fund-raising expenses. The IRS 990 form and CPA audit or review shall cover the same fiscal year and, if revenue and expenses on the two documents differ, these amounts must be reconciled on an accompanying statement by the CPA who completed the financial audit or review.

(5) A board statement of assurance of non-discrimination of employment, board membership and client services. The policy must be board approved, in written form, and available to the SECC.

(6) A description of the origin, purpose and structure of the organization, organization or copies of articles of incorporation and bylaws.

(7) A list of the current members of the board, including their addresses.

(8) A letter from the board of directors certifying compliance with the eligibility standards listed in Paragraph (b) of this Rule.

(9) When a federated fund raising organization submits an application, they may submit the credentials of the federation only, not each member agency. A federation may submit applications on behalf of its member agencies; however, the application shall include a completed and signed Certificate of Compliance for each member agency. If any member agency is new to the federation, or did not participate in the SECC during the previous year, the federation shall provide a complete application and sufficient documentation to show that the member agency is in compliance with all eligibility criteria. By the submission of such, the federations certify that all of their member agencies comply with all the SECC regulations, unless there are exceptions. If there are exceptions to the requirements, the federations must disclose such and explain to the satisfaction of the Statewide Combined Campaign Advisory Committee the reasons for the exception. The SECC Advisory Committee may elect to review, accept or reject the certifications of the eligibility of the member agencies of the federations. If the Committee requests information supporting a certification of eligibility, that information

shall be furnished promptly. Failure to furnish such information within 10 days of the notification postmark date constitutes grounds for the denial of eligibility of that member agency.

(10) The SECC Advisory Committee may elect to decertify a federation or independent agency which makes a false certification, subject to the requirement that any federation or independent agency that the Committee proposes to decertify shall be notified by the Statewide Campaign Organization of the Committee's decision stating the grounds for decertification.

(11) The federation or independent agency may file an appeal to the Committee within 10 days of the notification postmark date. False certifications are presumed to be deliberate. The presumption may be overcome by evidence presented at the appeal hearing.

(b) Organizations must meet the following criteria to be accepted as participants in the Combined Campaign:

(1) Must be licensed to solicit funds in North Carolina if a license is required by law, law and provide written proof of the same. All organizations applying as domestic or foreign nonprofit corporations must also submit a certificate of existence (for domestic corporations) or a certificate of authorization (for foreign corporations) issued by the office of the North Carolina Secretary of State pursuant to G.S. 55A-1-28.

(2) Must provide written proof of tax exempt status for both federal income tax under section 501(c)(3) of the Internal Revenue Code and N.C. state tax purposes under Sections 105-125 and 105-130.11(3), respectively, of the North Carolina General Statutes, but the organization must not be a private foundation as defined in section 509(a) of the Internal Revenue Code. Organizations must certify that contributions from state employees are tax deductible by the donor under N.C. and federal law.

(3) Must prepare and make available to the general public an audited financial statement, statement prepared by a CPA within the past two years. The SECC Advisory Committee shall permit organizations with annual budgets of less than three hundred thousand dollars (\$300,000) total support and revenue to submit an audited financial statement or review prepared by a CPA. Total support and revenue is determined by the IRS 990 form covering the organization's most recent fiscal year ending not more than two years prior to the current year's campaign date. The CPA opinion rendered on the financial statements must be unqualified. The year end of such audited financial statement or review must be no earlier than two years prior to the current

(4) Must provide a completed and signed copy of the organization's IRS 990 form exclusive of other IRS schedules regardless of whether or not the IRS requires the organization to file the form, to indicate program services, administrative and fund-raising expenses. The IRS 990 form and CPA audit or review shall cover the same fiscal year and, if revenue and expenses on the two documents differ, these amounts must be reconciled on an accompanying statement by the CPA who completed the financial audit or review. If fund-raising and administrative expenses are in excess of 25 percent of total revenue, must demonstrate to the satisfaction of the SECC that those expenses for this purpose are reasonable under all the circumstances of the case. The SECC may reject any application from an agency with fund-raising and administrative expenses in excess of 25 percent of total revenue, unless the agency demonstrates to the satisfaction of the Committee that its actual expenses for those purposes are reasonable under all the circumstances in its case. The Committee reserves the right to waive the 25 percent excess rule.

(5) Must certify that all publicity and promotional activities are truthful and non-deceptive and that all material provided to the SECC is truthful, non-deceptive, includes all material facts, and makes no exaggerated or misleading claims.

(6) Must agree to maintain the confidentiality of the contributor list.

(7) Must permit no payments of commissions, kickbacks, finders fees, percentages, bonuses, or overrides for fund-raising, and permit no paid solicitations by a fund-raising consultant or solicitor in the SECC.

(8) Must have a written board policy of non-discrimination on the basis of race, color, religion, sex, age, national origin or physical or mental disability for clients of the agency, employees of the agency and members of the governing board. Nothing herein denies eligibility to any voluntary agency which is otherwise eligible because it is organized by, on behalf of or to serve persons of a particular race, color, religion, sex, age, national origin or physical or mental disability.

(9) Must provide benefits or services to state employees or their families within a solicitation area, area and be available through a telephone number to respond to inquiries

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from state employees. Examples of services include:
(A) research and education in the health and welfare or education fields;
(B) family and child care services;
(C) protective services for children and adults;
(D) services for children and adults in foster care;
(E) services related to the management and maintenance of the home;
(F) day care services for adults and children;
(G) transportation services, information referral and counseling services;
(H) the preparation and delivery of meals;
(I) adoption services;
(J) emergency shelter care and relief services;
(K) safety services;
(L) neighborhood and community organization services;
(M) recreation services;
(N) social adjustment and rehabilitation services;
(O) health support services; or
(P) a combination of services designed to meet the needs of special groups such as the elderly or disabled.

However, an international organization which provides health and welfare services overseas, whose activities do not require a local presence and which meet the other eligibility criteria in these Rules, may be accepted for participation in the campaign.

(10) If included in the previous year's campaign, must have received a minimum of two hundred and fifty dollars (\$250.00) in designated funds. If this minimum level is not attained, the organization is ineligible to apply for inclusion in the campaign for the next three years. Undesignated money shall not be used to meet the minimum requirement. This provision applies to all member agencies of federations as well as independent organizations.
(11) Must not be created specifically to take advantage of the opportunity to participate in the SECC.
(12) Must not use SECC contributions for lobbying activities.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0203 REVIEW AND SCHEDULE

(a) Complete applications must be submitted to the Statewide Campaign Organization by February 15 annually to be included in the fall campaign. Incomplete applications shall not be considered by the Committee. The Statewide Campaign Organization will report to the Committee its recommendation on each application within four three weeks of the closing

deadline. The Committee shall affirm or reject each recommendation by the Statewide Campaign Organization and shall inform the Statewide Campaign Organization of its decisions.

(b) The Statewide Campaign Organization and the Committee shall review the application materials for accuracy, completeness and compliance with these regulations. The Committee may reject an application for failing to meet any of the criteria outlined in these Rules. Failure to supply any of the information required by the application may be judged a failure to comply with the requirements of public accountability, and the applicant may be ruled ineligible for inclusion.

(c) The Statewide Campaign Organization or the Committee may request such additional information required by these Rules as they deem necessary to complete these reviews. An organization that fails to comply with such requests within 10 days of the notification postmark date may be judged ineligible.

(d) The burden of demonstrating eligibility shall rest with the applicant.

(e) If the due date falls on a Saturday, Sunday or a legal holiday, then the information must be received by the Statewide Campaign Organization or postmarked by the end of the next day which is not a Saturday, Sunday or a legal holiday.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0204 RESPONSE

All applicants will be notified by the Statewide Campaign Organization of the Committee's decision within 45 days of the closing deadline. An applicant who is dissatisfied with the determination of its application may file an appeal to the State Advisory Committee within 10 days of the notification postmark date. An applicant who is dissatisfied with either the Committee's decision or the appeal determination of the Committee may commence a contested case by filing a petition under G.S. 150B-23 within 60 days of notification postmark date of the Committee's decision.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0205 AGREEMENTS

(a) Following acceptance into the SECC, federations and independent agencies shall execute a contract with the State. The parties shall agree to abide by the terms and conditions of the rules. The contract shall be signed by the State Chair, the Statewide Campaign Organization, the organization's board chair and the organization's chief executive officer.

(b) Each federation shall accept responsibility for the accuracy of the distribution amount to their member agencies. Each federation must be able to justify amounts deducted from their disbursements to participating agencies. These deductions shall not exceed 10% of gross receipts. Each federation must be willing and able to provide a bond, if required, in an amount satisfactory to the SECC Advisory Committee to protect the participant organizations and donors-contributors.

(c) Each federation is expected to disburse on the basis of actual funds received, both designated and undesignated, rather than the amount pledged. Each federation shall disburse contributions quarterly to participating member agencies.

(d) The SECC Advisory Committee at its discretion may discontinue distribution of funds to any independent agency that

ceases to comply with the criteria and procedures as set forth in these Rules. The remainder of the agency funds will be distributed as the SECC Advisory Committee may designate.

(e) In the event a federation ceases to comply with the criteria and procedures as set forth in these Rules, the SECC Advisory Committee will distribute the designated and undesignated funds contributed to the federation equally among the SECC charitable organizations under said federation.

(f) In the event a SECC charitable organization in a federation ceases to comply with the criteria and procedures as set forth in these Rules, the SECC Advisory Committee will distribute the funds contributed to that organization, designated and undesignated, to the federation for distribution in accordance with federation policy.

(g) In the event a SECC charitable organization or any of its directors, officers or employees are the subject of any investigation or legal proceeding by any federal, state or local law enforcement authority based upon its charitable solicitation activities, delivery of program services, or use of funds, the organization must disclose the same to the SECC within 10 days of its learning of the investigation or proceeding. It must also disclose within 10 days the outcome of any such investigation or proceeding.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

SECTION .0300 – GENERAL PROVISIONS

01 NCAC 35 .0301 OTHER SOLICITATION PROHIBITED

No charitable organization shall engage in any direct monetary solicitation activity at any state employee work site, except as a participant in the State Employees Combined Campaign and in accordance with 1 NCAC 35. Not more than one on-the-job solicitation for funds will be made in any year at any location on behalf of participating SECC agencies. The prohibition does not include Red Cross sponsored Bloodmobiles or employee association solicitations.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0302 COERCIVE ACTIVITIES PROHIBITED

(a) In order to insure that donations are made on a voluntary basis, actions that do not allow free choice or that create an impression of required giving are prohibited. Peer solicitation is encouraged. Employee gifts shall be kept confidential, except that employees may opt to have their designated contributions acknowledged by the recipient organizations.

(b) All activities of the campaign shall be conducted in a manner that promotes a unified solicitation on behalf of all participants. While it is permissible to individually identify, describe or explain the charitable organizations in the campaign for informational purposes, no person affiliated with the campaign shall engage in any campaign activity that is construed to either advocate or criticize any specific charitable organization.

(b)(c) The following activities are not permitted:

(1) The providing and using of contributor lists for purposes other than the routine collection, forwarding, and acknowledgement of

contributions. Recipient organizations that receive the names and addresses of state employees must segregate this information from all other lists of contributors and only use the lists for acknowledgement purposes. This segregated list may not be sold or in any way released to anyone outside of the recipient organization. Failure to protect the integrity of this information may result in penalties up to expulsion from the campaign.

(2) The establishment of personal dollar goals or quotas.

(3) The developing and using of lists of non-contributors.

(d) Violations of these Rules by a participant organization may result in the decertification of the organization. The organization shall be given notice of an opportunity to be heard prior to any action being taken by the Committee. Any organization who is dissatisfied with the determination of its decertification may file an appeal to the Committee within 10 days of the notification postmark date. An organization who is dissatisfied with either the Committee's decision or the appeal determination of the Committee may commence a contested case by filing a petition under G.S. 150B-23 within 60 days of notification postmark date of the Committee's decision.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0304 METHODS OF GIVING AND TERMS OF CONTRIBUTION

(a) Payment may be made by payroll deduction, cash, or personal check, check or credit card. If an employee chooses to use the payroll deduction method of contributing, he/she must agree to have the deduction continue for one year with equal amounts deducted from each check (monthly, semi-monthly or biweekly depending on the payroll). If the employee authorizes payroll deduction, the minimum amount of the deduction is five dollars (\$5.00) per month. All deductions will start with the January payroll and continue through December. If the employee discontinues employment, or actively chooses to discontinue payment, the state will not be responsible for the collection of the unpaid pledge. No deduction will be made for any period in which the employee's net pay, after all legal and previously authorized deductions, is insufficient to cover the allotment. No adjustments will be made in subsequent periods to make up for deductions missed. An employee who wishes to participate in a subsequent campaign must file a new pledge form valid for the subsequent campaign.

(b) The State of North Carolina will provide new employees the opportunity to contribute to the SECC when any State or university human resources office is reviewing the final details of employment with each new employee. There shall be no implication that a contribution is a requirement for employment, but material and an interpretation of the state policy and SECC shall be provided.

(c) An employee transferred from one state agency to another must request a copy of the employee's payroll deduction authorization form from the first state agency and submit the copy to the second state agency or complete and submit an additional form if required by the second state agency.

PROPOSED RULES

(d) Temporary, contract and retired state employees shall be eligible to participate in the SECC.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0305 CAMPAIGN LITERATURE

(a) Each charitable organization accepted as part of the campaign:

- (1) Shall provide adequate information about its services including administrative/fund-raising costs, to the Local Campaign Organization for use in the local campaign; and
- (2) Shall not be listed more than one time in the campaign literature. Shall not be listed more than one time in the campaign literature unless the SECC Advisory Committee, in consultation with the Statewide Campaign Organization, determine the following:
 - (A) It is in contributors' interests to more specifically direct their gifts to separate geographic locations; and
 - (B) The organization maintains records that determine that gifts so designated to that geographic area accrue only to the benefit and purposes of the organization in that designated area; and

(3) Shall not be permitted to distribute agency material that is a solicitation or that in any way provides revenue to such charitable organization.

(b) The State Employees Combined Campaign shall provide a campaign brochure designed by the SECC Advisory Committee and all publicity will be subject to the State Chair's approval and free of undue or disproportionate publicity in favor of any one agency or federation of agencies.

(c) The State Chair shall approve, prior to distribution, the content of any campaign pledge/designation card to ensure that the information contained is accurate and complies with the State Controllers requirements for format and substance.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0306 DESIGNATION CAMPAIGN

(a) Each employee shall be given the opportunity to designate which agency or group of agencies shall benefit from his or her contribution to the State Employees Combined Campaign. Each employee will be given a list of the approved agencies in the campaign in order to help them make the decision. The state employee may only designate the federations and agencies that are listed. Write-ins are prohibited.

(b) Designations made to organizations not listed are not invalid, but will be treated as undesignated funds and distributed accordingly.

(c) Contributions designated to a federation will be shared in accordance with the federation's policy.

(d) All designated contributions shall be a minimum contribution of ten dollars (\$10.00) annually per agency designated. If a designation does not comply with the minimum required, the designation is invalid, and will be treated as undesignated funds and distributed accordingly.

(e) An employee may not change the designated agency or group of agencies designated to receive amounts pledged outside the time the campaign is being conducted.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0308 EFFECTIVE DATE OF AMENDED RULES

These amended rules shall be effective for the 1994 SECC and thereafter.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

01 NCAC 35 .0309 CAMPAIGN OPERATION

(a) The official name of the state employee giving system of North Carolina is the State Employees Combined Campaign.

(b) The campaign solicitation period shall be conducted annually during the period after August 1 and before November 30; in any event it shall not extend beyond December 1. The Statewide Campaign Chair may specify the campaign period to be uniform statewide.

(c) The fiscal year for the State Employees Combined Campaign will be January 1 through December 31.

Authority G.S. 143-3.3; 143-340(26); 143B-10.

TITLE 07 – DEPARTMENT OF CULTURAL RESOURCES

Notice is hereby given in accordance with G.S. 150B-21.2 that the USS North Carolina Battleship Commission intends to amend the rule cited as 07 NCAC 05 .0203. Notice of Rule-making Proceedings was published in the Register on March 1, 2002.

Proposed Effective Date: April 1, 2003

Public Hearing:

Date: May 16, 2002

Time: 10:00 a.m.

Location: Captain's Cabin, Battleship North Carolina, Eagles Island, Wilmington, NC

Reason for Proposed Action: To increase the Admissions fee schedule for the Battleship North Carolina.

Comment Procedures: Provide comments in writing to Director, Battleship North Carolina, PO Box 480, Wilmington, NC 28402-04480 no later than 30 days of the publication of this notice. Comments will be accepted through May 31, 2002.

Fiscal Impact

- State
- Local
- Substantive ($\geq \$5,000,000$)
- None

CHAPTER 05 – USS NORTH CAROLINA BATTLESHIP COMMISSION

SECTION .0200 – USE REGULATIONS

07 NCAC 05 .0203 ADMISSION PRICES

(a) The admission price for the Battleship U.S.S. North Carolina is eight dollars (\$8.00)nine dollars (\$9.00) for persons age 12 and over, four dollars (\$4.00)four dollars and fifty cents (\$4.50) for children age 6 through 11, two dollars (\$2.00)two dollars and twenty-five cents (\$2.25) per student for organized school groups in grades kindergarten through 6, and four dollars (\$4.00)four dollars and fifty cents (\$4.50) per student for organized school groups in grades 7 through 12.
(b) There is no charge for children under 6.
(c) Classroom teachers, aides, and chaperones accompanying students in class field trips will be admitted without charge at the rate of one teacher/aide/chaperone for each 10 students.

Authority G.S. 143B-73.

TITLE 10 – DEPARTMENT OF HEALTH AND HUMAN SERVICES

Notice is hereby given in accordance with G.S. 150B-21.2 that the North Carolina Medical Care Commission intends to adopt the rules cited as 10 NCAC 03D .2501-.2524, .2601-.2616, .2701-.2704, .2801-.2809, .2901-.2909, .2911, .3001-.3004, .3101-.3102, .3201, .3301-.3305, .3401-.3403, .3501-.3503 and repeal the rules cited as 10 NCAC 03D .0801-.0805, .0807-.0808, .0901, .0903-.0904, .0906, .0910, .0912-.0916, .0925, .1001-.1004, .1101-.1104, .1201-.1206, .1301-.1302, .1401-.1403, .1501-.1503, .2001, .2101-.2106, .2201-.2203. Notice of Rule-making Proceedings was published in the Register on January 15, 2002 and September 4, 2001.

Proposed Effective Date: April 1, 2003

Public Hearing:

Date: May 31, 2002

Time: 10:00 a.m.

Location: Room 113, Council Bldg., NC Division of Facility Services, Dorothea Dix Campus, 701 Barbour Dr., Raleigh, NC

Reason for Proposed Action: The NC General Assembly recently ratified House Bill 452 (Session Law 2001-220) and House Bill 453 (Session Law 2001-211). These two pieces of legislation amended G.S. 143-56 and G.S. 143-50 to update existing Emergency Medical Services (EMS) terminology, definitions, roles and responsibilities. As such, changes are needed to ensure compliance with the new laws. The Commission is proposing to permanently repeal existing EMS rules and replace them with new permanent rules.

Comment Procedures: Written comments concerning this rule-making action must be submitted to Mark Benton, Chief of Budget & Planning/Rule-making Coordinator, NC Division of Facility Services, 2701 Mail Service Center, Raleigh, NC 27699-2701. Comments will be received through May 31, 2002.

Fiscal Impact

State 10 NCAC 03D .2607
 Local 10 NCAC 03D .2607

Substantive (≥\$5,000,000)

None 10 NCAC 03D .0801-.0805, .0807-.0808, .0901, .0903-.0904, .0906, .0910, .0912-.0916, .0925, .1001-.1004, .1101-.1104, .1201-.1206, .1301-.1302, .1401-.1403, .1501-.1503, .2001, .2101-.2106, .2201-.2203, 2501-.2524, .2601-.2606, .2608-.2616, .2701-.2704, .2801-.2809, .2901-.2909, .2911, .3001-.3004, .3101-.3102, .3201, .3301-.3305, .3401-.3403, .3501-.3503

CHAPTER 03 – FACILITY SERVICES

SUBCHAPTER 03D - RULES AND REGULATIONS GOVERNING AMBULANCE SERVICE

SECTION .0800 - DEFINITIONS

10 NCAC 03D .0801 AMBULANCE AND BASIC LIFE SUPPORT (BLS) PROFESSIONAL

~~(a) Definitions used in this Subchapter will be in accordance with those found in G.S. 131E-155 incorporated by reference including subsequent amendments and as follow.~~

~~(b) An ambulance must have a permit issued by the Department of Health and Human Services, Division of Facility Services, Office of Emergency Medical Services in one of the following categories:~~

~~(1) "Category I Ambulance" means an emergency ambulance used to transport patients with emergency traumatic or medical conditions or patients for which the need for emergency medical care is anticipated either at the scene of the emergency or enroute to a medical facility. Category I ambulances may be used to transport all types of patients.~~

~~(2) "Category II Ambulance" means an ambulance used solely to transport sick or infirm patients, having a known, non emergency medical condition, on a scheduled basis between facilities or between a residence and a facility. Category II ambulances must not be used to transport patients defined under any other category of ambulance.~~

~~(3) "Category III Ambulance" means an emergency ambulance specifically designed and equipped to transfer critically ill patients from one medical facility to another or as ground support to a permitted air ambulance program. The patient care compartment of Category III ambulances must be staffed by appropriately certified or licensed personnel approved for the mission by the program medical director. Category III ambulances must be utilized as part of an organized critical care transport program and may not be used in place of any other category of ambulance defined in this Subchapter.~~

~~(4) "Category IV Ambulance" means an ambulance specifically designed and equipped to transport patients by air. The patient care compartment of Category IV ambulances must be staffed by appropriately certified or licensed personnel approved for the mission by~~

the program medical director. Category IV ambulances must be operated as either:

- (A) Part of an approved mobile intensive care program and must comply with the criteria as outlined in 21 NCAC 32H; or
- (B) Part of an air ambulance program which complies with 21 NCAC 32H .1004.

(5) "Category V Ambulance" means a watercraft specifically designed and equipped to routinely transport patients.

(e) The term "Basic Life Support (BLS) professional" means a certified medical responder or emergency medical technician.

Authority G.S. 131E-157(a); 143-508.

10 NCAC 03D .0802 CERTIFIED EMT INSTRUCTOR

The term "certified Emergency Medical Technician (EMT) instructor" means a person who instructs or coordinates emergency medical services (EMS) educational programs and continuing education programs who meets the criteria defined in Rule .1202 of this Subchapter.

Authority G.S. 131E-159(b).

10 NCAC 03D .0803 APPROVED TEACHING INSTITUTION

The term "approved teaching institution" means any agency with a current contract with the Office of Emergency Medical Services to provide emergency medical services educational programs. Approved teaching institutions must meet the criteria found in Rule .1201 of this Subchapter.

Authority G.S. 131E-159(b).

10 NCAC 03D .0804 COMMISSION

The term "Commission" means the North Carolina Medical Care Commission.

Authority G.S. 131E-159(b).

10 NCAC 03D .0805 OFFICE OF EMERGENCY MEDICAL SERVICES

The term "Office of Emergency Medical Services" means a section of the Division of Facility Services of the North Carolina Department of Health and Human Services located at 701 Barbour Drive, Raleigh, North Carolina 27603.

Authority G.S. 131E-157(a); 131E-159(b).

10 NCAC 03D .0807 CRITICAL CARE TRANSPORT PROGRAM

The term "critical care transport program" means a defined system of care during transport from one medical facility to another for patients suffering from a specific injury or medical condition (i.e., neonatal, high risk obstetrics, burn, etc.). Such programs must include, at a minimum, a designated physician medical director and written transfer protocols.

Authority G.S. 131E-157(a).

10 NCAC 03D .0808 AMBULANCE PROVIDER LICENSE

The term "ambulance provider license" means the legal authorization issued by the Office of Emergency Medical Services for a person, firm, corporation, or association to operate an ambulance service within a specific geographical service area in accordance with Section .1500 of this Subchapter.

Authority G.S. 131E-155.1.

SECTION .0900 - VEHICLES

10 NCAC 03D .0901 INTERIOR DIMENSIONS

(a) Any vehicle issued a permit as a Category I, Category II, or Category III ambulance must have the following minimum patient compartment interior dimensions:

- (1) The length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, must be at least 102 inches.
- (2) The width of the compartment after cabinet and cot installation must provide at least 11 inches of clear aisle walkway between the primary cot and the squad bench, a second cot or curbside wall of the vehicle.
- (3) The height must be at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment.

(b) Category IV ambulances must have:

- (1) A patient care area sufficiently isolated from the cockpit to minimize inflight distractions and interference while providing sufficient working space to render patient care; and
- (2) Door openings of sufficient size to permit the safe loading and unloading of a person occupying a litter.

(c) Category V ambulances must have a patient care area which:

- (1) Provides access to the head, torso, and lower extremities of the patient while providing sufficient working space to render patient care;
- (2) Is covered to protect the patient and the technician from the elements; and
- (3) Has an opening of sufficient size to permit the safe loading and unloading of a person occupying a litter.

Authority G.S. 131E-157(a).

10 NCAC 03D .0903 WARNING DEVICES

(a) Each Category I ambulance and Category III ambulance for which a permit is issued must have emergency warning lights and audible warning devices other than those required by Federal Motor Vehicle Safety Standards. All warning devices must function in the manner in which they were designed to function.

(b) Each Category II ambulance for which a permit is issued shall not be equipped, permanently or temporarily, with emergency warning devices, audible or visual, other than those required by Federal Motor Vehicle Safety Standards.

PROPOSED RULES

(e) Each Category V ambulance for which a permit is issued must have a 360 degree beacon warning light in addition to warning devices required in Chapter 75A Article 1 of the North Carolina Statutes.

Authority G.S. 131E-157(a).

10 NCAC 03D .0904 VEHICLE BODY

The ambulance shall not have structural or functional defects which may adversely affect the patient, the technicians, or the safe operation of the vehicle.

Authority G.S. 131E-157(a).

10 NCAC 03D .0906 EQUIPMENT SECURED

All equipment in the patient compartment must be adequately secured.

Authority G.S. 131E-157(a).

10 NCAC 03D .0910 SEAT BELTS

Seat belts must be in place and in a useable condition for all Category I, II, III, and IV ambulances.

Authority G.S. 131E-157(a).

10 NCAC 03D .0912 DISPLAYED PERMIT

Any ambulance, after meeting the requirements of the rules contained in this Subchapter, must display a current ambulance permit issued by the Office of Emergency Medical Services at such a place on the vehicle as designated by a representative of the Office of Emergency Medical Services, indicating the vehicle has been inspected in accordance with the rules contained in this Subchapter.

Authority G.S. 131E-157(a).

10 NCAC 03D .0913 PERMIT

(a) The ambulance permit must include the following information:

- (1) vehicle identification number;
- (2) permit number;
- (3) ambulance provider identification number;
- (4) identification of inspector; and
- (5) expiration date.

(b) No person shall display or cause to be displayed or permit to be displayed or to knowingly possess, transfer, remove, imitate, or reproduce an ambulance permit, except by direction of the Office of Emergency Medical Services.

(c) An ambulance shall be permitted in only one category.

(d) Any vehicle permitted as a Category I Ambulance must contain all equipment required in 10 NCAC 3D .1001(a), .1002, .1003(a), and .1103 of this Subchapter.

(e) Any vehicle permitted as a Category I Ambulance which operates as a Mobile Intensive Care Unit as defined in 10 NCAC 3M .0102, .0103, or .0107 must contain all equipment required in 10 NCAC 3M .0202, .0203, or .0207.

(f) Any vehicle permitted as a Category V Ambulance must contain all equipment required in Rules .1001(h), and .1003(e) of this Subchapter.

(g) Any vehicle permitted as a Category V Ambulance which operates as a Mobile Intensive Care Unit as defined in 10 NCAC 3M .0102, .0103, or .0107 must contain all equipment required in 10 NCAC 3M .0202, .0203, or .0207.

(h) Each licensed ambulance provider planning to operate permitted ambulances at an ALS level must first meet the minimum permitting requirements for BLS operation. The licensed ambulance provider must provide for inspection the number of ALS equipment/supplies/medications packages in accordance with the approved protocols for that provider. The licensed ambulance provider shall not, except in a disaster, operate more permitted ambulances at an ALS level than the approved number of ALS packages.

Authority G.S. 131E-157(a); 143-508.

10 NCAC 03D .0914 PERMIT REQUIRED

No vehicle, aircraft, or watercraft shall be deemed an ambulance for the purpose of law unless the said vehicle, aircraft, or watercraft has been issued an ambulance permit by the Office of Emergency Medical Services, in accordance with this Subchapter. It shall be the responsibility of the ambulance provider to apply to the Office of Emergency Medical Services for a permit to operate that ambulance.

Authority G.S. 131E-157(a).

10 NCAC 03D .0915 AMBULANCE LETTERING: MARKINGS: SYMBOLS AND EMBLEMS

(a) Each ambulance must have the name of the ambulance provider permanently displayed on each side of the vehicle.

(b) Category II ambulances must have the words "CONVALESCENT AMBULANCE" permanently lettered on both sides and on the rear of the vehicle body.

(c) Category II ambulances may not use emergency medical symbols, such as the Star of Life, block design cross, or any other medical markings, symbols, or emblems, including the word "EMERGENCY," on the vehicle.

Authority G.S. 131E-157(a).

10 NCAC 03D .0916 GENERAL AMBULANCE REQUIREMENTS

The exterior of the ambulance and the patient area of the ambulance, to include interior and equipment surfaces, shall be maintained in a clean manner and shall be managed at all times in accordance with the infection control policy approved by county government. Provisions shall be available for the storage of both stocked medical supplies and bedding materials as well as for soiled supplies.

Authority G.S. 131E-157(a).

10 NCAC 03D .0925 INFECTIOUS DISEASE

When an ambulance has been utilized to transport a patient known to the licensed ambulance providers to have a communicable disease as defined in G.S. 130A-133(1), the licensed ambulance provider shall ensure that the ambulance, including its equipment and supplies, is taken out of service until appropriately cleansed and disinfected according to the infection control policy approved by county government.

Authority G.S. 131E-157(a).

SECTION .1000 - AMBULANCE EQUIPMENT

10 NCAC 03D .1001 MEDICAL AND RELATED EQUIPMENT

(a) Except as allowed by .0913(e) and (h) of these Rules, category I ambulances for which permits are issued shall contain at least the following operational and functional equipment exclusive of personal equipment carried by emergency medical technicians and medical responders:

- (1) One portable aspirator capable of a minimum vacuum of 300 millimeters of mercury and a minimum air flow rate of 16 liters per minute with rapid drawdown time. A minimum of three, single use, non opaque, one piece, rigid suction instruments or appropriate replacement containers for manually operated devices and a suction rinsing water bottle must be supplied with either unit;
- (2) One each portable squeeze bag ventilation unit (bag and mask) in adult, child, and infant sizes with transparent face mask capable of operation down to zero degrees fahrenheit and an attachment for oxygen hookup. A minimum of one transparent, flexible, disposable oxygen supply tube must be supplied with each unit;
- (3) Six nonmetallic, oropharyngeal airways sanitarily stored together in separate sizes ranging from 55 millimeters through 115 millimeters;
- (4) One portable oxygen unit consisting of the following components: 360 liter (D size) or larger oxygen cylinder; yoke regulator with cylinder contents gauge (2000 pounds per square inch) and gravity or non gravity dependent flow gauge (0-12 liters per minute minimum); a minimum of three transparent, nasal cannulas in adult and child sizes; and a minimum of three each, adult and child, disposable, transparent, oxygen masks with delivery tubes and headband. A full spare cylinder (D size) or larger of oxygen for this unit shall be furnished and stored on the ambulance vehicle;
- (5) Two small, two medium, and two large size adult extrication collars and two pediatric size extrication collars;
- (6) One rigid short backboard. The minimum size must be 14 inches wide by 32 inches long. A stabilization device which is of the design to allow horizontal flexibility and vertical rigidity, equipped with chest and leg straps and accessories for stabilization of the head and neck may be substituted for the rigid short backboard;
- (7) Two rigid long backboards a minimum of 16 inches wide by 72 inches long with two straps each for patient stabilization and other
- (8) Two each rigid padded board splints in the following sizes; 3 inches wide by 15 inches long, 3 inches wide by 3 feet long, and 3 inches wide by 4 1/2 feet long. Other splints, in kit form, of inflatable design or rigid laminated and high density polyurethane foam construction are acceptable. A kit must contain at least two full leg and two full arm splints;
- (9) One child and one adult size lower extremity traction splint with appropriate attachments;
- (10) Twelve 4 inch by 4 inch sterile gauze pads individually packaged;
- (11) Six sterile 5 inch by 9 inch or larger absorbent dressings individually wrapped;
- (12) Twelve rolls of roller gauze;
- (13) Four rolls of adhesive tape;
- (14) Two sterile nonadhering, nonporous dressings for an open chest wound. Minimum size shall be 3 inches by 8 inches;
- (15) Six triangular bandages;
- (16) One pair of bandage shears;
- (17) Two burn sheets, minimum size of 40 inches by 72 inches;
- (18) A total of 1000 cubic centimeters of sterile irrigating solution in plastic containers in addition to the fluids carried for intravenous use;
- (19) One emesis basin, or sealable emesis container;
- (20) One obstetrical kit containing gloves, scissors or surgical blades, umbilical cord clamps or tapes, dressings, towels, perinatal pad, a bulb syringe, and a receiving blanket;
- (21) One each small, regular and large size aneroid or electronic blood pressure cuff and adult and pediatric stethoscopes. One stethoscope with adult and pediatric attachments is acceptable;
- (22) One body bag;
- (23) One four wheeled, elevating cot with a mattress pad with a nonporous cover. The cot must be equipped with restraining straps (chest and thigh area). A crash stable fastener installed per the cot manufacturer's instructions and compatible with the model cot furnished must secure the specified cot to the floor or side wall;
- (24) Two sets of clean cot linen constructed of washable or disposable material in addition to a set on the cot (a set equals two sheets and one pillowcase);
- (25) Two pillows covered with a nonporous material;
- (26) Two blankets constructed of washable material; and
- (27) One child restraint device to safely transport pediatric patients in the patient compartment of the ambulance.

PROPOSED RULES

(b) Category II ambulances for which permits are issued shall contain at least the following operational and functional equipment exclusive of personal equipment carried by personnel:

- (1) One portable aspirator capable of a minimum vacuum of 300 millimeters of mercury and a minimum air flow rate of 16 liters per minute with rapid drawdown time. A minimum of three, single use, non opaque, one piece, rigid suction instruments or appropriate replacement collection containers for manually operated devices and a suction rinsing water bottle must be supplied with either unit;
- (2) One each portable squeeze bag ventilation unit (bag and mask) in adult, child, and infant sizes with transparent face mask capable of operation down to zero degrees fahrenheit and an attachment for oxygen hookup. A minimum of one transparent, flexible, disposable oxygen supply tube must be supplied with each unit;
- (3) Six nonmetallic, oropharyngeal airways sanitarily stored together in separate sizes ranging from 55 millimeters through 115 millimeters;
- (4) One portable oxygen unit consisting of the following components: 360 liter (D size) or larger oxygen cylinder; yoke regulator with cylinder contents gauge (2000 pounds per square inch) and gravity or non gravity dependent flow gauge (0.12 liters per minute); a minimum of three transparent, nasal cannulas in adult and child sizes; and a minimum of three each, adult and child, disposable, transparent, oxygen masks with delivery tubes and headband. A full spare cylinder (D size) or larger of oxygen for this unit shall be furnished and stored on the ambulance vehicle;
- (5) Six 4 inch by 4 inch sterile gauze pads individually packaged;
- (6) Three sterile 5 inch by 9 inch absorbent dressings individually wrapped;
- (7) Six rolls of roller gauze;
- (8) Two rolls of adhesive tape;
- (9) One pair of bandage shears;
- (10) One emesis basin, or sealable emesis container;
- (11) One each small, regular and large size aneroid or electronic blood pressure cuff and adult and pediatric stethoscopes. One stethoscope with adult and pediatric attachments is acceptable;
- (12) One four wheeled, elevating cot with a mattress pad with a nonporous cover. The cot must be equipped with restraining straps (chest and thigh area). A crash stable fastener installed per the cot manufacturer's instructions and compatible with the model cot furnished must secure the specified cot to the floor or side wall;
- (13) Two sets of clean cot linen constructed of washable or disposable material in addition to a set on the cot (a set equals two sheets and one pillowcase);
- (14) Two pillows covered with a nonporous material;
- (15) Two blankets constructed of washable material; and
- (16) A firm board of minimum size 14 inches by 32 inches to support the back during manual heart compressions.

(c) Category III ambulances for which permits are issued must have the following operational and functional medical equipment available to be loaded within five minutes on the vehicle:

- (1) One portable aspirator capable of a minimum vacuum of 300 millimeters of mercury and a minimum air flow rate of 16 liters per minute with rapid drawdown time. A minimum of three, single use, non opaque, one piece, rigid suction instruments or appropriate collection containers for manually operated devices and a suction rinsing water bottle must be supplied with either unit;
- (2) One each portable squeeze bag ventilation unit (bag and mask) in adult, child, and infant sizes with transparent face mask capable of operation down to zero degrees fahrenheit and an attachment for oxygen hookup. A minimum of one transparent, flexible, disposable oxygen supply tube must be supplied with each unit;
- (3) Six nonmetallic, oropharyngeal airways sanitarily stored together in separate sizes ranging from 55 millimeters through 115 millimeters;
- (4) One portable oxygen unit consisting of the following components: 360 liter (D size) or larger oxygen cylinder; yoke regulator with cylinder contents gauge (2000 pounds per square inch) and gravity or non gravity dependent flow gauge (0.12 liters per minute); a minimum of three transparent, nasal cannulas in adult and child sizes; and a minimum of three each, adult and child, disposable, transparent, oxygen masks with delivery tubes and headband. A full spare cylinder (D size) or larger of oxygen for this unit shall be furnished and stored on the ambulance vehicle;
- (5) Twelve 4 inch by 4 inch sterile gauze pads individually packaged;
- (6) Six sterile 5 inch by 9 inch absorbent dressings individually wrapped;
- (7) Six rolls of roller gauze;
- (8) Two rolls of adhesive tape;
- (9) One pair of bandage shears;
- (10) One emesis basin, or sealable emesis container;
- (11) Two burn sheets, minimum size of 40 inches by 72 inches;

(12) A total of 1000 cubic centimeters of sterile irrigating solution in plastic containers in addition to the fluids carried for intravenous use;

(13) One obstetrical kit containing gloves, scissors or surgical blades, umbilical cord clamps or tapes, dressings, towels, perinatal pad, a bulb syringe, and a receiving blanket;

(14) One each small, regular and large size aneroid or electronic blood pressure cuff and adult and pediatric stethoscopes. One stethoscope with adult and pediatric attachments is acceptable;

(15) One four wheeled, elevating cot with a mattress pad with a nonporous cover. The cot must be equipped with restraining straps (chest and thigh area). A crash stable fastener installed per the cot manufacturer's instructions and compatible with the model cot furnished must secure the specified cot to the floor or side wall. A self contained transport incubator with stand and capable of being secured in the ambulance may be substituted;

(16) Two sets of clean cot linen constructed of washable or disposable material in addition to a set on the cot (a set equals two sheets and one pillowcase);

(17) Two blankets constructed of washable material; and

(18) A firm board of minimum size 14 inches by 32 inches to support the back during manual heart compressions.

(d) Category IV ambulances for which permits are issued must have the following medical equipment available to be loaded within five minutes on the aircraft:

(1) One vehicular mounted and one portable aspirator with rapid drawdown time capable of providing a minimum vacuum of 300 millimeters of mercury and a minimum air flow rate of 16 liters per minute up to the maximum operating altitude of the aircraft. A minimum of three, single use, non opaque, one piece, rigid suction instruments or appropriate collection containers for manually operated devices and a suction rinsing water bottle must be supplied with either unit;

(2) One each portable squeeze bag ventilation unit (bag and mask) in adult, child, and infant sizes with transparent face mask capable of operation down to zero degrees fahrenheit and an attachment for oxygen hookup. A minimum of one transparent, disposable oxygen supply tube must be supplied with each unit;

(3) Six nonmetallic, oropharyngeal airways sanitarily stored together in separate sizes ranging from 55 millimeters through 115 millimeters;

(4) Oxygen unit containing a quantity of oxygen sufficient to supply an appropriate flow rate for the period of time it is anticipated oxygen will be needed, but not less than ten liters per minute for 30 minutes. The oxygen shall be carried in two separate containers, one of which must be portable. The portable oxygen unit shall have a yoke regulator with cylinder contents gauge, flow gauge, and DISS outlets;

(5) Twelve 4 inch by 4 inch sterile gauze pads individually packaged;

(6) Six sterile 5 inch by 9 inch absorbent dressings individually wrapped;

(7) Twelve rolls of roller gauze;

(8) Four rolls of adhesive tape;

(9) Two sterile nonadhering, nonporous dressings for an open chest wound. Minimum size shall be 3 inches by 8 inches;

(10) Six triangular bandages;

(11) Two burn sheets, minimum size of 40 inches by 72 inches;

(12) A total of 1000 cubic centimeters of sterile irrigating solution in plastic containers in addition to the fluids carried for intravenous use;

(13) One emesis basin, or sealable emesis container;

(14) Two IV pressure bags;

(15) An electronic means of measuring blood pressure while in flight;

(16) One stethoscope and manual blood pressure cuff;

(17) One ECG monitor/defibrillator/pacer;

(18) One complete kit for endotracheal intubation;

(19) One litter and attachment for securing the litter to the airframe inside the cabin of the aircraft. The litter must allow for elevation of the patient's head;

(20) One blanket constructed of washable material; and

(21) Three IV hooks.

(e) The medical director shall decide the combination of medical equipment specified in Paragraph (d) of this Rule that is carried on a mission based on what is in the best interest of patient care.

(f) All rotary wing aircraft permitted as a Category IV ambulance must have the following flight equipment operational in the aircraft:

(1) Two 360 channel VHF aircraft frequency transceivers;

(2) One VHF omnidirectional ranging (VOR) receiver;

(3) Attitude indicators;

(4) One nondirectional beacon (NDB) receiver;

(5) One glide scope receiver;

(6) One transponder with 4097 code, Mode C;

(7) Turn and slip indicator in the absence of three attitude indicators;

(8) Current FAA approved navigational aids and charts for the area of operations;

(9) Radar altimeter; and

(10) LORAN-C or Satellite Global Navigational system.

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(g) Any fixed wing aircraft issued a permit as a Category IV ambulance must have a current "Instrument Flight Rules" certification.

(h) Category V ambulances for which permits are issued shall contain at least the following operational and functional equipment exclusive of personal equipment carried by personnel:

- (1) One portable aspirator capable of a minimum vacuum of 300 millimeters of mercury and a minimum air flow rate of 16 liters per minute with rapid drawdown time. A minimum of three, single use, non opaque, one piece, rigid suction instruments or appropriate collection containers for manually operated devices and a suction rinsing water bottle must be supplied with either unit;
- (2) One each portable squeeze bag ventilation unit (bag and mask) in adult, child, and infant sizes with transparent face mask capable of operation down to zero degrees fahrenheit and an attachment for oxygen hookup. A minimum of one transparent, flexible, disposable oxygen supply tube must be supplied with each unit;
- (3) Six nonmetallic, oropharyngeal airways sanitarily stored together in separate sizes ranging from 55 millimeters through 115 millimeters;
- (4) One portable oxygen unit consisting of the following components: 360 liter (D size) or larger oxygen cylinder; yoke regulator with cylinder contents gauge (2000 pounds per square inch) and gravity or non gravity dependent flow gauge (0-12 liters per minute); a minimum of three transparent, nasal cannulas in adult and child sizes; and a minimum of three each, adult and child, disposable, transparent, oxygen masks with delivery tubes and headband. A full spare cylinder (D size) or larger of oxygen for this unit shall be furnished and stored on the ambulance vehicle;
- (5) Two small, two medium, and two large size adult extrication collars and two pediatric size extrication collars;
- (6) One rigid short backboard. The minimum size must be 14 inches wide by 32 inches long. A stabilization device which is of the design to allow horizontal flexibility and vertical rigidity, equipped with chest and leg straps and accessories for stabilization of the head and neck may be substituted for the rigid short backboard;
- (7) Two floatable rigid long backboards a minimum of 16 inches wide by 72 inches long with two straps each for patient stabilization and other accessories for stabilization of the head and neck;
- (8) Two each rigid padded board splints in the following sizes; three inches wide by 15 inches long, three inches wide by three feet long, and three inches wide by four and one half feet long. Other splints, in kit form, of inflatable design or rigid laminated and high density polyurethane foam construction are acceptable. A kit must contain at least two full leg and two full arm splints;

- (9) One child and one adult size lower extremity traction splint with appropriate attachments;
- (10) Twelve 4 inch by 4 inch sterile gauze pads individually packaged;
- (11) Six sterile 5 inch by 9 inch or larger absorbent dressings individually wrapped;
- (12) Twelve rolls of roller gauze;
- (13) Four rolls of adhesive tape;
- (14) Two sterile nonadhering, nonporous dressings for an open chest wound. Minimum size shall be three inches by eight inches;
- (15) Six triangular bandages;
- (16) One pair of bandage shears;
- (17) Two burn sheets, minimum size of 40 inches by 72 inches;
- (18) A total of 1000 cubic centimeters of sterile irrigating solution in plastic containers in addition to the fluids carried for intravenous use;
- (19) One emesis basin, or sealable emesis container;
- (20) One obstetrical kit containing gloves, scissors or surgical blades, umbilical cord clamps or tapes, dressings, towels, perinatal pad, a bulb syringe, and a receiving blanket;
- (21) One each small, regular and large size aneroid or electronic blood pressure cuff and adult and pediatric stethoscopes. One stethoscope with adult and pediatric attachments is acceptable;
- (22) One body bag;
- (23) One additional floatable litter with patient restraining straps and capable of being secured to the watercraft; and
- (24) Two blankets constructed of washable material.

Authority G.S. 131E-157(a).

10 NCAC 03D .1002 EXTRICATION AND ACCESS EQUIPMENT

Category I ambulances for which permits are issued must contain at least the following equipment:

- (1) Two pair heavy duty work gloves;
- (2) Two pair safety glasses; and
- (3) Two safety helmets.

Authority G.S. 131E-157(a).

10 NCAC 03D .1003 OTHER EQUIPMENT

(a) Ambulances for which permits are issued as Category I, II, or III must have at least the following:

- (1) Two operational flashlights;
- (2) A five pound fire extinguisher which must be a dry chemical or all purpose type with a pressure gauge and approved by Underwriters

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(1) Laboratories and U.S. Department of Transportation and must be mounted in a quick release bracket;

(3) "No Smoking" signs placed in cab or cabin and patient compartments; and

(4) Electric lights to illuminate the patient compartment which are designed and located so that no glare is reflected into the driver's eyes or line of vision.

(b) In addition to the equipment required under this certification:

(1) All Category IV ambulances must be equipped with an internal voice communication system to allow for communication between the medical crew and the flight crew; and

(2) All rotary wing Category IV ambulances must be equipped with:

(A) An external public address system;

(B) A remote control external search light; and

(C) A light which illuminates the tail rotor.

(c) Institutions or organizations which operate Category IV ambulances must submit to the Division of Facility Services, Office of Emergency Medical Services documentation that operation is coordinated with the local EMS system.

(d) In addition to that required in Paragraph (b) of this Rule, Category IV ambulances approved under Rule .0801(b)(4)(B) of these Rules must be equipped with: A two-way voice radio licensed by the Federal Communications Commission capable of operation on any frequency required in the Public Safety Radio Service or Special Emergency Radio Service to allow communications on an as needed basis with public safety agencies such as fire departments, police departments, ambulance and rescue units, hospitals and local government agencies.

(e) In addition to that required in Paragraph (a) of this Rule, Category V ambulances must be equipped with the following operational and functional equipment.

(1) Two floatable flashlights;

(2) Two five pound fire extinguishers which must be a dry chemical, all purpose type with a pressure gauge and approved by Underwriters Laboratories and U.S. Department of Transportation and must be mounted in a quick release bracket;

(3) Lighted compass;

(4) Radio navigational aids as ADF (automatic directional finder) or LORAN-C, Satellite Global Navigational system, navigational radar, or other comparable radio equipment suited for water navigation; and

(5) Marine radio.

Authority G.S. 131E-157(a); 143-507(a); 143-508.

10 NCAC 03D .1004 WEAPONS AND EXPLOSIVES FORBIDDEN

(a) Weapons as defined by the local county district attorney's office and explosives shall not be worn or carried aboard an ambulance vehicle within the State of North Carolina when such

ambulance vehicle is operating in any patient transport capacity or is available for such transport function.

(b) This Rule shall apply whether or not such weapons and explosives are concealed or visible.

(c) This Rule shall not apply to duly appointed law enforcement officers.

(d) Safety flares are authorized for use on ambulance vehicles with the following restrictions:

(1) These devices are not stored inside the patient compartment of the ambulance vehicle;

(2) These devices must be packaged and stored so as to prevent accidental discharge or ignition.

Authority G.S. 131E-157(a).

SECTION .1100 - COMMUNICATIONS

10 NCAC 03D .1101 PUBLIC ACCESS TO AMBULANCE SERVICE

(a) All ambulance services shall utilize the public dial telephone network as the primary method for the public to request ambulance assistance. Within an emergency ambulance service area there shall exist a well publicized telephone number for the public to call requesting emergency ambulance service.

(b) Calls for emergency ambulance assistance shall be answered by experienced telecommunicators with training in the management of calls for medical assistance. The point of public contact for answering calls for emergency medical ambulance assistance shall be operational and staffed on a continuous 24 hour per day basis.

(c) The telephone access point for emergency ambulance assistance shall be direct to emergency assistance, and shall not require any caller to be instructed to hang up the telephone and dial another telephone number. The person calling for emergency assistance shall never be required to talk with more than two persons to request emergency ambulance assistance.

Authority G.S. 131E-157(a); 143-509(4).

10 NCAC 03D .1102 DISPATCH

All EMS providers shall operate an organized system of communications that provides for the dispatch of the closest, most appropriate emergency medical response unit to any given caller's request for assistance. The dispatch of all ambulances shall be in accordance with an official written county plan for the management of emergency ambulances.

Authority G.S. 131E-157(a); 143-509(4).

10 NCAC 03D .1103 EQUIPMENT

(a) Each ambulance shall be equipped with a two-way radio capable of establishing radio communications from within the ambulance service area of the county in which the ambulance is based to the county designated dispatch coordination center in that county and to the emergency department of the hospital(s) to which patients are routinely transported. The radio shall be licensed by the Federal Communications Commission (FCC).

(b) For an ambulance permitted as a Category I ambulance as defined in Rule .0801(b)(1) or a Category III ambulance as defined in Rule .0801(b)(3) of this Subchapter, a radio telephone

~~type device such as a cellular telephone shall not be the sole source of two way voice communication.~~
~~(e) A communication instrument such as a cellular telephone capable of rapidly establishing two way voice communication mounted within the driver's compartment or patient treatment compartment used to summon emergency assistance is acceptable as the sole communications device for an ambulance that is permitted as a Category II ambulance, as defined in Rule .0801(b)(2) of this Subchapter.~~

Authority G.S. 131E-157(a); 143-509(4).

10 NCAC 03D .1104 LICENSE REQUIRED

~~Copies of the FCC radio license shall be on file at the base of operations of the emergency ambulance service, and displayed at the control point for the two way radio in accordance with FCC Rules Part 90.113.~~

Authority G.S. 131E-157(a); 143-509(4).

SECTION .1200 - TRAINING AND PERFORMANCE OF PERSONNEL

10 NCAC 03D .1201 CRITERIA FOR APPROVED TEACHING INSTITUTIONS

~~An approved Teaching Institution as defined in Rule .0803 of this Subchapter shall provide, at a minimum, the following:~~

- ~~(1) Emergency medical services training courses following guidelines established by the Commission;~~
- ~~(2) Adequate number of instructors, with a minimum of one instructor for each ten students during practical skills instruction;~~
- ~~(3) Equipment of the type and quantity needed to train students in the required practical skills;~~
- ~~(4) Transfer of information necessary to allow students to sit for the appropriate state certification examination(s) to the Office of Emergency Medical Services; and~~
- ~~(5) Attendance records of students for periodic review by the Office of Emergency Medical Services.~~

Authority G.S. 131E-159(b).

10 NCAC 03D .1202 CRITERIA FOR CERTIFIED EMT INSTRUCTOR

~~A certified EMT Instructor as defined in Rule .0802 of this Subchapter shall meet the following criteria:~~

- ~~(1) Recognition from the Office of Emergency Medical Services that he meets the following standards of the Certified EMT Instructor Program:~~
 - ~~(a) Current North Carolina certification as an EMT, EMT defibrillation technician, EMT intermediate, or EMT paramedic;~~
 - ~~(b) Three years experience within the last five years of direct clinical patient contact in critical or emergency care;~~

- ~~(c) Documentation of 100 hours of formal, classroom teaching experience;~~
- ~~(d) Successful completion of the U.S. Department of Transportation's, EMT Instructor Course or equivalent;~~
- ~~(e) High school diploma or General Education Development certificate;~~
- ~~(f) Current affiliation with an approved teaching institution; and~~
- ~~(g) Be recommended for certification by the approved teaching institution with which the person is affiliated.~~

~~(2) Annually attends an EMT Evaluator and Instructor/Coordinator Workshop offered by the Office of Emergency Medical Services.~~

~~(3) Certification shall be valid for a period not to exceed four years.~~

~~(4) To be recertified as an EMT Instructor, a person shall meet the following criteria:~~

- ~~(a) Current North Carolina certification as an EMT, EMT defibrillation technician, EMT intermediate, or EMT paramedic;~~
- ~~(b) Clinical patient care experience in critical or emergency care within the last two years;~~
- ~~(c) Current affiliation with an approved teaching institution; and~~
- ~~(d) Be recommended for recertification by the approved teaching institution with which the person is affiliated.~~

~~The recommendation must address the instructional performance of the candidate as well as the number of courses taught during the previous certification period.~~

Authority G.S. 131E-159(b); 143-507(c); 143-508; S.L. 1983, c.1034,s.98.

10 NCAC 03D .1203 EDUCATIONAL PROGRAMS

~~Educational programs intended to qualify personnel for certification or recertification as Medical Responders or Emergency Medical Technicians must be approved by the Office of Emergency Medical Services, offered by an approved teaching institution, and meet the appropriate following guidelines:~~

- ~~(1) Medical Responder Curriculum:~~
 - ~~(a) Course Prerequisites:~~
 - ~~(i) High school diploma or general education development (GED); or~~
 - ~~(ii) Successful completion of an entrance examination assessing basic reading comprehension skill at a minimum at the tenth grade level.~~
 - ~~(b) Didactic component:~~
 - ~~(i) Module 1: Preparatory;~~

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(ii) Module 2: Airway;
(iii) Module 3: Patient Assessment;
(iv) Module 4: Cardiac Emergencies;
(v) Module 5: Illness and Injury;
(vi) Module 6: Childbirth and Children;
(vii) Module 7: EMS Operations; and
(viii) Module 8: Course Evaluations.

(2) Emergency Medical Technician Curriculum:
(a) Course Prerequisites:
(i) High school diploma or general education development (GED); or
(ii) Successful completion of an entrance examination assessing basic reading comprehension skill at a minimum at the tenth grade level.
(b) Didactic component:
(i) Module 1: Preparatory;
(ii) Module 2: Airway/CPR;
(iii) Module 3: Patient Assessment;
(iv) Module 4: Medical/Behavioral & Obstetrics/Gynecology;
(v) Module 5: Trauma;
(vi) Module 6: Infants and Children;
(vii) Module 7: EMS Operations;
(viii) Module 8: Course Evaluations; and
(ix) Module 9: Clinical Education.

(3) Medical Responder / Emergency Medical Technician Refresher Curriculum:
(a) Module 1: Preparatory;
(b) Module 2: Airway;
(c) Module 3: Patient Assessment;
(d) Module 4: Medical/Behavioral;
(e) Module 5: Trauma;
(f) Module 6: Obstetrics, Infants and Children; and
(g) Module 7: EMS Operations.

Authority G.S. 131E-159(b).

10 NCAC 03D .1204 AEROMEDICAL FLIGHT CREW MEMBERS

(a) All flight crew members who operate as the pilot in command and who fly rotary wing aircraft as air ambulances must meet, at a minimum, the following criteria:

(1) 2,000 hours helicopter flight time;
(2) Commercial rotocraft certificate;
(3) Instrument helicopter rating.

(4) Ten hours additional flight training when making a transition from single to twin engine aircraft;
(5) Five hours additional flight training when making a transition from one model aircraft to another;
(6) Four hours flight time orientation of which two shall be day time and two shall be night time for new pilots if unfamiliar with the program service area; and
(7) Two hours flight time orientation for new pilots if familiar with the program service area including night flights.

(b) All flight crew members must meet, at a minimum, the following criteria:
(1) Fly an average of at least five missions per month per six month period or complete refresher training in aircraft safety every six months; and
(2) Complete refresher training in aircraft safety on an annual basis.
(c) Relief pilots utilized by the program may assume operational duties at the discretion of the Lead Pilot/Aviation Site Manager.

Authority G.S. 131E-159(b).

10 NCAC 03D .1205 MEDICAL RESPONDER PERFORMANCE

Medical responders educated in approved programs and certified by the Office of Emergency Medical Services may assist the emergency medical technician in performing any of the following procedures if allowed by the County Emergency Medical Services System in which they function:

(1) Patient assessment;
(2) Basic life support techniques in accordance with the American Heart Association or American Red Cross including airway management and cardiopulmonary resuscitation;
(3) Hemorrhage control;
(4) Oxygen administration;
(5) Treatment for shock;
(6) Bandaging and dressing soft tissue injuries;
(7) Splinting fractures and dislocations;
(8) Treatment of injuries to the skull, spine, and chest;
(9) Assisting in normal and abnormal childbirth;
(10) Lifting and moving patients for transfer to a medical facility;
(11) Treatment of injuries as a result of exposure to heat and cold;
(12) Treatment of burns;
(13) Providing of basic life support for medical emergencies; and
(14) Use of an automated external defibrillator.

Authority G.S. 143-507(c); 143-508.

10 NCAC 03D .1206 EMERGENCY MEDICAL TECHNICIAN PERFORMANCE

Emergency Medical Technicians educated in approved programs and certified by the Office of Emergency Medical Services may perform any of the following procedures if allowed by the County Emergency Medical Services System in which they function:

- (1) Patient assessment;
- (2) Basic life support techniques in accordance with the American Heart Association or American Red Cross including airway management and cardiopulmonary resuscitation;
- (3) Oxygen administration;
- (4) Hemorrhage control;
- (5) Treatment for shock;
- (6) Bandaging and dressing soft tissue injuries;
- (7) Application of military anti-shock trousers;
- (8) Splinting fractures and dislocations;
- (9) Treatment of injuries to the head, face, eye, neck, and spine;
- (10) Treatment of injuries to the chest, abdomen and genitalia;
- (11) Provision of basic life support for medical injuries;
- (12) Assisting in normal and abnormal childbirths;
- (13) Treatment of injuries as a result of exposure to heat and cold;
- (14) Treatment of burns;
- (15) Lifting and moving patients for transfer to a medical facility;
- (16) Extrication of patients from confined areas; and
- (17) Use of an automated external defibrillator.

Authority G.S. 143-507(c); 143-508.

SECTION .1300 - CERTIFICATION REQUIREMENTS FOR BASIC LIFE SUPPORT PERSONNEL

10 NCAC 03D .1301 CERTIFICATION REQUIREMENTS: MEDICAL RESPONDER

(a) To become certified as a Medical Responder, a person shall successfully complete either of the following options within one year of the approved educational program course completion date:

- (1) **OPTION I**
 - (A) Be at least 18 years of age;
 - (B) Successfully complete an approved Medical Responder program meeting the requirements found in Rule .1203(1) of this Subchapter. When the approved educational program was completed over one year prior to application, a person shall submit evidence of completion of continuing education in emergency medicine taken in the past year to the Office of Emergency Medical Services;
 - (C) Pass a basic life support practical examination administered by the Office of Emergency Medical Services; and

(D) Pass a Medical Responder written examination administered by the Office of Emergency Medical Services; or

(2) **OPTION II**

- (A) Be at least 18 years of age;
- (B) Successfully complete an approved Emergency Medical Technician program meeting the requirements found in Rule .1203(2) of this Subchapter. When the approved educational program was completed over one year prior to application, a person shall submit evidence of completion of continuing education in emergency medicine taken in the past year to the Office of Emergency Medical Services;
- (C) Pass a basic life support practical examination administered by the Office of Emergency Medical Services; and
- (D) Complete an Emergency Medical Technician written examination administered by the Office of Emergency Medical Services and achieve a minimum score of 70% on the Medical Responder subset contained within the Emergency Medical Technician written examination.

(b) Persons holding current certification equivalent to a Medical Responder with the National Registry of Emergency Medical Technicians or in another state where the education and certification requirements have been approved for legal recognition by the Office of Emergency Medical Services may become certified by:

- (1) Presenting evidence of such certification for verification by the Office of Emergency Medical Services; and
- (2) Be at least 18 years of age.

(c) Certification obtained through legal recognition shall be valid for a period not to exceed the length of the current certification or a period not to exceed four years whichever is shorter. No certification shall be valid for a period exceeding four years. Persons who live in a state that borders North Carolina and are currently affiliated with an ambulance provider in North Carolina may continue to obtain a North Carolina certification through legal recognition if they continue to meet the recertification requirements in the state in which they reside. Persons who live in North Carolina and are currently certified in another state that borders North Carolina may continue to obtain a North Carolina certification through legal recognition if they continue to meet the recertification requirements in the state in which they are certified. Persons who were previously certified in North Carolina and are currently certified in another state or with the National Registry of Emergency Medical Technicians, shall present evidence of continuing education and skill evaluation prior to becoming certified through legal recognition.

(d) To become recertified as a Medical Responder a person must successfully complete either of the following options:

(1) **OPTION I**

(A) A continuing education program consisting of a minimum of 48 hours during each two year period of the person's four year certification period conducted under the direction of a Certified EMT Instructor. The continuing education program shall meet the requirements found in Rule .1203(3) of this Subchapter.

(B) A continuing education program consisting of a minimum of 48 hours during each two year period of the person's four year certification period conducted under the direction of a Medical Director as defined in 21 NCAC 32H .0102(8). The continuing education program shall meet the requirements found in Rule .1203(3) of this Subchapter; and

(C) A basic life support skill evaluation(s) approved by the Office of Emergency Medical Services conducted under the direction of a Certified EMT Instructor or Medical Director as defined in 21 NCAC 32H .0102(8) assessing the ability to perform the skills of a Medical Responder; or

(2) **OPTION II**

(A) A continuing education program consisting of a minimum of 96 hours during the person's four year certification period conducted under the direction of a Certified EMT Instructor. The continuing education program shall meet the requirements found in Rule .1203(3) of this Subchapter.

(B) A basic life support practical examination administered by the Office of Emergency Medical Services; or

(3) **OPTION III**

(A) An approved Medical Responder refresher course conducted under the direction of a Certified EMT Instructor consisting of a minimum of 48 hours during the person's last year of certification. This refresher course shall meet the requirements found in Rule .1203(3) of this Subchapter.

(B) A basic life support practical examination administered by the Office of Emergency Medical Services; and

(C) A Medical Responder written examination administered by the Office of Emergency Medical Services.

Authority G.S. 131E-159(a); 1984 S.L., c. 1034, s. 98; S.L. 1983, c. 1034, s. 98.

10 NCAC 03D .1302 CERTIFICATION REQUIREMENTS: EMERGENCY MEDICAL TECHNICIAN

(a) To become certified as an Emergency Medical Technician, a person shall meet the following criteria within one year of the approved educational program course completion date:

(1) Be at least 18 years of age;

(2) Successfully complete an approved Emergency Medical Technician program meeting the requirements found in Rule .1203(2) of this Subchapter. When the approved educational program was completed over one year prior to application, a person shall submit evidence of completion of continuing education in emergency medicine taken in the past year to the Office of Emergency Medical Services;

(3) Pass a basic life support practical examination administered by the Office of Emergency Medical Services; and

(4) Pass an Emergency Medical Technician written examination administered by the Office of Emergency Medical Services.

(b) Persons holding current certification equivalent to an Emergency Medical Technician with the National Registry of Emergency Medical Technicians or in another state where the educational and certification requirements have been approved for legal recognition by the Office of Emergency Medical Services may become certified by:

(1) Presenting evidence of such certification for verification by the Office of Emergency Medical Services; and

(2) Be at least 18 years of age.

(c) Certification obtained through legal recognition shall be valid for a period not to exceed the length of the current certification or a period not to exceed four years whichever is shorter. No certification shall be valid for a period exceeding four years. Persons who live in a state that borders North Carolina and are currently affiliated with an ambulance provider in North Carolina may continue to obtain a North Carolina certification through legal recognition if they continue to meet the recertification requirements in the state in which they reside. Persons who live in North Carolina and are currently certified in another state that borders North Carolina may continue to obtain a North Carolina certification through legal recognition if they continue to meet the recertification requirements in the state in which they are certified. Persons who were previously certified in North Carolina and are currently certified in another state or with the National Registry of Emergency Medical Technicians, shall present evidence of continuing education and skill evaluation prior to becoming certified through legal recognition.

(d) To become recertified as an Emergency Medical Technician a person shall successfully complete either of the following options:

(1) **OPTION I**

(A) A continuing education program consisting of a minimum of 48 hours during each two year period of the

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person's four year certification period conducted under the direction of a Certified EMT Instructor. The continuing education program shall meet the requirements found in Rule .1203(3) of this Subchapter.

(B) A continuing education program consisting of a minimum of 48 hours during each two year period of the person's four year certification period conducted under the direction of a Medical Director as defined in 21 NCAC 32H .0102(8). The continuing education program shall meet the requirements found in Rule .1203(3) of this Subchapter; and

(C) A basic life support skill evaluation(s) approved by the Office of Emergency Medical Services conducted under the direction of a Certified EMT Instructor or Medical Director as defined in 21 NCAC 32H .0102(8) assessing the ability to perform the skills of an Emergency Medical Technician; or

(2) **OPTION II**

(A) A continuing education program consisting of a minimum of 96 hours during the person's four year certification period. The continuing education program shall meet the requirements found in Rule .1203(3) of this Subchapter.

(B) A basic life support practical examination administered by the Office of Emergency Medical Services; or

(3) **OPTION III**

(A) An approved Emergency Medical Technician refresher course consisting of a minimum of 48 hours during the person's last year of certification. This refresher course shall meet the requirements found in Rule .1203(3) of this Subchapter.

(B) A basic life support practical examination administered by the Office of Emergency Medical Services; and

(C) An Emergency Medical Technician written examination administered by the Office of Emergency Medical Services.

AMENDMENT OR REVOCATION

(a) The Department may deny, suspend, or revoke the permit of a specific vehicle for any of the following reasons:

- (1) Failure to substantially comply with the requirements of Section .0900 of this Subchapter;
- (2) Obtaining a permit through fraud or misrepresentation; or
- (3) Failure to provide emergency medical care to the defined ambulance service area in a timely and professional manner.

(b) The Department may issue a temporary permit for a specific vehicle whenever the Department finds that:

- (1) the ambulance provider to which that vehicle is assigned has substantially failed to comply with the provisions of G.S. 131E, Article 7 and the rules adopted under that article; and
- (2) there is a reasonable probability that the ambulance provider can remedy the permit deficiencies within a reasonable length of time; and
- (3) there is a reasonable probability that the ambulance provider will be able thereafter to remain in compliance with the rules regarding ambulance permits for the foreseeable future.

(c) The Department shall give the ambulance provider written notice of the temporary ambulance permit. This notice shall be given personally or by certified mail and shall set forth:

- (1) the length of the temporary ambulance permit not to exceed 60 days;
- (2) a copy of the ambulance inspection form;
- (3) the statutes or rules alleged to be violated; and
- (4) notice to the ambulance provider's right to a contested case hearing on the temporary ambulance permit.

(d) The temporary ambulance permit shall be effective immediately upon its receipt by the ambulance provider. The temporary ambulance permit shall remain in effect until:

- (1) the Department restores the vehicle to full permitted status; or
- (2) the Department revokes the vehicle's ambulance permit.

(e) The Department may deny, suspend, or revoke the certification of a BLS professional or Certified EMT instructor for any of the following reasons:

- (1) Failure to comply with the applicable performance and certification requirements as found in this Subchapter;
- (2) Immoral conduct;
- (3) Making false statements or representations to the Office of Emergency Medical Services or willfully concealing of material information in connection with an application for certification;
- (4) Being unable to perform as a BLS professional with reasonable skill and safety to patients and the public by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality;

Authority G.S. 131E-159(b); 1984 S.L., c. 1034, s. 98; S.L. 1983, c. 1034, s. 98.

SECTION .1400 - ADMINISTRATION

10 NCAC 03D .1401 LICENSE, PERMIT OR CERTIFICATION DENIAL, SUSPENSION,

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(5) Unprofessional conduct, including but not limited to a failure to comply with the rules relating to the proper function of a BLS professional or certified EMT instructor contained in this Subchapter or the performance of or attempt to perform a procedure which is detrimental to the health and safety of a patient or which is beyond the scope and responsibility of the BLS professional or certified EMT instructor;

(6) Conviction in any court of a crime involving moral turpitude, a conviction of a felony, or conviction of a crime involving the function of a BLS professional;

(7) By false representations obtaining or attempting to obtain money or anything of value from a patient;

(8) Adjudication of mental incompetence;

(9) Lack of professional competence to practice with a reasonable degree of skill and safety for patients including but not limited to a failure to perform a prescribed procedure, failure to perform a prescribed procedure competently or performance of a procedure which is not within the scope of the official duties of the BLS professional;

(10) Failure to respond within a reasonable period of time and in a reasonable manner to inquiries from the Office of Emergency Medical Services concerning any matter relating to the practice of a BLS professional or certified EMT instructor;

(11) Testing positive for substance abuse by blood, urine or breath testing while on duty as a BLS professional or certified EMT instructor; or

(12) Representing or allowing others to represent that the BLS professional or Certified EMT instructor has a certification that the BLS professional or certified EMT instructor does not in fact have.

(f) The Department may amend any Ambulance Provider License by reducing it from a full license to a provisional license whenever the Department finds that:

- (1) the licensee has substantially failed to comply with the provisions of G.S. 131E, Article 7 and the rules adopted under that article; and
- (2) there is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and
- (3) there is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

(g) The Department shall give the licensee written notice of the amendment to the Ambulance Provider License. This notice shall be given personally or by certified mail and shall set forth:

- (1) the length of the provisional Ambulance Provider License;
- (2) the factual allegations;
- (3) the statutes or rules alleged to be violated; and

(4) notice to the ambulance provider's right to a contested case hearing on the amendment of the Ambulance Provider License.

(h) The provisional Ambulance Provider License shall be effective immediately upon its receipt by the licensee and shall be posted in a prominent location at the primary business location of the ambulance provider, accessible to public view, in lieu of the full license. The provisional license shall remain in effect until:

- (1) the Department restores the licensee to full licensure status; or
- (2) the Department revokes the licensee's license.

(i) The Department may revoke or suspend an Ambulance Provider License whenever:

- (1) the Department finds that:
 - (A) the licensee has substantially failed to comply with the provisions of G.S. 131E, Article 7 and the rules adopted under that article; and
 - (B) it is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or
- (2) the Department finds that:
 - (A) the licensee has substantially failed to comply with the provisions of G.S. 131E, Article 7 and the rules adopted under that article; and
 - (B) although the licensee may be able to remedy the deficiencies within a reasonable period of time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or
- (3) the Department finds that there has been any failure to comply with the provision of G.S. 131E, Article 7 and the rules adopted under that article that endanger the health, safety or welfare of the patients cared for and transported by the licensee.

(j) The issuance of a provisional Ambulance Provider License is not a procedural prerequisite to the revocation or suspension of a license pursuant to Paragraph (i) of this Rule.

Authority G.S. 131E-155.1; 131E-156; 131E-157(a); 131E-159(b); 143-508; S.L. 1983, c. 1034, s. 98.

10 NCAC 03D .1402 PROCEDURES FOR DENIAL, SUSPENSION, AMENDMENT, OR REVOCATION
Denial, suspension, amendment or revocation of a license, permit or certification shall follow the law regarding contested cases found in G.S. 150B.

Authority G.S. 131E-157(a); 131E-159(b).

10 NCAC 03D .1403 APPLICATION PROCEDURES, REQUIRED FORMS
(a) All applications for licensure, certification, or recertification must be filed with the Office of Emergency Medical Services on the appropriate forms.

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(b) At a minimum, the following forms are required for application:

- (1) Certification Application Form for certification of personnel;
- (2) Certified EMT Instructor Application Form; and
- (3) Ambulance Provider License Application Form for issuance of licenses.

(c) EMS providers shall complete all forms, surveys, and requests for data, as required by these Rules.

Authority G.S. 131E-155.1; 131E-157(a); 131E-159(b); 143-508.

SECTION .1500 - AMBULANCE PROVIDER LICENSING REQUIREMENTS

10NCAC 03D .1501 LICENSING REQUIREMENTS: AMBULANCE PROVIDER

(a) To become licensed as an ambulance provider, a person, firm, corporation, or association shall meet the following criteria:

- (1) Demonstrate the intent and ability to operate an "ambulance" as defined in G.S. 131E-155;
- (2) Present evidence of the intent to apply for a permit for all ambulances which will be in service as required by G.S. 131E-156;
- (3) Submit a written plan detailing how the provider will furnish certified personnel to respond to calls as required by G.S. 131E-158;
- (4) Where there is a franchise ordinance in effect which covers the proposed service area, have a current franchise to operate or present written evidence of intent to issue a franchise from the franchisor; and
- (5) Present written documentation of a standard operating procedure for the systematic and periodic inspection, repair and maintenance of permitted ambulances.

(b) An Ambulance Provider License may be renewed by presenting documentation that the provider meets the criteria found in Paragraph (a) of this Rule.

(c) Applications for Ambulance Provider License must be received by the Office of Emergency Medical Services at least 30 days prior to the date that the provider proposes to initiate service. Applications for renewal of an Ambulance Provider License must be received by the Office of Emergency Medical Services at least 30 days prior to the expiration date of the current license.

(d) As of the effective date of this Rule, ambulance providers currently operating in North Carolina with ambulances permitted by the Department may continue to operate without an ambulance provider license until such time as the permitted vehicles are due for annual inspection by the Department. At that time, a representative of the Department shall assist the provider in completing the proper forms to obtain an ambulance provider license.

Authority G.S. 131E-155.1.

10 NCAC 03D .1502 ISSUANCE OF LICENSE

(a) Only one license shall be issued to each ambulance provider. The Department shall issue a license to the ambulance provider following verification of compliance with applicable laws and rules.

(b) Licenses shall not be transferred.

(c) The license shall be posted in a prominent location accessible to public view at the primary business location of the ambulance provider.

Authority G.S. 131E-155.1.

10 NCAC 03D .1503 LENGTH OF LICENSURE

Ambulance Provider Licenses shall remain in effect up to six years, unless any of the following occurs:

- (1) the Department imposes an administrative sanction which specifies license expiration;
- (2) closure of the ambulance provider;
- (3) change of ownership of the ambulance provider; or
- (4) substantial failure to comply with Rule 1501(a) of this Section.

Authority G.S. 131E-155.1.

SECTION .2000 - GENERAL INFORMATION

10 NCAC 03D .2001 DEFINITIONS

The following definitions apply throughout this Subchapter:

- (1) "Advanced Life Support Professional (ALS Professional)" means a certified emergency medical dispatcher, emergency medical technician, emergency medical technician-intermediate, or emergency medical technician-paramedic whether working on a paid or volunteer basis.
- (2) "Advanced Life Support Program (ALS Program)" means a program of prehospital emergency medical care whereby definitive medical care is delivered to a victim of sudden injury or illness by appropriately educated and certified ALS professionals operating under the direction of a sponsor hospital.
- (3) "Ambulance Call Report" means a written or electronic record of out of hospital activities pertaining to the care of an individual patient.
- (4) "Bypass" means the transport of an Emergency Medical Services patient past a normally used Emergency Medical Services receiving facility for the purposes of accessing a designated trauma center or a higher level trauma center.
- (5) "Contingencies" means conditions placed on a hospital's designation which, if unmet, can result in the loss or amendment of a hospital's designation.
- (6) "Continuous Quality Improvement (CQI)" means a system in which outcome data is used to modify the process of patient care and prevent repetition of adverse events.
- (7) "Deficiencies" are criteria for a trauma center's designation as specified in Section 2100 of this Subchapter that are determined to

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be unsatisfactory which can serve as the basis for the denial of a trauma center designation or renewal.

(8) "Department" means the North Carolina Department of Health and Human Services.

(9) "Diversion" means that a hospital of its own volition reroutes a trauma patient to a trauma center.

(10) "E Code" is a numeric identifier that defines the cause of injury, taken from the International Classification of Diseases (ICD).

(11) "Hospital" means a licensed facility as defined in G.S. 131E-176.

(12) "Level I Trauma Center" is a regional resource trauma center that has the capability of providing leadership, research and total care for every aspect of injury from prevention to rehabilitation.

(13) "Level II Trauma Center" is a hospital that provides definitive trauma care regardless of the severity of injury, but may not be able to provide the same comprehensive care as a Level I trauma center, and does not have trauma research as a primary objective.

(14) "Level III Trauma Center" is a hospital that provides prompt assessment, resuscitation, emergency operations, and stabilization and arranges for hospital transfer as needed to a Level I or II trauma center.

(15) "NCOEMS" means the North Carolina Office of Emergency Medical Services.

(16) "Regional Advisory Committee (RAC)" is a group representing trauma care providers and the community, affiliated with a Level I or II trauma center, for the purpose of regional trauma planning, establishing, and maintaining a coordinated trauma system.

(17) "Request for Proposal (RFP)" is a standardized state document that must be completed by each hospital seeking initial or renewal trauma center designation.

(18) "Transfer Agreement" means a formal written agreement between two agencies specifying the appropriate transfer of patient populations delineating the conditions and methods of transfer.

(19) "Trauma Center" is a hospital facility designated by the state of North Carolina and distinguished by its ability to immediately manage, on a 24 hour basis, the severely injured patient or those at risk for severe injury.

(20) "Trauma Center Criteria" means essential or desirable characteristics to define Level I, II or III trauma centers.

(21) "Trauma Center Designation" means a formalized process of approval in which a hospital voluntarily seeks to have its trauma care capabilities and performance evaluated by experienced on site reviewers.

(22) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the trauma statewide database.

(23) "Trauma Patient" is a person who has sustained acute injury and by means of a standardized field triage criteria (anatomic, physiologic and mechanism of injury) is judged to be at significant risk of mortality or major morbidity.

(24) "Trauma Protocols" are standards for practice in a variety of situations within the trauma system.

(25) "Trauma Registry" is an OEMS maintained database to provide information for analysis and evaluation of the quality of patient care, including epidemiological and demographic characteristics of trauma patients.

(26) "Trauma Service" means a clinical service established by the medical staff that has oversight of and responsibility for the care of the trauma patient.

(27) "Trauma System" means an integrated network that ensures that acutely injured patients are expeditiously taken to hospitals appropriate for their level of injury.

(28) "Trauma Team" means a group of health care professionals organized to provide coordinated and timely care to the trauma patient.

(29) "Triage" is a predetermined schematic for patient distribution based upon established medical needs.

(30) "Weaknesses" are significant areas of concern identified in conjunction with a hospital's request for trauma center designation or renewal. A significant number or magnitude of weaknesses can result in denial of a hospital's request for initial or renewal trauma center designation.

Authority G.S. 131-162.

SECTION .2100 - TRAUMA CENTER STANDARDS AND APPROVAL

10 NCAC 03D .2101 LEVEL I TRAUMA CENTER CRITERIA

(a) To receive designation as a Level I Trauma Center, a hospital shall have the following:

- (1) a trauma service which has been operational for at least six months prior to application;
- (2) membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry for at least six months prior to submitting an RFP application;
- (3) a trauma medical director who is a board certified general surgeon. The trauma medical director must:
 - (A) have a minimum of three years clinical experience on a trauma service and/or trauma fellowship training;

(B) serve on the center's trauma service;

(C) participate in providing care to patients with life threatening or urgent injuries;

(D) participate in the North Carolina Chapter of the American College of Surgeons' Committee on Trauma;

(E) remain a current provider in the American College of Surgeons' Advanced Trauma Life Support Course and in the provision of trauma related instruction to other health care personnel; and

(F) be involved with trauma research and the publication of results and presentations;

(4) a full time trauma nurse coordinator (TNC) who is a registered nurse, licensed by the North Carolina Board of Nursing;

(5) a full time trauma registrar (TR) who has a working knowledge of medical terminology, is able to operate a personal computer, and has demonstrated the ability to extract data from the medical record;

(6) clinical services in General Surgery, Neurologic Surgery, Orthopedic Surgery, Emergency Medicine, and Anesthesiology;

(7) response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:

(A) an in house Post Graduate Year 4 or senior general surgical resident, at a minimum, who is a member of that hospital's surgical residency program and responds within 20 minutes of notification;

(B) a trauma attending who responds within 20 minutes of notification and participates in therapeutic decisions and is present at all operative procedures;

(C) an emergency physician who is present in the emergency department 24 hours per day who is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This physician serves as a designated member of the trauma team until the arrival of the trauma surgeon;

(D) neurosurgery and orthopaedic surgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are available within 30 minutes of notification as long as there is either an in house attending neurosurgeon/orthopedic surgeon; a Post Graduate Year 2 or higher in house neurosurgery/orthopedic surgery resident or an in house trauma surgeon or emergency physician as long as the institution can document management guidelines and annual continuing medical education for neurosurgical/orthopedic emergencies. There must be a specified written back up on the call schedule whenever the neurosurgical/orthopedic is simultaneously on call at a hospital other than the trauma center;

(E) An in house anesthesiologist or a Post Graduate Year 4 anesthesiology chief resident as long as an anesthesiologist on call is advised and promptly available within 20 minutes;

(8) a written credentialing process established by the department of surgery to approve attending general surgeons covering the trauma service. These surgeons must have a minimum of board certification in general surgery within five years of completing residency;

(9) two separate call schedules. One shall be for trauma, one for general surgery. In those instances where a physician may simultaneously be listed on both schedules, there must be a defined back up surgeon listed on the trauma schedule. If a surgeon is simultaneously on call at more than one hospital, there must be a defined back up listed on the trauma schedule. In addition, the hospital shall publish an on call schedule for neurosurgeons, orthopedic surgeons and other major specialists;

(10) standard written protocols relating to trauma care management must be formulated and routinely updated;

(11) Criteria to ensure team activation within 20 minutes prior to patient arrival (in instances where the hospital has at least 20 minutes notification), trauma service admission, and evaluation of patients with multiple system or major injury based upon the earliest recognition of the following physiologic criteria:

(A) Shock;

(B) Respiratory distress;

(C) airway compromise;

(D) spinal cord injury;

(E) unresponsiveness (Glasgow Coma Scale < 8) with potential for multiple injuries;

(F) revised trauma score less than or equal to eight (when in field);

(12) prompt surgical consults that shall be initiated based upon the following criteria:

- (A) falls > 20 feet;
- (B) pedestrian struck by motor vehicle;
- (C) motor vehicle crash with:
 - (i) ejection (includes motorcycle);
 - (ii) rollover;
 - (iii) speed > 40 miles per hour; or
 - (iv) death at the scene;
- (D) proximal amputations;
- (E) burn plus trauma;
- (F) vascular compromise;
- (G) crush to chest or pelvis;
- (H) two or more proximal long bone fractures; and
- (I) gunshot wound to torso, neck, or proximal extremities;

(13) within 30 minutes of notification, availability of services to include:

- (A) cardiac surgery;
- (B) cardiology;
- (C) hand surgery;
- (D) infectious disease;
- (E) internal medicine and subspecialties;
- (F) microvascular surgery (replant/flaps);
- (G) obstetric/gynecologic surgery;
- (H) ophthalmic surgery;
- (I) oral/maxillofacial surgery;
- (J) pediatric surgery;
- (K) pediatrics;
- (L) plastic surgery;
- (M) pulmonary medicine;
- (N) radiology;
- (O) thoracic surgery provided by a board certified thoracic surgeon or general trauma surgeon with thoracic surgical privileges; and
- (P) urologic surgery;

(14) an emergency department which has at a minimum:

- (A) a designated physician director who, if hired after January 1, 1992, is board certified or board prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);
- (B) 24 hour per day staffing by physicians physically present in the Emergency Department who:
 - (i) are either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of

Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine;

- (ii) are designated members of the trauma team; and
- (iii) and practices emergency medicine as his primary specialty;

(C) nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;

(D) resuscitation equipment for patients of all ages to include:

- (i) airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators, pocket masks, and oxygen);
- (ii) pulse oximetry;
- (iii) end tidal carbon dioxide determination equipment;
- (iv) suction devices;
- (v) electrocardiograph-oscilloscope defibrillator;
- (vi) apparatus to establish central venous pressure monitoring;
- (vii) intravenous fluids and administration devices to include large bore catheters;
- (viii) sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, and chest decompression;
- (ix) apparatus for gastric decompression;
- (x) 24 hour per day X-ray capability;
- (xi) two way communication equipment for communication with the emergency transport system;
- (xii) skeletal traction devices, including capability for cervical traction;
- (xiii) arterial catheters;
- (xiv) thermal control equipment for patients; and
- (xv) thermal control equipment for blood and fluids;

(15) an operating suite which is immediately available 24 hours per day and has at a minimum;

(A) 24 hour per day immediate availability of in house staffing;

(B) equipment for patients of all ages to include:

(i) cardiopulmonary bypass capability;

(ii) operating microscope;

(iii) thermal control equipment for patients;

(iv) thermal control equipment for blood and fluids;

(v) 24 hour per day X ray capability including c-arm image intensifier;

(vi) endoscopes;

(vii) craniotomy instruments; and

(viii) capability of fixation of long bone and pelvic fractures;

(16) a postanesthetic recovery room or surgical intensive care unit which has at a minimum;

(A) 24 hour per day in house staffing by registered nurses and other essential personnel;

(B) equipment for patients of all ages to include:

(i) capability for continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) capability for continuous monitoring of intracranial pressure;

(iii) pulse oximetry;

(iv) end tidal carbon dioxide determination capability;

(v) thermal control equipment for patients; and

(vi) thermal control equipment for blood and fluids;

(17) an intensive care unit for trauma patients which has at a minimum;

(A) a designated surgical director of trauma patients;

(B) a physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on call for the emergency department;

(C) maximum ratio of one nurse per two patients on each shift;

(D) equipment for patients of all ages to include:

(i) airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators and pocket masks);

(ii) oxygen source with concentration controls;

(iii) cardiac emergency cart;

(iv) temporary transvenous pacemaker;

(v) electrocardiograph-oscilloscope defibrillator;

(vi) cardiac output monitoring capability;

(vii) electronic pressure monitoring capability;

(viii) mechanical ventilator;

(ix) patient weighing devices;

(x) pulmonary function measuring devices;

(xi) temperature control devices; and

(xii) intracranial pressure monitoring devices;

(E) within 30 minutes of request, be able to perform blood gas measurements, hematocrit level, and chest X-ray studies;

(18) acute hemodialysis capability;

(19) physician directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;

(20) acute spinal cord management capability or written transfer agreement with a designated spinal cord injury rehabilitation center when one exists within the region;

(21) acute head injury management capability or written transfer agreement with a designated head injury center when one exists within the region;

(22) radiological capabilities which has at a minimum:

(A) 24 hour per day in house radiology technician;

(B) 24 hour per day in house computerized tomography technician;

(C) sonography;

(D) nuclear scanning;

(E) computed tomography;

(F) angiography; and

(G) neuroradiology;

(23) a rehabilitation service which provides at a minimum:

(A) a professional staff trained in rehabilitation care of critically injured patients;

(B) for major trauma patients, functional assessment and recommendations regarding short and long term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable;

(C) full in house rehabilitation service or a written transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities; and

(D) substance abuse evaluation and counseling capability;

(24) 24 hour per day clinical laboratory service which must include at a minimum:

(A) standard analysis of blood, urine, and other body fluids;

(B) blood typing and cross matching;

(C) coagulation studies;

(D) comprehensive blood bank or access to a community central blood bank with storage facilities;

(E) blood gases and pH determination;

(F) microbiology; and

(G) drug and alcohol screening capability;

(25) a quality improvement program to include:

(A) a state approved trauma registry;

(B) morbidity and mortality reviews;

(C) multidisciplinary trauma conference, at least quarterly, to include physicians, nurses, pre hospital personnel, and a variety of other care givers which critiques individual cases and discusses educational issues related to trauma;

(D) utilization review;

(E) documentation and review of times and reasons for trauma related diversion of patients; and

(F) documentation and review of response times for trauma surgeons, neurosurgeons, anesthesiologists, and orthopedists;

(26) an outreach program to include:

(A) written transfer agreements to address the transfer and receipt of trauma patients;

(B) programs for physicians within the community and within the referral area (to include telephone and on site consultations) about how to access the trauma center resources and refer patients within the system;

(C) development of a Regional Advisory Committee (RAC) as specified in Section .2302 of this Subchapter;

(D) development of regional criteria for coordination of trauma care;

(E) assessment of impact on trauma morbidity and mortality and on patient outcome; and

(F) assessment of trauma system operations at the regional level;

(27) a program of trauma prevention and public education to include:

(A) epidemiology research to include studies in injury control,

collaboration with other institutions on research, monitoring progress of prevention programs, and consultation with qualified researchers on evaluation measures;

(B) surveillance methods to include trauma registry data, special Emergency Department and field collection projects;

(C) designation of a trauma prevention coordinator, which may be part of the trauma nurse coordinator effort; and

(D) outreach activities, program development, information resources and collaboration with existing national, regional, and state trauma programs;

(28) a trauma research program designed to produce new knowledge applicable to the care of injured patients to include:

(A) a designated trauma research director;

(B) regular meetings of a research group;

(C) if required, proposals reviewed by institutional review board;

(D) study designs which include the development and testing of clearly defined hypotheses;

(E) presentation of research material at local, regional, or national meetings; and

(F) publication of research material in peer reviewed journals;

(29) a documented continuing education program for staff physicians, nurses, allied health personnel, and community physicians to include:

(A) an annual education program on the rehabilitation of major trauma patients for physicians, nurses and ancillary staff that deal in the early phase of care of these patients, including the efficacy of early rehabilitation interventions, long term sequelae of neurologic trauma, and long term functional prognosis of major trauma patients;

(B) assurance of:

(i) 20 hours of category I trauma related continuing medical education every two years for all attending general surgeons on the trauma service;

(ii) 20 hours of category I trauma related continuing medical education every two years for all emergency physicians;

(iii) 20 hours of category I trauma related continuing medical education (beyond

in house in services) every two years for the trauma nurse coordinator;

(iv) eight hours of trauma registry related or trauma related continuing education each year, as deemed appropriate by the trauma nurse coordinator, for the trauma registrar;

(v) at least an 80% compliance rate for 16 hours of trauma related continuing education (as approved by the trauma nurse coordinator) every two years related to trauma care for RN's and LPN's in transport programs, emergency departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator; and

(vi) eight contact hours of trauma related continuing education each year for physician assistants and mid-level practitioners routinely caring for trauma patients; and

(30) an organ procurement program which includes medical and legal criteria for donation, role of organ procurement organizations and role of trauma care professionals.

(b) Initial designation as a Level I Trauma Center is valid for a period of three years. Hospitals may be issued a renewal designation for four years by demonstrating continued compliance with all criteria specified in Subparagraph (a) of this Rule.

Authority G.S. 131E-162.

10 NCAC 03D .2102 LEVEL II TRAUMA CENTER CRITERIA

(a) To receive designation as a Level II Trauma Center, a hospital shall have the following:

(1) a trauma service which has been operational for at least six months prior to application;

(2) membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry for at least six months prior to application;

(3) a trauma medical director who is a board certified general surgeon. The trauma medical director must:

(A) have a minimum of three years clinical experience on a trauma service and/or trauma fellowship training;

(B) serve on the center's trauma service;

(C) participate in providing care to patients with life threatening or urgent injuries;

(D) participate in the North Carolina Chapter of the American College of Surgeons' Committee on Trauma;

(E) remain a current provider in the American College of Surgeons' Advanced Trauma Life Support Course and in the provision of trauma related instruction to other health care personnel; and

(4) a full time trauma nurse coordinator (TNC) who is a registered nurse, licensed by the North Carolina Board of Nursing;

(5) a full time trauma registrar (TR) who has a working knowledge of medical terminology, is able to operate a personal computer, and has demonstrated the ability to extract data from the medical record;

(6) clinical services in General Surgery, Neurologic Surgery, Orthopedic Surgery, Emergency Medicine, and Anesthesiology;

(7) response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:

(A) a trauma attending who responds within 20 minutes of notification and participates in therapeutic decisions and is present at all operative procedures;

(B) an emergency physician who is present in the emergency department 24 hours per day who is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This physician serves as a designated member of the trauma team until the arrival of the trauma surgeon;

(C) neurosurgery and orthopedic surgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are available within 30 minutes of notification as long as there is either an in house attending neurosurgeon/orthopedic surgeon; a Post Graduate Year 2 or higher in house neurosurgery/orthopedic surgery resident; or an in house emergency physician or the on call trauma surgeon as long as the

institution can document management guidelines and annual continuing medical education for neurosurgical/orthopedic emergencies. There must be a specified written back-up on the call schedule whenever the neurosurgeon/orthopedic surgeon is simultaneously on call at a hospital other than the trauma center;

(D) An in-house anesthesiologist or a Post Graduate Year 1 anesthesiology chief resident as long as an anesthesiologist on call is advised and promptly available within 20 minutes or an in-house CRNA under physician supervision, practicing in accordance with G.S. 90-171.20(7)e., pending the arrival of the anesthesiologist;

(8) a written credentialing process established by the department of surgery to approve attending general surgeons covering the trauma service. These surgeons must have a minimum of board certification in general surgery within five years of completing residency;

(9) two separate call schedules. One shall be for trauma, one for general surgery. In those instances where a physician may simultaneously be listed on both schedules, there must be a defined back-up surgeon listed on the trauma schedule. If a surgeon is simultaneously on call at more than one hospital, there must be a defined back-up listed on the trauma schedule. In addition, the hospital shall publish an on call schedule for neurosurgeons, orthopedic surgeons and other major specialists;

(10) standard written protocols relating to trauma care management must be formulated and routinely updated;

(11) Criteria to ensure team activation within 20 minutes prior to patient arrival (in instances where the hospital has at least 20 minutes notification), trauma service admission, and evaluation of patients with multiple system or major injury based upon the earliest recognition of the following physiologic criteria:

(A) Shock;

(B) Respiratory distress;

(C) airway compromise;

(D) spinal cord injury;

(E) unresponsiveness (Glasgow Coma Scale < 8) with potential for multiple injuries;

(F) revised trauma score less than or equal to eight (when in field);

(12) prompt surgical consults that shall be initiated based upon the following criteria:

(A) falls > 20 feet;

(B) pedestrian struck by motor vehicle;

(C) motor vehicle crash with:

(i) ejection (includes motorcycle);

(ii) rollover;

(iii) speed > 40 miles per hour; or

(iv) death at the scene;

(D) proximal amputations;

(E) burn plus trauma;

(F) vascular compromise;

(G) crush to chest or pelvis;

(H) two or more proximal long bone fractures; and

(I) gunshot wound to torso, neck, or proximal extremities;

(13) within 30 minutes of notification, availability of services to include:

(A) cardiology;

(B) internal medicine and subspecialties;

(C) obstetric/gynecologic surgery;

(D) ophthalmic surgery;

(E) oral/maxillofacial surgery;

(F) pediatrics;

(G) plastic surgery;

(H) pulmonary medicine;

(I) radiology;

(J) thoracic surgery provided by a board certified thoracic surgeon or general trauma surgeon with thoracic surgical privileges; and

(K) urologic surgery;

(14) an emergency department which has at a minimum:

(A) a designated physician director who, if hired after January 1, 1992, is board certified or board prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);

(B) 24 hour per day staffing by physicians physically present in the Emergency Department who:

(i) are either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine;

(ii) are designated members of the trauma team; and

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(iii) practice emergency medicine as their primary specialty;

(C) nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;

(D) resuscitation equipment for patients of all ages to include:

- (i) airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators, pocket masks, and oxygen);
- (ii) pulse oximetry;
- (iii) end tidal carbon dioxide determination equipment;
- (iv) suction devices;
- (v) electrocardiograph-oscilloscope-defibrillator;
- (vi) apparatus to establish central venous pressure monitoring;
- (vii) intravenous fluids and administration devices to include large bore catheters;
- (viii) sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, and chest decompression;
- (ix) apparatus for gastric decompression;
- (x) 24 hour per day X-ray capability;
- (xi) two way communication equipment for communication with the emergency transport system;
- (xii) skeletal traction devices, including capability for cervical traction;
- (xiii) arterial catheters;
- (xiv) thermal control equipment for patients; and
- (xv) thermal control equipment for blood and fluids;

(15) an operating suite which is immediately available 24 hours per day and which has at a minimum:

- (A) 24 hour per day immediate availability of in house staffing;
- (B) equipment for patients of all ages to include:

 - (i) thermal control equipment for patients;
 - (ii) thermal control equipment for blood and fluids;

(iii) 24 hour per day X-ray capability including c-arm image intensifier;

(iv) endoscopes;

(v) craniotomy instruments; and

(vi) capability of fixation of long bone and pelvic fractures;

(16) a postanesthetic recovery room or surgical intensive care unit which has at a minimum:

- (A) 24 hour per day in house staffing by registered nurses and other essential personnel;
- (B) equipment for patients of all ages to include:

 - (i) capability for continuous monitoring of temperature, hemodynamics, and gas exchange;
 - (ii) capability for continuous monitoring of intracranial pressure;
 - (iii) pulse oximetry;
 - (iv) end tidal carbon dioxide determination capability;
 - (v) thermal control equipment for patients; and
 - (vi) thermal control equipment for blood and fluids;

(17) an intensive care unit for trauma patients which has at a minimum:

- (A) a designated surgical director of trauma patients;
- (B) a physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on call for the emergency department;
- (C) maximum ratio of one nurse per two patients on each shift;
- (D) equipment for patients of all ages to include:

 - (i) airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators and pocket masks);
 - (ii) oxygen source with concentration controls;
 - (iii) cardiac emergency cart;
 - (iv) temporary transvenous pacemaker;
 - (v) electrocardiograph-oscilloscope-defibrillator;
 - (vi) cardiac output monitoring capability;
 - (vii) electronic pressure monitoring capability;
 - (viii) mechanical ventilator;

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(ix) patient weighing devices;

(x) pulmonary function measuring devices;

(xi) temperature control devices; and

(xii) intracranial pressure monitoring devices;

(E) within 30 minutes of request, be able to perform blood gas measurements, hematocrit level, and chest X-ray studies;

(18) acute hemodialysis capability or utilization of a written transfer agreement;

(19) physician directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;

(20) acute spinal cord management capability or written transfer agreement with a designated spinal cord injury rehabilitation center when one exists within the region;

(21) acute head injury management capability or written transfer agreement with a designated head injury center when one exists within the region;

(22) radiological capabilities which has at a minimum:

- (A) 24 hour per day in house radiology technician;
- (B) 24 hour per day in house computerized tomography technician;
- (C) sonography;
- (D) computed tomography; and
- (E) angiography;

(23) a rehabilitation service which provides at a minimum:

- (A) a professional staff trained in rehabilitation care of critically injured patients;
- (B) for major trauma patients, functional assessment and recommendations regarding short and long term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable;
- (C) full in house rehabilitation service or a written transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities; and
- (D) substance abuse evaluation and counseling capability;

(24) 24 hour per day clinical laboratory service which must include at a minimum:

- (A) standard analysis of blood, urine, and other body fluids;
- (B) blood typing and cross matching;
- (C) coagulation studies;
- (D) comprehensive blood bank or access to a community central blood bank with storage facilities;

(E) blood gases and pH determination;

(F) microbiology; and

(G) drug and alcohol screening capability;

(25) a quality improvement program to include:

- (A) a state approved trauma registry;
- (B) morbidity and mortality reviews;
- (C) multidisciplinary trauma conference, at least quarterly, to include physicians, nurses, pre hospital personnel, and a variety of other care givers which critiques individual cases and discusses educational issues related to trauma;

(D) utilization review;

(E) documentation and review of times and reasons for trauma related diversion of patients; and

(F) documentation and review of response times for trauma surgeons, neurosurgeons, anesthesiologists, and orthopedists;

(26) an outreach program to include:

- (A) written transfer agreements to address the transfer and receipt of trauma patients;
- (B) programs for physicians within the community and within the referral area (to include telephone and on site consultations) about how to access the trauma center resources and refer patients within the system;
- (C) development of a Regional Advisory Committee (RAC) as specified in Section 2302 of this Subchapter;
- (D) development of regional criteria for coordination of trauma care;
- (E) assessment of impact on trauma morbidity and mortality and on patient outcome; and
- (F) assessment of trauma system operations at the regional level;

(27) a program of trauma prevention and public education to include:

- (A) designation of a trauma prevention coordinator, which may be part of the trauma nurse coordinator effort; and
- (B) outreach activities, program development, information resources and collaboration with existing national, regional, and state trauma programs;

(28) a documented continuing education program for staff physicians, nurses, allied health personnel, and community physicians to include:

- (A) an annual education program on the rehabilitation of major trauma patients for physicians, nurses and ancillary staff that deal in the early phase of care of these patients, including the efficacy of early

rehabilitation interventions, long term sequelae of neurologic trauma, and long term functional prognosis of major trauma patients;

(B) assurance of:

- (i) 20 hours of category I trauma related continuing medical education every two years for all attending general surgeons on the trauma service;
- (ii) 20 hours of category I trauma related continuing medical education every two years for all emergency physicians;
- (iii) 20 hours of category I trauma related continuing medical education (beyond in house in services) every two years for the trauma nurse coordinator;
- (iv) eight hours per year trauma registry related or trauma related continuing education, as deemed appropriate by the trauma nurse coordinator, for the trauma registrar;
- (v) at least an 80% compliance rate for 16 hours of trauma related continuing education (as approved by the trauma nurse coordinator) every two years related to trauma care for RN's and LPN's in transport programs, emergency departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator; and
- (vi) eight contact hours of trauma related continuing education each year for physician assistants and mid-level practitioners routinely caring for trauma patients; and

(29) an organ procurement program which includes medical and legal criteria for donation, role of organ procurement organizations and role of trauma care professionals.

(b) Initial designation as a Level II Trauma Center is valid for a period of three years. Hospitals may be issued a renewal designation for four years by demonstrating continued compliance with all criteria specified in Subparagraph (a) of this Rule.

10 NCAC 03D .2103

CRITERIA

LEVEL III TRAUMA CENTER

(a) To receive designation as a Level III Trauma Center, a hospital shall have the following:

- (1) a trauma service which has been operational for at least six months prior to application;
- (2) membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry for at least six months prior to application;
- (3) a trauma medical director who is a board certified surgeon with demonstrated special competence in trauma care;
- (4) a designated trauma nurse coordinator (TNC) who is a registered nurse, licensed by the North Carolina Board of Nursing;
- (5) a trauma registrar (TR) who has a working knowledge of medical terminology, is able to operate a personal computer, and has demonstrated the ability to extract data from the medical record;
- (6) clinical services in General Surgery, Emergency Medicine, and Anesthesiology;
- (7) response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:
 - (A) a trauma attending who responds within 30 minutes of notification and participates in therapeutic decisions and is present at all operative procedures;
 - (B) an emergency physician who is present in the emergency department 24 hours per day who is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This physician serves as a designated member of the trauma team until the arrival of the trauma surgeon;
 - (C) an anesthesiologist who is on call and available within 20 minutes of notification or an in-house CRNA under physician supervision, practicing in accordance with G.S. 90-171.20(7)e., pending the arrival of the anesthesiologist within 20 minutes of notification;
- (8) a written credentialing process established by the department of surgery to approve attending general surgeons covering the trauma service. These surgeons must have a minimum of

board certification in general surgery within five years of completing residency;

(9) two separate call schedules. One shall be for trauma, one for general surgery. In those instances where a physician may simultaneously be listed on both schedules, there must be a defined back up surgeon listed on the trauma schedule. If a surgeon is simultaneously on call at more than one hospital, there must be a defined back up listed on the trauma schedule;

(10) standard written protocols relating to trauma care management must be formulated and routinely updated;

(11) Criteria to ensure team activation within 20 minutes prior to patient arrival (in instances where the hospital has at least 20 minutes notification), trauma service admission, and evaluation of patients w/multiple system or major injury based upon the earliest recognition of the following physiologic criteria:

(A) shock;

(B) respiratory distress;

(C) airway compromise;

(D) spinal cord injury;

(E) unresponsiveness (Glasgow Coma Scale < 8) w/potential for multiple injuries;

(F) revised trauma score less than or equal to eight (when in field);

(12) prompt surgical consults that shall be initiated based upon the following criteria:

(A) falls greater than 20 feet;

(B) pedestrian struck by motor vehicle;

(C) motor vehicle crash with:

(i) ejection (includes motorcycle);

(ii) rollover;

(iii) speed greater than 40 miles per hour; or

(iv) death at the scene;

(D) proximal amputations;

(E) burn plus trauma;

(F) vascular compromise;

(G) crush to chest or pelvis;

(H) two or more proximal long bone fractures; and

(I) gunshot wound to torso, neck, or proximal extremities;

(13) internal medicine and subspecialties within 30 minutes of notification;

(14) an emergency department which has at a minimum:

(A) a designated physician director who, if hired after January 1, 1992, is board certified or board prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);

(B) 24 hour per day staffing by physicians physically present in the Emergency Department who:

(i) are either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine;

(ii) are designated members of the trauma team; and

(iii) practice emergency medicine as their primary specialty;

(C) nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;

(D) resuscitation equipment for patients of all ages to include:

(i) airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators, pocket masks, and oxygen);

(ii) pulse oximetry;

(iii) suction devices;

(iv) electrocardiograph-oscilloscope defibrillator;

(v) apparatus to establish central venous pressure monitoring;

(vi) intravenous fluids and administration devices to include large bore catheters;

(vii) sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, and chest decompression;

(viii) apparatus for gastric decompression;

(ix) 24 hour per day X-ray capability;

(x) two way communication equipment for communication with the emergency transport system;

(xi) skeletal traction devices, including capability for cervical traction;

(xii) thermal control equipment for patients; and

(xiii) thermal control equipment for blood and fluids;

(15) an operating suite which has at a minimum:

(A) thermal control equipment for patients;

(B) thermal control equipment for blood and fluids;

(16) a postanesthetic recovery room or surgical intensive care unit which has at a minimum:

(A) 24 hour per day availability of registered nurses within 30 minutes from inside or outside the hospital;

(B) equipment for patients of all ages to include:

(i) capability for continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) pulse oximetry;

(iii) thermal control equipment for patients; and

(iv) thermal control equipment for blood and fluids;

(17) an intensive care unit for trauma patients which has at a minimum:

(A) a designated surgical director of trauma patients;

(B) a physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital (which may be a physician who is the sole physician on call for the Emergency Department);

(C) equipment for patients of all ages to include:

(i) airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators and pocket masks);

(ii) oxygen source with concentration controls;

(iii) cardiac emergency cart;

(iv) temporary transvenous pacemaker;

(v) electrocardiograph-oscilloscope defibrillator;

(vi) cardiac output monitoring capability;

(vii) electronic pressure monitoring capability;

(viii) mechanical ventilator;

(ix) patient weighing devices;

(x) pulmonary function measuring devices; and

(xi) temperature control devices;

(D) within 30 minutes of request, be able to perform blood gas measurements, hematocrit level, and chest X-ray studies;

(18) physician directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;

(19) acute spinal cord management capability or written transfer agreement with a designated spinal cord injury rehabilitation center when one exists within the region;

(20) acute head injury management capability or written transfer agreement with a designated head injury center when one exists within the region;

(21) radiological capabilities which have at a minimum:

(A) radiology technician available within 30 minutes of notification or documentation that procedures are available within 30 minutes;

(B) if the capability of computed tomography exists in the hospital, the computed tomography technician must be available within 30 minutes of notification;

(22) full in house rehabilitation service or a written transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;

(23) 24 hour per day clinical laboratory service which must include at a minimum:

(A) standard analysis of blood, urine, and other body fluids;

(B) blood typing and cross matching;

(C) coagulation studies;

(D) comprehensive blood bank or access to a community central blood bank with storage facilities;

(E) blood gases and pH determination; and

(F) microbiology;

(24) a quality improvement program to include:

(A) a state approved trauma registry;

(B) morbidity and mortality reviews;

(C) multidisciplinary trauma conference, at least quarterly, to include physicians, nurses, pre-hospital personnel, and a variety of other care givers which critiques individual cases and discusses educational issues related to trauma;

(D) utilization review;

(E) documentation and review of times and reasons for trauma related diversion of patients; and

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(F) documentation and review of response times for trauma surgeons and anesthesiologists;

(25) an outreach program to include:

(A) written transfer agreements to address the transfer and receipt of trauma patients;

(B) programs for physicians within the community and within the referral area (to include telephone and on site consultations) about how to access the trauma center resources and refer patients within the system; and

(C) participation in a Regional Advisory Committee (RAC);

(26) a documented continuing education program for staff physicians, nurses, allied health personnel, and community physicians to assure:

(A) 20 hours of category I trauma related continuing medical education every two years for all attending general surgeons on the trauma service;

(B) 20 hours of category I trauma related continuing medical education every two years for all emergency physicians;

(C) 20 hours of category I trauma related continuing medical education (beyond in house in services) every two years for the trauma nurse coordinator;

(D) eight hours per year trauma registry related or trauma related continuing education, as deemed appropriate by the trauma nurse coordinator, for the trauma registrar;

(E) at least an 80% compliance rate for 16 hours of trauma related continuing education (as approved by the trauma nurse coordinator) every two years related to trauma care for RN's and LPN's in transport programs, emergency departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator; and

(F) eight contact hours of trauma related continuing education each year for physician assistants and mid level practitioners routinely caring for trauma patients;

(27) an organ procurement program which includes medical and legal criteria for donation, role of organ procurement organizations and role of trauma care professionals; and

(28) a written plan specifying its role in the regional trauma network.

(6) Initial designation as a Level III Trauma Center is valid for a period of three years. Hospitals may be issued a renewal

designation for four years by demonstrating continued compliance with all criteria specified in Paragraph (a) of this Rule.

Authority G.S. 131E-162.

10 NCAC 03D .2104 SUBMISSION OF REQUEST FOR PROPOSAL (RFP)

(a) Hospitals desiring to be considered for initial trauma center designation shall complete and submit an original and five copies of a bound RFP to the Office of Emergency Medical Services at least 30 days prior to the State Emergency Medical Services Advisory Council meeting at which the application is to be considered. A schedule of meetings for the State Emergency Medical Services Advisory Council may be obtained from the Office of Emergency Medical Services at PO Box 29530, Raleigh, North Carolina 27626-0530. The RFP shall include, at a minimum, the following:

(1) information which supports compliance with the criteria contained in "North Carolina's Trauma Center Criteria," dated November 1, 1996 which is incorporated by reference;

(2) a justification by Level I or II applicants of the need for the trauma center that includes, at a minimum

(A) the population to be served and the extent to which the population is under served for trauma care with the methodology used to reach this conclusion;

(B) geographic considerations to include catchment area and distance from other trauma centers; and

(C) trauma patient volume and severity of injury for the facility for the twenty-four month period of time preceding the application. The trauma center shall show that its trauma service will be taking care of at least 200 trauma patients with an Injury Severity Score (ISS) greater than or equal to 13 during the first two year period of its designation. This criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II trauma center sharing all or part of its catchment area or by jeopardizing the existing trauma center's ability to meet this same 200 patient minimum.

(b) Hospitals seeking a renewal of trauma center designation shall complete and submit an original and five copies of a bound RFP to the Office of Emergency Medical Services at least 30 days prior to the site survey.

(c) For initial trauma center designation, the hospital shall request a consultant visit by the Office of Emergency Medical Services and have a visit within one year prior to submission of the RFP.

(d) The RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in Rule .2101, .2102, or .2103 of this Section.

Authority G.S. 131E-162.

**10 NCAC 03D .2105 INITIAL DESIGNATION
PROCESS**

(a) A hospital interested in pursuing trauma center designation shall submit a letter of intent to the Office of Emergency Medical Services and request approval to submit an RFP based upon a review of the regional data. The Office of Emergency Medical Services shall procure the regional data to ascertain the hospital's ability to satisfy the justification of need information on trauma patient volume and severity of injury required in Rule .2104(a)(2)(A-C) of this subchapter. The Office of Emergency Medical Services shall notify the hospital in writing of its decision. The RAC shall also be notified of the approval so necessary changes in protocols can be considered.

(b) The Office of Emergency Medical Services shall review the RFP and provide comments to the State Emergency Medical Services Advisory Council.

(c) The State Emergency Medical Services Advisory Council shall make a recommendation to the Office of Emergency Medical Services to proceed with a site visit or identify documentation necessary prior to a site visit.

(d) If the State Emergency Medical Services Advisory Council does not recommend a site visit, and the Office of Emergency Medical Services concurs, the reasons shall be forwarded to the hospital in writing within thirty days of the decision. The Office of Emergency Medical Services shall specify a period of time, which shall be no longer than one year, during which the hospital shall address the concerns in writing and request reconsideration. If the hospital fails to respond within the required time period, it shall reapply for designation by following the process outlined in Rule .2104 of this subchapter.

(e) If the State Emergency Medical Services Advisory Council recommends the hospital for a site visit, and the Office of Emergency Medical Services concurs, the hospital shall be notified within thirty days and the site visit shall be conducted within six months of the recommendation. The site visit shall be scheduled on a date mutually agreeable to the hospital and the Office of Emergency Medical Services.

(f) The composition of a Level I or II site survey team shall be as follows:

- (1) one out of state Fellow of the American College of Surgeons;
- (2) one in state emergency physician, who is a member of the North Carolina College of Emergency Physicians;
- (3) one in state trauma surgeon who is a member of the North Carolina Committee on Trauma;
- (4) one out of state trauma nurse coordinator;
- (5) the medical advisor of the Office of Emergency Medical Services; and
- (6) the Hospital Programs Specialist of the Office of Emergency Medical Services.

One physician, usually the one from out of state, shall be designated the primary reviewer. Any in state reviewer (except the Office of Emergency Medical Services representatives) shall be from outside the planning region in which the hospital is located.

(g) The composition of a Level III site survey team shall be as follows:

- (1) one Fellow of the American College of Surgeons, who is a member of the North Carolina Committee on Trauma;
- (2) one emergency physician who is a member of the North Carolina College of Emergency Physicians;
- (3) a trauma nurse coordinator;
- (4) the medical advisor of the Office of Emergency Medical Services; and
- (5) the Hospital Programs Specialist of the Office of Emergency Medical Services.

All site team members for a Level III visit shall be from in-state, and all (except for the Office of Emergency Medical Services representatives) shall be from outside the planning region in which the hospital is located. One of the physicians shall be designated the primary reviewer.

(h) On the day of the site visit, the hospital shall make available all required patient medical charts.

(i) When a hospital is approved for a site visit, the Office of Emergency Medical Services shall notify the Regional Emergency Medical Services Councils within the primary catchment area of the proposed trauma center to allow for comment on the request for designation.

(j) All criteria defined in Rule .2101, .2102 or .2103 of this subchapter shall be met for initial designation at the level requested. No deficiencies shall be permitted.

(k) The reports of the site survey team and the staff recommendation shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting which is more than 45 days following the site visit. Based upon the RFP, the site visit report, and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the Office of Emergency Medical Services that the request for trauma center designation be approved or denied.

(l) The hospital shall be notified, in writing, of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(m) The final decision regarding trauma center designation shall be rendered by the Office of Emergency Medical Services. Contingencies on the designation, as well as required due dates and documentation, shall be specified at the time written notification is provided of the designation. Satisfaction of contingencies may require an additional site visit.

Authority G.S. 131E-162; 143-509(3).

**10 NCAC 03D .2106 RENEWAL DESIGNATION
PROCESS**

(a) Prior to the end of the designation period, the Office of Emergency Medical Services shall forward to the hospital an RFP for completion. Simultaneously, the Office of Emergency Medical Services shall notify the Regional Emergency Medical Services Councils within the primary catchment area of the trauma center to allow for comment on the request for renewal.

(b) The RFP shall be submitted at least 30 days prior to the site visit in accordance with Rule .2104(b) of this subchapter.

(c) A site visit shall be conducted within 120 days prior to the end of the designation period. The site visit shall be scheduled

on a date mutually agreeable to the hospital and the Office of Emergency Medical Services.

(d) The composition of a Level I or II site survey team shall be the same as that specified in Rule .2105(g) of this subchapter. One physician, usually the one from out of state, shall be designated the primary reviewer. Any in-state reviewer (except the Office of Emergency Medical Services representatives) shall be from outside the planning region in which the hospital is located.

(e) The composition of a Level III site survey team shall be the same as that specified in Rule .2105(h) of this subchapter. All site team members for a Level III visit shall be from in-state, and all (except for the Office of Emergency Medical Services representatives) shall be from outside the planning region in which the hospital is located. One of the physicians shall be designated the primary reviewer.

(f) On the day of the site visit, the hospital shall make available all required patient medical charts.

(g) The written reports of the site survey team and the staff recommendation shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting which is more than 45 days following the site visit. Based upon the RFP, the site visit report, and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the Office of Emergency Medical Services that the request for trauma center renewal be approved or denied.

(h) The hospital shall be notified in writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(i) The final decision regarding trauma center renewal shall be rendered by the Office of Emergency Medical Services. Contingencies on the renewal, as well as required due dates and documentation, shall be specified at the time written notification is provided of the renewal. Satisfaction of contingencies may require an additional site visit.

Authority G.S. 131E-162; 143-509(3).

SECTION .2200 - ENFORCEMENT

10 NCAC 03D .2201 DENIAL, PROBATION, VOLUNTARY WITHDRAWAL OR REVOCATION OF TRAUMA CENTER DESIGNATION

(a) The Office of Emergency Medical Services may deny the designation of a trauma center for any of the following reasons:

- (1) failure to substantially comply with the requirements of section .2100 of this subchapter;
- (2) attempting to obtain a trauma center designation through fraud or misrepresentation; or
- (3) a significant number or magnitude of deficiencies or weaknesses to suggest that patient care may be compromised.

(b) The Office of Emergency Medical Services may amend any trauma center designation from a full designation to a probationary designation whenever the Office of Emergency Medical Services finds that:

- (1) the trauma center has substantially failed to comply with the provisions of NC General Statute 131E-162 and the rules adopted under that article; or
- (2) there is no reasonable probability the trauma center can remedy the deficiencies or weaknesses within a reasonable length of time; or
- (3) the trauma center fails to meet contingencies placed upon it at the time of its initial designation or renewal; or
- (4) there is no reasonable probability the trauma center shall be able to remain in compliance with the designation rules for the foreseeable future.

(c) The Office of Emergency Medical Services shall give the trauma center written notice of the amendment to the designation. This notice shall be given personally or by certified mail and shall set forth:

- (1) the length of the probationary designation (not to exceed one year);
- (2) the factual allegations;
- (3) the statutes or rules alleged to be violated; and
- (4) notice of the hospital's right to a contested case hearing on the amendment of the designation.

(d) The probationary designation shall be effective immediately upon its receipt by the trauma center and shall be posted in a prominent location at the primary business location of the trauma center, accessible to public view, in lieu of the full designation. The probationary designation shall remain in effect until:

- (1) the Office of Emergency Medical Services restores the trauma center to full designation status; or
- (2) the Office of Emergency Medical Services revokes the designation.

(e) The Office of Emergency Medical Services may revoke a trauma center designation whenever the Office of Emergency Medical Services finds that the trauma center has substantially failed to comply with the provisions of NC General Statute 131E-162 and the rules adopted under that article and:

- (1) it is not reasonably probable that the trauma center can remedy the deficiencies within a reasonable length of time; or
- (2) although the trauma center may be able to remedy the deficiencies within a reasonable period of time, it is not reasonably probable that the trauma center shall be able to remain in compliance with designation rules for the foreseeable future; or
- (3) the trauma center fails to meet contingencies placed upon it at the time of its initial designation or renewal; or
- (4) failure to comply endangers the health, safety or welfare of the patients cared for in the trauma center.

(f) The Office of Emergency Medical Services may revoke a trauma center designation whenever it finds that the trauma center fails to resolve issues that resulted in a voluntary withdrawal of the designation.

(g) The issuance of a probationary designation is not a procedural prerequisite to the revocation of a designation pursuant to Subparagraph (e) of this Rule.

(h) With the Office of Emergency Medical Services' approval, a trauma center may voluntarily withdraw its designation for a maximum of one year by submitting a written request. This request shall include the reasons for withdrawal and a plan for resolution of the issues. To reactivate the designation, the facility shall provide written documentation of compliance that is acceptable to the Office of Emergency Medical Services. Voluntary withdrawal shall not affect the original expiration date of the trauma center's designation.

(i) In the event of a revocation or voluntary withdrawal, the Office of Emergency Medical Services shall provide written notification to all hospitals and Emergency Medical Services providers within the regional trauma network. The Office of Emergency Medical Services shall provide written notification to same if, and when, the voluntary withdrawal reverts to full designation.

Authority G.S. 131E-162.

10 NCAC 03D .2202 PROCEDURES FOR APPEAL OF DENIAL, PROBATION, OR REVOCATION

Appeal of denial, probation, or revocation of a trauma center designation shall follow the law regarding contested cases found in G.S. 150B.

Authority G.S. 131E-162.

10 NCAC 03D .2203 MISREPRESENTATION OF DESIGNATION

(a) Hospitals shall not represent themselves as a trauma center unless they are currently designated by the Department pursuant to Section 2000 of this Subchapter.

(b) Designation applies only to the hospital that submitted the RFP and underwent the formal site survey and does not extend to its satellite facilities or affiliates.

Authority G.S. 131E-162.

SECTION .2500 – DEFINITIONS

10 NCAC 03D .2501 ABBREVIATIONS

The following abbreviations are used throughout this Subchapter:

- (1) EMS: Emergency Medical Services;
- (2) OEMS: Office of Emergency Medical Services;
- (3) PreMIS: Prehospital Medical Information System;
- (4) MR: Medical Responder;
- (5) EMT: Emergency Medical Technician;
- (6) EMT-D: EMT-Defibrillation;
- (7) EMT-I: EMT-Intermediate;
- (8) EMT-P: EMT-Paramedic;
- (9) EMD: Emergency Medical Dispatcher;
- (10) EMDPRS: Emergency Medical Dispatch Priority Reference System;
- (11) EMS-NP: EMS Nurse Practitioner;
- (12) EMS-PA: EMS Physician Assistant;

- (13) MICN: Mobile Intensive Care Nurse;
- (14) AHA: American Heart Association; and
- (15) CPR: Cardiopulmonary Resuscitation.

Authority G.S. 143-508(b).

10 NCAC 03D .2502 AIR MEDICAL AMBULANCE

"Air Medical Ambulance" means an aircraft specifically designed and equipped to transport patients by air. The patient care compartment of air medical ambulances shall be staffed by medical crewmembers approved for the mission by the medical director.

Authority G.S. 143-508(b); 143-508(d)(8).

10 NCAC 03D .2503 AIR MEDICAL PROGRAM

"Air Medical Program" means a Specialty Care Transport Program designed and operated for transportation of patients by either fixed or rotary wing aircraft.

Authority G.S. 143-508(b); 143-508(d)(1).

10 NCAC 03D .2504 ASSISTANT MEDICAL DIRECTOR

"Assistant Medical Director" means a physician, EMS-PA, or EMS-NP who assists the medical director with the medical management of an EMS system or EMS Specialty Care Transport Program.

Authority G.S. 143-508(b).

10 NCAC 03D .2505 CONVALESCENT AMBULANCE

"Convalescent Ambulance" means an ambulance used on a scheduled basis solely to transport patients having a known non-emergency medical condition. Convalescent ambulances shall not be used in place of any other category of ambulance defined in this Subchapter.

Authority G.S. 143-508(b); 143-508(d)(8).

10 NCAC 03D .2506 EDUCATIONAL MEDICAL ADVISOR

"Educational Medical Advisor" means the physician responsible for overseeing the medical components of approved EMS educational programs in continuing education, basic, and advanced EMS educational institutions.

Authority G.S. 143-508(b); 143-508(d)(3).

10 NCAC 03D .2507 EMS EDUCATIONAL INSTITUTION

"EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS educational programs.

Authority G.S. 143-508(b); 143-508(d)(4).

10 NCAC 03D .2508 EMS INSTRUCTOR

"EMS Instructor" means a person who is credentialed by the OEMS as a Level I or II EMS Instructor and who is approved to instruct or coordinate EMS educational programs.

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Authority G.S. 143-508(b); 143-508(d)(3); 143-508(d)(4).

10 NCAC 03D .2509 EMS NONTRANSPORTING VEHICLE

"EMS Nontransporting Vehicle" means a motor vehicle dedicated and equipped to move medical equipment and EMS personnel functioning within the scope of practice of EMT-I or EMT-P to the scene of a request for assistance. EMS nontransporting vehicles shall not be used for the transportation of patients on the streets, highways, waterways, or airways of the state.

Authority G.S. 143-508(b); 143-508(d)(8).

10 NCAC 03D .2510 EMS SYSTEM

"EMS System" means a coordinated arrangement of resources (including personnel, equipment, and facilities) organized to respond to medical emergencies and integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

Authority G.S. 143-508(b).

10 NCAC 03D .2511 GROUND AMBULANCE

"Ground Ambulance" means an ambulance used to transport patients with traumatic or medical conditions or patients for whom the need for emergency medical care is anticipated either at the patient location or during transport. Ground ambulances may be used to transport all types of patients.

Authority G.S. 143-508(b); 143-508(d)(8).

10 NCAC 03D .2512 MEDICAL CREW MEMBERS

"Medical Crew Member" means EMS personnel or other health care professionals who hold current North Carolina credentials and are affiliated with a Specialty Care Transport Program.

Authority G.S. 143-508(b); 143-508(d)(3).

10 NCAC 03D .2513 MEDICAL DIRECTOR

"Medical Director" means the physician responsible for the medical aspects of the management of an EMS System or EMS Specialty Care Transport Program.

Authority G.S. 143-508(b).

10 NCAC 03D .2514 MEDICAL OVERSIGHT

"Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of an EMS system. Medical Oversight includes physician direction of the initial education and continuing education of EMS personnel; development and monitoring of both operational and treatment protocols; evaluation of the medical care rendered by EMS personnel; participation in system evaluation; and directing, by two-way voice communications, the medical care rendered by the EMS personnel.

Authority G.S. 143-508(b).

10 NCAC 03D .2515 MODEL EMS SYSTEM

"Model EMS System" means an approved EMS system that chooses to meet the criteria for and receives this designation by the OEMS.

Authority G.S. 143-508(b).

10 NCAC 03D .2516 OFFICE OF EMERGENCY MEDICAL SERVICES

"Office of Emergency Medical Services (OEMS)" means a section of the Division of Facility Services of the North Carolina Department of Health and Human Services located at 701 Barbour Drive, Raleigh, North Carolina 27603.

Authority G.S. 143-508(b).

10 NCAC 03D .2517 OPERATIONAL PROTOCOLS

"Operational Protocols" means the written administrative policies and procedures of an EMS system that provide guidance for the day-to-day operation of the system.

Authority G.S. 143-508(b).

10 NCAC 03D .2518 PHYSICIAN

"Physician" means a medical or osteopathic doctor licensed by the NC Medical Board to practice medicine in the state of North Carolina.

Authority G.S. 143-508(b).

10 NCAC 03D .2519 QUALITY MANAGEMENT COMMITTEE

"Quality Management Committee" means a committee within an EMS system or Specialty Care Transport Program that is affiliated with a medical review committee as referenced in G.S. 143-518(a)(5) and is responsible for the continued monitoring and evaluation of medical and operational issues within the system and for improvement of the system.

Authority G.S. 143-508(b); 143-518(a)(5).

10 NCAC 03D .2520 SPECIALTY CARE TRANSPORT PROGRAM

"Specialty Care Transport Program" means a program designed and operated for the provision of specialized medical care and transportation of critically ill or injured patients.

Authority G.S. 143-508(b); 143-508(d)(1);

10 NCAC 03D .2521 SPECIALTY CARE TRANSPORT PROGRAM CONTINUING EDUCATION COORDINATOR

"Specialty Care Transport Program Continuing Education Coordinator" means a Level I EMS Instructor within a Specialty Care Transport Program who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

Authority G.S. 143-508(b); 143-508(d)(3).

10 NCAC 03D .2522 SYSTEM CONTINUING EDUCATION COORDINATOR

"System Continuing Education Coordinator" means a Level I EMS Instructor within a model EMS system who is responsible for the coordination of EMS continuing education programs.

Authority G.S. 143-508(b); 143-508(d)(3).

10 NCAC 03D .2523 TREATMENT PROTOCOLS

"Treatment Protocols" means a written document approved by the medical directors of both the local EMS system or Specialty Care Transport Program and the OEMS specifying the diagnostic procedures, treatment procedures, medication administration, and patient-care-related policies that shall be completed by EMS personnel or medical crew members based upon the assessment of a patient.

Authority G.S. 143-508(b); 143-508(d)(6); 143-508(d)(7).

10 NCAC 03D .2524 WATER AMBULANCE

"Water Ambulance" means a watercraft specifically designed and equipped to transport patients.

Authority G.S. 143-508(b); 143-508(d)(8).

SECTION .2600 – EMS SYSTEMS

10 NCAC 03D .2601 EMS SYSTEM REQUIREMENTS

(a) County government shall establish EMS Systems. Each EMS System shall have:

- (1) A defined geographical service area for the EMS System. The minimum service area for an EMS System shall be one county. There may be multiple EMS provider service areas within the service area of an EMS System. The highest level of care offered within any EMS provider service area must be available to the citizens within that service area 24 hours per day;
- (2) A scope of practice within the parameters defined by the North Carolina Medical Board pursuant to G.S. 143-514;
- (3) A written plan describing the dispatch and coordination of all responders that provide EMS care within the system;
- (4) A minimum of one licensed EMS provider. For those systems with providers operating within the EMD, EMT-D, EMT-I or EMT-P scope of practice, there shall be a plan for medical oversight required by Section .2800 of this Subchapter;
- (5) An identified number of permitted ambulances to provide coverage to the service area 24 hours per day;
- (6) Personnel credentialed to perform within the scope of practice of the system to staff the ambulance vehicles as required by G.S. 131E-158. There shall be a written plan for the use of credentialed EMS personnel for all practice settings used within the system;
- (7) A system to collect and submit by facsimile or other electronic means to the OEMS data that uses the basic data set and data dictionary as

specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection";

- (8) A written infection control policy that addresses the cleansing and disinfecting of vehicles and equipment that are used to treat or transport patients;
- (9) A written plan to provide orientation to personnel on EMS operations and related issues for hospitals routinely receiving patients from the EMS system;
- (10) A listing of facilities that will provide online medical direction for systems with providers operating within the EMT-D, EMT-I, or EMT-P scope of practice. To provide online medical direction, the facility shall have, at a minimum:
 - (A) Availability of a physician, Mobile Intensive Care Nurse, EMS-nurse practitioner, or EMS-physician assistant to provide online medical direction to EMS personnel during all hours of operation of the facility;
 - (B) A written plan to provide physician backup to the MICN, EMS-NP, or EMS-PA providing online medical direction to EMS personnel;
 - (C) A mechanism for persons providing online medical direction to provide feedback to the Quality Management system; and
 - (D) A plan to provide orientation and education regarding treatment protocols for those individuals providing online medical direction;
- (11) A written plan to ensure that each facility that routinely receives patients and also provides clinical education for EMS personnel that is precepted by a nurse, has a nurse liaison as defined by the "North Carolina Board of Nursing: Guidelines for the Selection and Performance of the Emergency Medical Services Nurse Liaison";
- (12) A written plan for providing emergency vehicle operation education for system personnel who operate emergency vehicles;
- (13) An EMS communication system that provides for:
 - (A) Public access using the emergency telephone number 9-1-1 within the public dial telephone network as the primary method for the public to request emergency assistance. This number shall be connected to the emergency communications center or Public Safety Answering Point (PSAP) with immediate assistance available such that no caller will be instructed to hang up the telephone and dial another telephone number. A person calling for emergency

assistance shall never be required to speak with more than two persons to request emergency medical assistance;

(B) An emergency communications system operated by public safety telecommunicators with training in the management of calls for medical assistance available 24 hours per day;

(C) Dispatch of the most appropriate emergency medical response unit or units to any caller's request for assistance. The dispatch of all response vehicles shall be in accordance with an official written EMS system plan for the management and deployment of response vehicles including requests for mutual aid; and

(D) Two-way radio voice communications from within the defined service area to the emergency communications center or PSAP and to facilities where patients are routinely transported. The emergency communications system shall maintain all Federal Communications Commission (FCC) radio licenses or authorizations required;

(14) A written plan addressing the use of specialty care transport programs within the system; and

(15) A written continuing education plan for EMS personnel that meets the requirements of the North Carolina Medical Board pursuant to G.S. 143-514.

(b) An application to establish an EMS System shall be submitted by the county to the OEMS for review. When the system is comprised of more than one county, only one application shall be submitted. The proposal shall demonstrate that the system meets the requirements in Paragraph (a) of this Rule. System approval shall be granted for a period not to exceed six years. Systems shall apply to OEMS for reapproval.

(c) Counties shall have one year from the effective date of these Rules to apply for initial system approval.

Authority G.S. 143-508(b); (d)(1),(5) (9); 143-509(1); 143-517.

10 NCAC 03D .2602 MODEL EMS SYSTEMS

(a) Some EMS Systems may choose to move beyond the minimum requirements in Rule .2601 of this Section and receive designation from the OEMS as a Model EMS System. To receive this designation, an EMS System shall document that, in addition to the system requirements in Rule .2601 of this Section, the following criteria have been met:

(1) A uniform level of care throughout the system available 24 hours per day;

(2) A plan for medical oversight that meets the requirements found in Section .2800 of this Subchapter. Specifically, Model EMS Systems shall meet the additional requirements for medical director and written treatment protocols as defined in Rules .2801 Subparagraph (1)(b) and .2805 Subparagraph (a)(2) of this Subchapter;

(3) A mechanism to collect and electronically submit to the OEMS data corresponding to the advanced data set and data dictionary as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection";

(4) A written plan to address management of the EMS system to include:

(A) Triage of patients to appropriate facilities;

(B) Transport of patients to facilities outside of the system;

(C) Arrangements for transporting patients to appropriate facilities when diversion or bypass plans are activated;

(D) A mechanism for reporting, monitoring, and establishing standards for system response times;

(E) A disaster plan; and

(F) A mass gathering plan;

(5) A written continuing education plan for EMS personnel that meets the requirements of the North Carolina Medical Board pursuant to G.S. 143-514, under the direction of the System Continuing Education Coordinator, developed and modified based on feedback from system data, review and evaluation of patient outcomes, and quality management reviews;

(6) A written plan to assure participation in clinical and field internship educational components for all EMS personnel;

(7) Operational protocols for the management of equipment, supplies, and medications. These protocols shall include a methodology:

(A) to assure that each vehicle contains the required equipment and supplies on each response;

(B) for cleaning and maintaining the equipment and vehicles; and

(C) to assure that supplies and medications are not used beyond the expiration date and stored in a temperature controlled atmosphere according to manufacturer's specifications;

(8) A written plan for the systematic and periodic inspection, repair, and maintenance of all vehicles used in the system;

(9) A written plan addressing the role of the EMS system in the areas of public education, injury prevention, and community health;

(10) Documentation of affiliation with one or more trauma Regional Advisory Committees; and

(11) A system-wide communication system which meets the requirements of Subparagraph

(a)(13) of Rule .2601 of this Section, and in addition:

- (A) Operates an EMD program; and
- (B) Has an operational E-911 system.

(b) EMS Systems holding current accreditation by a national accreditation agency may use this as documentation of completion of the equivalent requirements outlined above.

(c) The county shall submit an application for designation as a Model EMS System to the OEMS for review. When the system is comprised of more than one county, only one application shall be submitted. The application shall demonstrate that the system meets the standards found in Paragraph (a) of this Rule. Designation as a Model EMS System shall be awarded for a period not to exceed six years, after which time the system shall apply to OEMS for Model EMS System redesignation.

Authority G.S. 143-508(b); (d)(1),(5),(9); 143-509(1).

10 NCAC 03D .2603 SPECIAL SITUATIONS

Upon application of interested citizens in North Carolina, the North Carolina Medical Care Commission may approve the furnishing and providing of programs within the scope of practice of EMD, EMT, EMT-D, EMT-I, or EMT-P in North Carolina by persons who have been approved to provide these services by an agency of a state or federal jurisdiction adjoining North Carolina. This approval may be granted where the North Carolina Medical Care Commission concludes that the requirements enumerated in Rule .2601 of this Subchapter cannot be reasonably obtained by reason of lack of geographical access.

Authority G.S. 143-508(b).

10 NCAC 03D .2604 EMS PROVIDER LICENSE REQUIREMENTS

(a) Any firm, corporation, agency, organization or association that provides emergency medical services as its primary responsibility shall be licensed as an EMS provider by meeting the following criteria:

- (1) Be affiliated with an EMS System. Providers that apply for an initial EMS Provider License after January 1, 2002, shall have until December 31, 2002, to comply with this requirement;
- (2) Present an application for a permit for any ambulance which will be in service as required by G.S. 131E-156;
- (3) Submit a written plan detailing how the provider will furnish credentialed personnel;
- (4) Where there is a franchise ordinance in effect which covers the proposed service area, be granted a current franchise to operate or present written documentation of impending receipt of a franchise from the county; and
- (5) Present a written plan and method for recording systematic, periodic inspection repair, cleaning, and routine maintenance of all EMS responding vehicles.

(b) Presenting documentation to the OEMS that the provider meets the criteria found in Paragraph (a) of this Rule may renew an EMS Provider License.

Authority G.S. 131E-155.1(c).

10 NCAC 03D .2605 EMS PROVIDER LICENSE CONDITIONS

(a) Applications for an EMS Provider License shall be received by the OEMS at least 30 days prior to the date that the provider proposes to initiate service. Applications for renewal of an EMS Provider License shall be received by the OEMS at least 30 days prior to the expiration date of the current license.

(b) Only one license shall be issued to each EMS provider. The Department shall issue a license to the EMS provider following verification of compliance with applicable laws and rules.

(c) EMS Provider Licenses shall not be transferred.

(d) The license shall be posted in a prominent location accessible to public view at the primary business location of the EMS provider.

(e) In order to provide a transition time for implementation of these rules, EMS providers that have a current EMS Provider License as of December 31, 2001, with an expiration date in 2002, shall be issued a one-year extension to the current license from the current expiration date.

Authority G.S. 131E-155.1(c).

10 NCAC 03D .2606 TERM OF EMS PROVIDER LICENSE

(a) EMS Provider Licenses shall remain in effect up to six years, unless any of the following occurs:

- (1) The Department imposes an administrative sanction which specifies license expiration;
- (2) The EMS provider closes or goes out of business;
- (3) The EMS provider changes name or ownership; or
- (4) Substantial failure to comply with Rule .2604 of this Section.

(b) When the name or ownership of the EMS provider changes, an EMS Provider License application shall be submitted to the OEMS at least 30 days prior to the effective date of the change; and

(c) For EMS providers maintaining affiliation with a Model EMS System, licenses may be renewed without requirement for submission of an application.

Authority G.S. 131E-155.1(c).

10 NCAC 03D .2607 GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

To be permitted as a Ground Ambulance, a vehicle shall have:

- (1) A patient compartment that meets the following minimum interior dimensions:
 - (a) The length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, shall be at least 102 inches; and
 - (b) The height shall be at least 48 inches over the patient area, measured from

the approximate center of the floor, exclusive of cabinets or equipment;

(2) Patient care equipment and supplies as defined in the treatment protocols for the system. Vehicles used by EMS providers that are not required to have treatment protocols shall have patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) Other equipment to include:

(a) One fire extinguisher that shall be a dry chemical or all-purpose type with a pressure gauge mounted in a quick-release bracket; and

(b) The availability of one pediatric restraint device to safely transport pediatric patients under 20 pounds in the patient compartment of the ambulance;

(4) The name of the ambulance provider permanently displayed on each side of the vehicle;

(5) Reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(6) Emergency warning lights and audible warning devices mounted on the vehicle other than those required by Federal Motor Vehicle Safety Standards. All warning devices shall function properly;

(7) No structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(8) An operational two-way radio that shall:

(a) Be mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(b) Have sufficient range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS system to the emergency communications center or public safety answering point (PSAP) designated to direct or dispatch the deployment of the ambulance;

(c) Be capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(d) Be equipped with a radio control device mounted in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(e) Be licensed or authorized by the Federal Communications Commission (FCC);

(9) Ground ambulances shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication; and

(10) Other communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2608 CONVALESCENT AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

To be permitted as a Convalescent Ambulance, a vehicle shall have:

(1) A patient compartment that meets the following minimum interior dimensions:

(a) The length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, shall be at least 102 inches; and

(b) The height shall be at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment;

(2) Patient care equipment and supplies as defined in the treatment protocols for the system. Vehicles used by EMS providers that are not required to have treatment protocols shall have patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) Other equipment to include:

(a) One fire extinguisher that shall be a dry chemical or all-purpose type with a pressure gauge mounted in a quick-release bracket; and

(b) The availability of one pediatric restraint device to safely transport pediatric patients under 20 pounds in the patient compartment of the ambulance;

(4) Convalescent ambulances shall:

(a) Not be equipped, permanently or temporarily, with any emergency warning devices, audible or visual, other than those required by Federal Motor Vehicle Safety Standards;

- (b) Have the name of the ambulance provider permanently displayed on each side of the vehicle;
- (c) Not have emergency medical symbols, such as the Star of Life, block design cross, or any other medical markings, symbols, or emblems, including the word "EMERGENCY," on the vehicle;
- (d) Have the words "CONVALESCENT AMBULANCE" lettered on both sides and on the rear of the vehicle body; and
- (e) Have reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;
- (5) A two-way radio or radiotelephone device such as a cellular telephone shall be available to summon emergency assistance for a vehicle permitted as a convalescent ambulance; and
- (6) The convalescent ambulance shall not have structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2609 AIR MEDICAL AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

To be permitted as an Air Medical Ambulance, an aircraft shall meet the following requirements:

- (1) Configuration of the aircraft interior shall not compromise the ability to provide appropriate care or prevent providers from performing emergency procedures if necessary;
- (2) Patient care equipment and supplies as defined in the treatment protocols for the program. Air Medical Ambulances used by EMS providers that are not required to have treatment protocols shall have patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;
- (3) Internal voice communication system to allow for communication between the medical crew and flight crew;
- (4) Due to the different configurations and space limitations of air medical ambulances, the medical director shall designate the combination of medical equipment specified in Paragraph (b) of this Rule that is carried on a mission based on anticipated patient care needs;
- (5) Air Medical Ambulances shall have the name of the organization permanently displayed on each side of the aircraft;
- (6) Air Medical Ambulances shall be equipped with a two-way voice radio licensed by the Federal Communications Commission capable

of operation on any frequency required to allow communications with public safety agencies such as fire departments, police departments, ambulance and rescue units, hospitals, and local government agencies within the defined service area;

- (7) All rotary wing aircraft permitted as an air medical ambulance shall have the following flight equipment operational in the aircraft:
 - (a) Two 360-channel VHF aircraft frequency transceivers;
 - (b) One VHF omnidirectional ranging (VOR) receiver;
 - (c) Attitude indicators;
 - (d) One transponder with 4097 code, Mode C with altitude encoding;
 - (e) Turn and slip indicator in the absence of three attitude indicators;
 - (f) Current FAA approved navigational aids and charts for the area of operations;
 - (g) Radar altimeter;
 - (h) Satellite Global Navigational system;
 - (i) Emergency Locator Transmitter (ELT);
 - (j) A remote control external search light;
 - (k) A light which illuminates the tail rotor;
 - (l) A fire extinguisher; and
 - (m) Survival gear appropriate for the service area and the number of occupants;
- (8) Any fixed wing aircraft issued a permit to operate as an air medical ambulance shall have a current "Instrument Flight Rules" certification.
- (9) The availability of one pediatric restraint device to safely transport pediatric patients under 20 pounds in the patient compartment of the air medical ambulance; and
- (10) The Air Medical Ambulance shall not have structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the aircraft.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2610 WATER AMBULANCE: WATERCRAFT AND EQUIPMENT REQUIREMENTS

To be permitted as a Water Ambulance, a watercraft shall meet the following requirements:

- (1) A patient care area which:
 - (a) Provides access to the head, torso, and lower extremities of the patient while providing sufficient working space to render patient care;
 - (b) Is covered to protect the patient and EMS personnel from the elements; and

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(c) Has an opening of sufficient size to permit the safe loading and unloading of a person occupying a litter;

(2) Patient care equipment and supplies as defined in the treatment protocols for the system. Water ambulances used by EMS providers that are not required to have treatment protocols shall have patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) Water ambulances shall have the name of the ambulance provider permanently displayed on each side of the watercraft;

(4) Water ambulances shall have a 360-degree beacon warning light in addition to warning devices required in G.S. 75A, Article 1;

(5) Water ambulances shall be equipped with:

- (a) Two floatable rigid long backboards with proper accessories for securing infant, pediatric, and adult patients and stabilization of the head and neck;
- (b) One floatable litter with patient restraining straps and capable of being secured to the watercraft;
- (c) One fire extinguisher that shall be a dry chemical or all-purpose type with a pressure gauge mounted in a quick-release bracket;
- (d) Lighted compass;
- (e) Radio navigational aids such as ADF (automatic directional finder), Satellite Global Navigational system, navigational radar, or other comparable radio equipment suited for water navigation;
- (f) Marine radio; and
- (g) The availability of one pediatric restraint device to safely transport pediatric patients under 20 pounds in the patient compartment of the ambulance; and

(6) The water ambulance shall not have structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the watercraft.

(c) Only one Ambulance Permit shall be issued for each ambulance.

(d) An ambulance shall be permitted in only one category.

(e) Ambulance Permits shall not be transferred except in the case of Air Medical Ambulance replacement aircraft when the primary aircraft is out of service.

(f) The Ambulance Permit shall be posted as designated by the OEMS inspector.

(g) In order to provide a transition time for implementation of these Rules, ambulances with a current ambulance permit as of December 31, 2001, shall be issued a one-year extension to the current Ambulance Permit from the current expiration date.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2612 TERM OF AMBULANCE PERMIT

(a) Ambulance Permits shall remain in effect up to two years in an EMS System or four years in a Model EMS system, unless any of the following occurs:

- (1) The Department imposes an administrative sanction which specifies permit expiration;
- (2) The EMS provider closes or goes out of business;
- (3) The EMS provider changes name or ownership; or
- (4) Substantial failure to comply with the applicable Paragraphs of Rules .2607, .2608, .2609, or .2610 of this Section.

(b) Ambulance Permits will be renewed without OEMS inspection for those ambulances currently operated within a Model EMS System.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2613 EMS NONTRANSPORTING VEHICLE REQUIREMENTS

To be permitted as an EMS nontransporting vehicle, a vehicle shall have:

- (1) Patient care equipment and supplies as defined in the treatment protocols for the system. The equipment and supplies shall be clean, in working order, and secured in the vehicle;
- (2) EMS nontransporting vehicles shall have the name of the organization permanently displayed on each side of the vehicle;
- (3) EMS nontransporting vehicles shall have reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;
- (4) Emergency warning lights and audible warning devices mounted on the vehicle other than those required by Federal Motor Vehicle Safety Standards. All warning devices shall function properly;
- (5) The vehicle shall not have structural or functional defects that may adversely affect the EMS personnel or the safe operation of the vehicle;
- (6) One fire extinguisher that shall be a dry chemical or all-purpose type with a pressure gauge, mounted in a quick-release bracket;

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2611 AMBULANCE PERMIT CONDITIONS

(a) An EMS provider shall apply to the OEMS for the appropriate Ambulance Permit prior to placing an ambulance in service.

(b) The Department shall issue a permit for an ambulance following verification of compliance with applicable laws and rules.

(7) An operational two-way radio that shall:

- (a) Be mounted to the EMS nontransporting vehicle and installed for safe operation and controlled by the driver;
- (b) Have sufficient range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS system to the emergency communications center or public safety answering point (PSAP) designated to direct or dispatch the deployment of the ambulance;
- (c) Be capable of establishing two-way voice radio communication from within the defined service area to facilities that provide on-line medical direction to EMS personnel; and
- (d) Be licensed or authorized by the Federal Communications Commission (FCC);

(8) EMS nontransporting vehicles shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication;

(9) Other communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission-dedicated radio.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2614 EMS NONTRANSPORTING VEHICLE PERMIT CONDITIONS

- (a) An EMS provider shall apply to the OEMS for an EMS Nontransporting Vehicle permit prior to placing such a vehicle in service.
- (b) The Department shall issue a permit for a vehicle following verification of compliance with applicable laws and rules.
- (c) Only one EMS Nontransporting Vehicle permit shall be issued for each vehicle.
- (d) EMS Nontransporting Vehicle permits shall not be transferred.
- (e) The EMS Nontransporting Vehicle permit shall be posted as designated by the OEMS inspector.
- (f) In order to provide a transition time for implementation of these rules, EMS Nontransporting Vehicles with a current permit as of December 31, 2001, shall be issued a one-year extension to the current permit from the current expiration date.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2615 TERM OF EMS NONTRANSPORTING VEHICLE PERMIT

- (a) EMS Nontransporting Vehicle permits shall remain in effect up to two years in an EMS System or four years in a Model EMS System, unless any of the following occurs:

- (1) The Department imposes an administrative sanction that specifies permit expiration;
- (2) The EMS provider closes or goes out of business;
- (3) The EMS provider changes name or ownership; or
- (4) Substantial failure to comply with Rule .2613 of this Section.

(b) EMS Nontransporting Vehicle permits will be renewed without OEMS inspection for those vehicles currently operated within a Model EMS System.

Authority G.S. 131E-157(a); 143-508(d)(8).

10 NCAC 03D .2616 WEAPONS AND EXPLOSIVES FORBIDDEN

- (a) Weapons, as defined by the local county district attorney's office, and explosives shall not be worn or carried aboard an ambulance or EMS nontransporting vehicle within the State of North Carolina when the vehicle is operating in any patient treatment or transport capacity or is available for such function.
- (b) This Rule shall apply whether or not such weapons and explosives are concealed or visible.
- (c) This Rule shall not apply to duly appointed law enforcement officers.
- (d) Safety flares are authorized for use on an ambulance or EMS nontransporting vehicle with the following restrictions:
 - (1) These devices are not stored inside the patient compartment of the ambulance; and
 - (2) These devices shall be packaged and stored to prevent accidental discharge or ignition.

Authority G.S. 131E-157(a); 143-508(d)(8).

SECTION .2700 – SPECIALTY CARE TRANSPORT PROGRAMS

10 NCAC 03D .2701 PROGRAM CRITERIA

- (a) Programs seeking designation to provide specialty care transports shall submit an application for program approval to the OEMS at least 60 days prior to field implementation. The application shall document that the program has:
 - (1) A defined service area;
 - (2) A medical oversight plan meeting the requirements of Section .2800;
 - (3) Service continuously available on a 24-hour-per-day basis;
 - (4) The capability to provide the following patient care skills and procedures:
 - (A) Advanced airway techniques including rapid sequence induction, cricothyrotomy, and ventilator management, including continuous monitoring of the patient's oxygenation;
 - (B) Insertion of femoral lines;
 - (C) Maintaining invasive monitoring devices to include central venous pressure lines, arterial and venous catheters, arterial lines, intra-

TRANSPORT PROGRAMS

(a) When transporting patients that have a medical need for one or more of the skills or procedures as defined in Rule .2701(a)(4) for Specialty Care Transport Programs of this Section, staffing for the vehicle used in the Ground Specialty Care Transport Program shall be at a level to ensure the capability to provide in the patient compartment, when the patient condition requires, two of the following personnel approved by the medical director as medical crew members:

- (1) EMT-Paramedic;
- (2) Nurse practitioner;
- (3) Physician;
- (4) Physician assistant;
- (5) Registered nurse; or
- (6) Respiratory therapist.

(b) When transporting patients that do not require specialty care transport skills or procedures, staffing for the vehicles used in the Ground Specialty Care Transport Program shall be at a level to ensure compliance with G.S. 131E-158 (a).

(c) In addition to the general requirements of Specialty Care Transport Programs in Rule .2701 of this Section, ground programs providing specialty care transports shall document that the program has:

- (1) A communication system that will provide, at a minimum, two-way voice communications to medical crew members anywhere in the service area of the program. The medical director shall verify that the communications system is satisfactory for on-line medical direction;
- (2) Medical crew members that have all completed training regarding:
 - (A) Operation of the EMS communications system used in the program;
 - (B) The medical and safety equipment specific to the vehicles used in the program. This training shall be conducted every six months;
- (3) Operational protocols for the management of equipment, supplies, and medications. These protocols shall include:
 - (A) A standard equipment and supply listing for all ambulance vehicles used in the program. This listing shall meet or exceed the requirements for each category of ambulance used in the program as found in Rules .2607, .2608, .2609, and .2610 of this Subchapter;
 - (B) A standard listing of medications for all ambulance and EMS nontransporting vehicles used in the system. This listing shall be based on the local treatment protocols and be approved by the medical director;
 - (C) A methodology to assure that each vehicle contains the required equipment and supplies on each response;

Authority G.S. 143-508(d)(1);(8);(9).

10 NCAC 03D .2702 AIR MEDICAL SPECIALTY CARE TRANSPORT PROGRAM

(a) In addition to the general requirements of Specialty Care Transport Programs in Rule .2701 of this Section, Air Medical Programs shall document that the program has:

- (1) Medical crew members that have all completed training regarding:
 - (A) Altitude physiology;
 - (B) The operation of the EMS communications system used in the program;
 - (C) In-flight emergencies specific to the aircraft used in the program; and
 - (D) Aircraft safety. This training shall be conducted every six months;
- (2) A Certificate of Need obtained from the Department when applicable;
- (3) A written plan for transporting patients to appropriate facilities when diversion or bypass plans are activated;
- (4) A written plan for providing emergency vehicle operation education for program personnel who operate ground emergency vehicles; and
- (5) A written plan specifying how EMS systems will request ground support ambulances operated by the program.

(b) Air Medical Programs based outside of North Carolina that provide specialty care transports may be granted approval by the OEMS to operate in North Carolina by submitting an application for program approval. The application shall document that the program meets all criteria specified in Rules .2604 and .2701 of this Subchapter and Paragraph (a) of this Rule.

Authority G.S. 143-508(d)(1).

10 NCAC 03D .2703 GROUND SPECIALTY CARE

- (D) A methodology for cleaning and maintaining the equipment and vehicles; and
- (E) A methodology for assuring that supplies and medications are not used beyond the expiration date and stored in a temperature-controlled atmosphere according to manufacturer's specifications;
- (4) A written plan for providing emergency vehicle operation education for program personnel who operate emergency vehicles; and
- (5) A written plan specifying how EMS systems will request ambulances operated by the program.

(d) Ground Specialty Care Transport Programs based outside of North Carolina may be granted approval by the OEMS to operate in North Carolina by submitting an application for program approval. The application shall document that the program meets all criteria specified in Rules .2604 and .2701 of this Subchapter and Paragraphs (a) and (b) of this Rule.

Authority G.S. 143-508(d)(1),(8),(9).

10 NCAC 03D .2704 HOSPITAL-AFFILIATED GROUND SPECIALTY CARE TRANSPORT PROGRAMS USED FOR INPATIENT TRANSPORTS

(a) Patients transported by this type Specialty Care Transport Program shall:

- (1) Have a medical need for one or more of the skills or procedures as defined for Specialty Care Transport Programs as defined in Rule .2701 Subparagraph (a)(4) of this Section; or
- (2) Be a patient of the hospital administering the program, or be scheduled for admission to or discharged from the hospital administering the program.

(b) In addition to the general requirements of specialty care transport programs in Rule .2701 of this Section, hospital-affiliated ground programs providing specialty care transports shall document that the program has:

- (1) A communication system that will provide, at a minimum, two-way voice communications to medical crew members anywhere in the service area of the program. The medical director shall verify that the communications system is satisfactory for on-line medical direction;
- (2) Medical crew members that have all completed training regarding:
 - (A) Operation of the EMS communications system used in the program; and
 - (B) The medical and safety equipment specific to the vehicles used in the program. This training shall be conducted every six months;
- (3) Staffing at a level to ensure the capability to provide in the patient compartment, when the patient's condition requires, two of the

- following personnel approved by the medical director as medical crew members:
 - (A) EMT-Paramedic;
 - (B) Nurse practitioner;
 - (C) Physician;
 - (D) Physician assistant;
 - (E) Registered nurse; or
 - (F) Respiratory therapist.
- (4) Operational protocols for the management of equipment, supplies, and medications. These protocols shall include:
 - (A) A standard equipment and supply listing for all ambulance vehicles used in the program. This listing shall meet or exceed the requirements for each category of ambulance used in the program as found in Rules .2607, .2608, .2609, and .2610 of this Subchapter;
 - (B) A standard listing of medications for all ambulance and EMS nontransporting vehicles used in the program. This listing shall be based on the local treatment protocols and be approved by the medical director;
 - (C) A methodology to assure that each vehicle contains the required equipment and supplies on each response
 - (D) A methodology for cleaning and maintaining the equipment and vehicles; and
 - (E) A methodology for assuring that supplies and medications are not used beyond the expiration date and stored in a temperature-controlled atmosphere according to manufacturer's specifications;
- (5) A written plan for providing emergency vehicle operation education for program personnel who operate emergency vehicles; and
- (6) A written plan specifying how EMS systems will request ambulances operated by the program.

(c) Hospital-Affiliated Ground Specialty Care Transport Programs based outside of North Carolina may be granted approval by the OEMS to operate in North Carolina by submitting an application for program approval. The application shall document that the program meets all criteria specified in Rules .2604 and .2701 of this Subchapter and Paragraphs (a) and (b) of this Rule.

Authority G.S. 143-508(d)(1),(8),(9).

SECTION .2800 -- MEDICAL OVERSIGHT

10 NCAC 03D .2801 COMPONENTS OF MEDICAL OVERSIGHT FOR EMS SYSTEMS

Each EMS System operating within the scope of practice for EMD, EMT-D, EMT-I, or EMT-P or seeking designation as a

Model EMS System shall have the following components in place to assure medical oversight of the system:

- (1) A medical director appointed, either directly or by clearly documented delegation, by the county responsible for establishing the EMS system. Systems may elect to appoint one or more assistant medical directors:
 - (a) For EMS Systems, the medical director and assistant medical directors shall meet the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection"; and
 - (b) For Model EMS Systems, the medical director and assistant medical directors shall also meet the additional criteria for medical directors of Model EMS Systems as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection";
- (2) Written treatment protocols for use by EMS personnel;
- (3) For systems providing EMD service, an EMDPRS approved by the medical director;
- (4) A quality management committee; and
- (5) Written procedures for use by EMS personnel to obtain on-line medical direction. On-line medical direction shall:
 - (a) Be restricted to medical orders that fall within the scope of practice of the EMS personnel and within the scope of approved system treatment protocols;
 - (b) Be provided only by physicians, EMS-physician assistants, EMS-nurse practitioners, or mobile intensive care nurses. Only physicians may deviate from written treatment protocols; and
 - (c) Be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2802 COMPONENTS OF MEDICAL OVERSIGHT FOR SPECIALTY CARE TRANSPORT PROGRAMS

Each Specialty Care Transport Program shall have the following components in place to assure Medical Oversight of the system:

- (1) A medical director. The administration of the Specialty Care Transport Program shall appoint a medical director following the criteria for medical directors of Specialty Care Transport Programs as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data

Collection." The program administration may elect to appoint one or more assistant medical directors;

- (2) Treatment protocols for use by medical crew members;
- (3) A quality management committee; and
- (4) A written protocol for use by medical crew members to obtain on-line medical direction. On-line medical direction shall:
 - (a) Be restricted to medical orders that fall within the scope of practice of the medical crew members and within the scope of approved program treatment protocols;
 - (b) Be provided only by physicians, EMS-physician assistants, EMS-nurse practitioners, or mobile intensive care nurses. Only physicians may deviate from written treatment protocols; and
 - (c) Be obtained via a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2803 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR EMS SYSTEMS

- (a) The Medical Director for an EMS System shall be responsible for the following:
 - (1) Ensure that medical control is available 24 hours a day;
 - (2) The establishment, approval, and annual updating of treatment protocols;
 - (3) For EMD programs, the establishment, approval, and annual updating of the EMDPRS;
 - (4) Medical supervision of the selection, system orientation, continuing education, and performance of EMS personnel;
 - (5) Medical supervision of a scope of practice performance evaluation for all EMS personnel in the system based on the treatment protocols for the system;
 - (6) The medical review of the care provided to patients;
 - (7) Providing guidance regarding decisions about the equipment, medical supplies, and medications that will be carried on ambulances or EMS nontransporting vehicles within the scope of practice of EMT-D, EMT-I, or EMT-P; and
 - (8) Keeping the care provided up to date with current medical practice.

- (b) Any tasks related to Paragraph (a) of this Rule may be completed, through clearly established written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, EMD's, or EMT-P's.
- (c) The medical director shall have the authority to suspend temporarily, pending due process review, any EMS personnel

from further participation in the EMS system when it is determined the activities or medical care rendered by such personnel may be detrimental to the care of the patient, constitute unprofessional behavior, or result in non-compliance with credentialing requirements.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2804 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The medical director for a Specialty Care Transport Program shall be responsible for the following:

- (1) The establishment, approval, and periodic updating of treatment protocols
- (2) Medical supervision of the selection, program orientation, continuing education, and performance of medical crew members;
- (3) Medical supervision of a scope of practice performance evaluation for all medical crew members in the program based on the treatment protocols for the program;
- (4) The medical review of the care provided to patients;
- (5) Keeping the care provided up to date with current medical practice; and
- (6) In air medical programs, determination and specification of the medical equipment required in Paragraph (2) of Rule .2609 of this Subchapter that is carried on a mission based on anticipated patient care needs.

(b) Any tasks related to Paragraph (a) of this Rule may be completed, through clearly established written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, or medical crew members.

(c) The medical director shall have the authority to suspend temporarily, pending due process review, any medical crew members from further participation in the Specialty Care Transport Program when it is determined the activities or medical care rendered by such personnel may be detrimental to the care of the patient, constitute unprofessional behavior, or result in non-compliance with credentialing requirements.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2805 REQUIREMENTS FOR TREATMENT PROTOCOLS FOR EMS SYSTEMS

(a) Written Treatment Protocols:

- (1) Used in EMS Systems shall meet the minimum standard treatment protocols as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection";
- (2) Used in Model EMS Systems shall also meet the minimum standard treatment protocols for Model EMS Systems as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection"; and
- (3) Shall not contain medical procedures, medications, or intravenous fluids which

exceed the scope of practice defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the level of care offered in the EMS system or any other applicable health care licensing board.

(b) Treatment protocols developed locally shall, at a minimum, meet the requirements of Paragraph (a) of this Rule, shall be reviewed annually and any change in the treatment protocols shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2806 REQUIREMENTS FOR TREATMENT PROTOCOLS FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) Treatment protocols used by medical crew members within a Specialty Care Transport Program shall:

- (1) Incorporate all skills, medications, equipment, and supplies for Specialty Care Transport Programs as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" and shall be approved by the OEMS Medical Director; and
- (2) Not contain medical procedures, medications, or intravenous fluids that exceed the scope of practice of the medical crew members.

(b) Treatment protocols shall be reviewed annually, and any change in the treatment protocols shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2807 REQUIREMENTS FOR EMERGENCY MEDICAL DISPATCH PRIORITY REFERENCE SYSTEM (EMDPRS)

(a) EMDPRS used by EMD's within an approved EMD program shall:

- (1) Meet or exceed the statewide standard for EMDPRS as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" and shall be approved by the OEMS Medical Director; and
- (2) Not exceed the EMD scope of practice.

(b) An EMDPRS developed locally shall be reviewed and updated annually and submitted to the OEMS medical director for approval. Any change in the EMDPRS shall be submitted to the OEMS medical director for review and approval at least 30 days prior to the implementation of the change.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2808 QUALITY MANAGEMENT COMMITTEE FOR EMS SYSTEMS

(a) The quality management committee for an EMS system shall:

PROPOSED RULES

(1) Be composed of at least one voting representative from each of the following components of the system:

(A) Physicians;

(B) Nurses;

(C) Medical facility personnel such as pharmacists or respiratory therapists;

(D) EMS educators;

(E) County government officials; and

(F) EMS providers;

(2) Appoint a physician as chairperson;

(3) Meet, at a minimum, on a quarterly basis;

(4) Ensure that a medical review committee as referenced in G.S. 143-518(a)(5), or sub-committee thereof, analyzes system data to evaluate the ongoing quality of patient care and medical direction within the system;

(5) Use information gained from system data analysis to make recommendations regarding the content of educational programs for EMS personnel;

(6) Review treatment protocols of the EMS system and make recommendations to the medical director for changes;

(7) Establish a written procedure to guarantee reviews for EMS personnel temporarily suspended by the medical director; and

(8) Maintain minutes of committee meetings throughout the approval period of the EMS System.

(b) The quality management committee shall adopt written guidelines which address at a minimum:

(1) Structure of committee membership;

(2) Appointment of committee officers;

(3) Appointment of committee members;

(4) Length of terms of committee members;

(5) Frequency of attendance of committee members;

(6) Establishment of a quorum for conducting business; and

(7) Confidentiality of medical records and personnel issues.

Authority G.S. 143-508(b); 143-509(12).

10 NCAC 03D .2809 QUALITY MANAGEMENT COMMITTEE FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The quality management committee for a Specialty Care Transport Program shall:

(1) Be composed of at least one voting representative from each of the following components of the program:

(A) Physicians;

(B) Nurses;

(C) Medical facility personnel such as pharmacists or respiratory therapists;

(D) Educators; and

(E) Medical crew members;

(2) Appoint a physician as chairperson;

(3) Meet, at a minimum, on a quarterly basis;

(4) Ensure that a medical review committee as referenced in G.S. 143-518(a)(5), or sub-committee thereof, analyzes system data to evaluate the ongoing quality of patient care and medical direction within the program;

(5) Use information gained from program data analysis to make recommendations regarding the content of educational programs for medical crew members;

(6) Review treatment protocols of the Specialty Care Transport Programs and make recommendations to the medical director for changes;

(7) Establish a written procedure to guarantee reviews for medical crew members temporarily suspended by the medical director; and

(8) Maintain minutes of committee meetings throughout the approval period of the Specialty Care Transport Program.

(b) Each quality management committee shall adopt written guidelines which address at a minimum:

(1) Structure of committee membership;

(2) Appointment of committee officers;

(3) Appointment of committee members;

(4) Length of terms of committee members;

(5) Frequency of attendance of committee members;

(6) Establishment of a quorum for conducting business; and

(7) Confidentiality of medical records and personnel issues.

Authority G.S. 143-508(b); 143-509(12).

SECTION .2900 – EMS PERSONNEL

10 NCAC 03D .2901 EDUCATIONAL PROGRAMS

(a) An Educational Program approved to qualify EMS personnel to perform within their scope of practice shall be offered by an EMS Educational Institution.

(b) Educational Programs approved to qualify EMS personnel or EMS Instructors for credentialing or renewal of credentials shall meet the requirements of the North Carolina Medical Board pursuant to G.S. 143-514.

Authority G.S. 143-508(d)(3),(4); 143-514.

10 NCAC 03D .2902 INITIAL CREDENTIALING REQUIREMENTS FOR EMS PERSONNEL

(a) EMS personnel applicants shall meet the following criteria within one year of the completion date of the approved educational program for their level of application. If the educational program was completed over one year prior to application, applicants shall submit evidence of completion of continuing education during the past year. This continuing education shall be consistent with their level of application and approved by the OEMS.

(1) Be at least 18 years of age;

PROPOSED RULES

(2) Successfully complete a scope of practice performance evaluation, approved by the OEMS, for the level of application:

(A) For MR and EMT credentialing, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application or other person approved by the OEMS; and

(B) For EMT-D, EMT-I, EMT-P, EMD, MICN, EMS-PA, and EMS-NP credentialing, this evaluation shall be conducted under the direction of the educational medical advisor, a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor, or other person approved by the OEMS; and

(3) Successfully complete a written examination approved or administered by the OEMS. Applicants who fail the written EMT examination but achieve a minimum score of 70% on the medical responder subset contained within the examination may be credentialed as medical responders.

(b) EMD applicants shall successfully complete, within one year prior to application, an AHA CPR course or equivalent, including infant, pediatric and adult CPR, in addition to Subparagraphs (a)(1) and (a)(3) and Part (a)(2)(B), of this Rule;

(c) MICN applicants shall currently be a registered nurse who is licensed to practice nursing in North Carolina and have two years emergency or critical care experience, or a combination of this experience in addition to Subparagraph (a)(1) and Part (a)(2)(B) of this Rule;

(d) EMS-NP applicants shall currently be a registered nurse who is licensed to practice nursing in North Carolina and approved as a nurse practitioner by the North Carolina Board of Nursing and the North Carolina Medical Board and have two years emergency or critical care experience, or a combination of this experience in addition to Subparagraph (a)(1) and Part (a)(2)(B) of this Rule; and

(e) EMS-PA applicants shall currently be a physician assistant licensed by the North Carolina Medical Board and have two years emergency or critical care experience, or a combination of this experience in addition to Subparagraph (a)(1) and Part (a)(2)(B) of this Rule.

Authority G.S. 143-508(d)(3); 131E-159(a),(b).

10 NCAC 03D .2903 CREDENTIALING REQUIREMENTS LEGAL RECOGNITION APPLICANTS

(a) Applicants holding current credentials with the National Registry of Emergency Medical Technicians, a national credentialing agency approved by the OEMS, or another state where the education and credentialing requirements are approved for legal recognition by the OEMS may be eligible for credentialing at their level of application without examination.

(b) Persons who live in a state that borders North Carolina may continue to obtain a North Carolina credential through legal

recognition if they continue to renew their credentials in the state in which they reside.

(c) Persons who live in North Carolina and have a current credential in another state that borders North Carolina may renew their North Carolina credential through legal recognition if they continue to meet the credentialing requirements in the state in which they are credentialed.

(d) Persons who were previously credentialed in North Carolina and are currently credentialed in another state, the National Registry of Emergency Medical Technicians, or a national credentialing agency approved by the OEMS may be eligible for credentialing at their level of application without examination.

Authority G.S. 143-508(d)(3),(4); 131E-159(a),(b),(c),(d).

10 NCAC 03D .2904 TERM OF CREDENTIALS FOR EMS PERSONNEL

(a) Credentials for EMS personnel shall be valid for the period stated on the credential issued to the applicant. This period shall not exceed four years.

(b) Credentials obtained through legal recognition shall be valid for four years or the unexpired term of the credential that was used to obtain a credential in this state, whichever is shorter.

Authority G.S. 131E-159(a),(c),(d).

10 NCAC 03D .2905 RENEWAL OF CREDENTIALS FOR EMS PERSONNEL AND EMS INSTRUCTORS

Persons shall renew credentials by presenting documentation to the OEMS that they have successfully completed the requirements for their level of application as defined by the North Carolina Medical Board pursuant to G.S. 143-514.

Authority G.S. 131E-159(a); 143-508(d)(3).

10 NCAC 03D .2906 SCOPE OF PRACTICE FOR EMS PERSONNEL

EMS Personnel educated in approved programs, credentialed by the OEMS, and affiliated with an approved EMS system may perform acts and administer intravenous fluids and medications as allowed by the North Carolina Medical Board pursuant to G.S. 143-514.

Authority G.S. 143-508(d)(6); 143-514.

10 NCAC 03D .2907 PRACTICE SETTINGS FOR EMS PERSONNEL

EMS Personnel may function in the following practice settings in accordance with the protocols approved by the medical director of the EMS System or Specialty Care Transport Program with which they are affiliated, and by the OEMS:

(1) At the location of a physiological or psychological illness or injury including transportation to an appropriate treatment facility if required;

(2) At public or community health facilities in conjunction with public and community health initiatives;

(3) In hospitals and clinics;

(4) In residences, facilities, or other locations as part of wellness or injury prevention initiatives

within the community and the public health system; and

(5) At mass gatherings or special events.

Authority G.S. 143-508(d)(7).

10 NCAC 03D .2908 CREDENTIALING REQUIREMENTS FOR LEVEL I EMS INSTRUCTORS

(a) Applicants for credentialing as a Level I EMS Instructor shall meet the following:

(1) Be currently credentialed by the OEMS as an EMT, EMD EMT-D, EMT-I, or EMT-P;

(2) Three years equivalent experience at the scope of practice for the level of application;

(3) Within one year prior to application, successfully complete a scope of practice performance evaluation, approved by the OEMS, for the level of EMS personnel application;

(A) For a credential to teach at the EMT level this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application or other person approved by the OEMS.

(B) For a credential to teach at the EMT-D, EMT-I, or EMT-P levels, this evaluation shall be conducted under the direction of the educational medical advisor, a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor, or other person approved by the OEMS.

(C) For a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor, a Level I Instructor credentialed at the EMD level designated by the educational medical advisor, or other person approved by the OEMS.

(4) 100 hours of formal teaching experience in an approved EMS educational program or equivalent;

(5) Successful completion of a Level I EMS Instructor methodology course as defined by the North Carolina Medical Board pursuant to G.S. 143-514;

(6) Attendance at a Level I EMS Instructor workshop approved by the OEMS; and

(7) A high school diploma or General Education Development certificate.

(b) Persons who have a current EMT Instructor Certification as of December 31, 2001, shall be issued a Level I EMS Instructor credential consistent with the term of their EMT Instructor Certification.

(c) Persons currently approved by the OEMS as EMD Instructors shall be issued a Level I Instructor credentialed at the EMD level valid through December 31, 2003.

(d) The credential of a Level I EMS Instructor shall remain in effect up to four years, unless any of the following occurs:

(1) The OEMS imposes an administrative action against the instructor credential;

(2) The instructor fails to maintain a current EMS personnel credential at the highest level that the instructor is approved to teach.

Authority G.S. 143-508(d)(3).

10 NCAC 03D .2909 CREDENTIALING REQUIREMENTS FOR LEVEL II EMS INSTRUCTORS

(a) Applicants for credentialing as a Level II EMS instructor shall meet the following:

(1) Requirements defined in Paragraph (a) of Rule .2908 of this Section;

(2) Completion of post-secondary level education equal to or exceeding an Associate Degree. Persons who have a current EMT Instructor Certification as of December 31, 2001, and apply for Level II EMS Instructor credentials by December 31, 2003, are exempt from this requirement;

(3) Within one year prior to application, successfully complete a scope of practice performance evaluation, approved by the OEMS, for the level of EMS personnel application;

(A) For EMT instructor credentialing, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application or other person approved by the OEMS.

(B) For EMT-D, EMT-I, and EMT-P instructor credentialing, this evaluation shall be conducted under the direction of the educational medical advisor, a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor, or other person approved by the OEMS.

(C) For a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor, a Level I Instructor credentialed at the EMD level designated by the educational medical advisor, or other person approved by the OEMS.

(4) Two years teaching experience as a Level I EMS Instructor or equivalent, as defined by the North Carolina Medical Board pursuant to G.S. 143-514;

(5) Successful completion of an EMS Education Administration Course as defined by the North Carolina Medical Board pursuant to G.S. 143-514; and

(6) Attendance at a Level II EMS Instructor workshop approved by the OEMS.

(b) The credential of a Level II EMS Instructor shall remain in effect up to four years, unless any of the following occurs:

- (1) The OEMS imposes an administrative action against the instructor credential;
- (2) The instructor fails to maintain a current EMS Personnel credential at the highest level that the instructor is approved to teach.

Authority G.S. 143-508(d)(3).

10 NCAC 03D .2911 CREDENTIALING OF INDIVIDUALS TO ADMINISTER LIFESAVER TREATMENT TO PERSONS SUFFERING AN ADVERSE REACTION TO INSECT STINGS

(a) To become credentialed by the North Carolina Medical Care Commission to administer epinephrine to persons who suffer adverse reactions to insect stings, a person shall meet the following:

- (1) Be 18 years of age or older; and
- (2) Successfully complete an educational program taught by a physician licensed to practice medicine in North Carolina or designee of the physician. The educational program shall instruct individuals in the appropriate use of procedures for the administration of epinephrine to pediatric and adult victims who suffer adverse reactions to insect stings and shall include at a minimum the following:
 - (A) Definition of anaphylaxis;
 - (B) Agents which might cause anaphylaxis and the distinction between them, including drugs, insects, foods, and inhalants;
 - (C) Recognition of symptoms of anaphylaxis for both pediatric and adult victims;
 - (D) Appropriate emergency treatment of anaphylaxis as a result of insect stings;
 - (E) Availability and design of packages containing equipment for administering epinephrine to victims suffering from anaphylaxis as a result of insect stings;
 - (F) Pharmacology of epinephrine including indications, contraindications, and side effects;
 - (G) Discussion of legal implications of rendering aid; and
 - (H) Instruction that treatment is to be utilized only in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment.

(b) A credential to administer epinephrine to persons who suffer adverse reactions to insect stings may be issued by the North Carolina Medical Care Commission upon receipt of a completed application signed by the applicant and the physician who taught or was responsible for the educational program. All credentials shall be valid for the period stated on the credential issued to the applicant, and this period shall not exceed four years.

Authority G.S. 143-508(d)(11).

SECTION .3000 – EMS EDUCATIONAL INSTITUTIONS

10 NCAC 03D .3001 CONTINUING EDUCATION EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) Continuing Education EMS Educational Institutions shall be credentialed by the OEMS to provide EMS continuing education programs.

(b) Continuing Education EMS Educational Institutions shall have, at a minimum:

- (1) A Level I credentialed instructor as program coordinator. The program coordinator shall hold a Level I instructor credentialed at a level equal to or greater than the highest level of continuing education program offered in the system. Educational Institutions offering only EMD continuing education programs may meet this requirement with a credentialed Level I Instructor credentialed at the EMD level;
- (2) A continuing education program consistent with the system continuing education plan for EMS personnel:
 - (A) In an EMS System the continuing education programs for EMD, EMT-D, EMT-I, and EMT-P shall be reviewed and approved by the medical director of the EMS System;
 - (B) In a Model EMS System the continuing education program shall be reviewed and approved by the system continuing education coordinator and medical director; and
 - (C) In a Specialty Care Transport Program the continuing education program shall be reviewed and approved by Specialty Care Transport Program Continuing Education Coordinator and the medical director;
- (3) Instructional supplies and equipment, a record-keeping system detailing student attendance and performance, and facilities as defined by the North Carolina Medical Board pursuant to G.S. 143-514;
- (4) Educational programs offered in accordance with Rule .2901 of this Subchapter;
- (5) An Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" if offering educational programs that have not been reviewed and approved by a medical director of an EMS System or Specialty Care Transport Program; and
- (6) An educational plan approved by the OEMS addressing program components as defined by the North Carolina Medical Board pursuant to G.S. 143-514.

(c) An application for credentialing as a Continuing Education EMS Educational Institution shall be submitted to the OEMS for review. The application shall demonstrate that the applicant meets the requirements in Paragraph (b) of this Rule.

(d) Continuing Education EMS Educational Institution credentials shall be valid for a period not to exceed four years.

(e) For Continuing Education EMS Educational Institutions maintaining affiliation with a Model EMS System, credentials may be renewed without requirement for submission of an application.

Authority G.S. 143-508(d)(4).

10 NCAC 03D .3002 BASIC EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) Basic EMS Educational Institutions may offer MR, EMT, EMT-D, EMD, EMS-NP, EMS-PA, and MICN courses for which they have been credentialed by the OEMS.

(b) For initial courses, Basic EMS Educational Institutions shall have, at a minimum:

- (1) A Level I EMS Instructor as lead course instructor for MR, EMT, and EMT-D courses;
- (2) An Level I Instructor credentialed at the EMD level as lead course instructor for EMD courses;
- (3) Instructors for EMS-NP, EMS-PA, and MICN appointed by the EMS educational program coordinator and approved by the educational medical advisor;
- (4) A lead EMS educational program coordinator. This individual may be either a Level II EMS Instructor credentialed at or above the highest level of course offered by the institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor referenced in this Paragraph. These individuals may share the responsibilities of the lead EMS educational coordinator. The details of this option shall be defined in the educational plan required in Paragraph (b)(6) of this Rule. Basic EMS Educational Institutions offering only EMD courses may meet this requirement with a credentialed Level I Instructor credentialed at the EMD level;
- (5) An Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection";
- (6) An educational plan approved by the OEMS addressing program components as defined by the North Carolina Medical Board pursuant to G.S. 143-514; and
- (7) Instructional supplies and equipment, a record-keeping system detailing student attendance and performance, and facilities as defined by the North Carolina Medical Board pursuant to G.S. 143-514.

(c) For EMS continuing education programs, Basic EMS Educational Institutions shall meet the requirements defined in Paragraphs (a) and (b) of Rule .3001 of this Section.

(d) An application for credentialing as a Basic EMS Educational Institution shall be submitted to the OEMS for review. The proposal shall demonstrate that the applicant meets the requirements in Paragraphs (b) and (c) of this Rule.

(e) Basic EMS Educational Institution credentials shall be valid for a period not to exceed four years.

(f) For Basic EMS Educational Institutions maintaining affiliation with a Model EMS System, credentials may be renewed without requirement for submission of an application.

Authority G.S. 143-508(d)(4).

10 NCAC 03D .3003 ADVANCED EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) Advanced EMS Educational Institutions may offer all EMS educational programs for which they have been credentialed by the OEMS.

(b) For initial courses, Advanced EMS Educational Institutions shall have, at a minimum:

- (1) A Level I EMS Instructor as lead course instructor for MR, EMT, and EMT-D courses;
- (2) A Level I Instructor credentialed at the EMD level as lead course instructor for EMD courses;
- (3) Instructors for EMS-NP, EMS-PA, and MICN appointed by the EMS educational program coordinator and approved by the educational medical advisor;
- (4) A Level II EMS Instructor as lead instructor for EMT-I and EMT-P courses;
- (5) A lead EMS educational program coordinator. This individual may be either a Level II EMS Instructor credentialed at or above the highest level of course offered by the institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor referenced in this Paragraph. These individuals may share the responsibilities of the lead EMS educational coordinator. The details of this option shall be defined in the educational plan required in Paragraph (b)(7) of this Rule;
- (6) An Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection";
- (7) An educational plan approved by OEMS addressing program components as defined by the North Carolina Medical Board pursuant to G.S. 143-514; and
- (8) Instructional supplies and equipment, a record-keeping system detailing student attendance and performance, and facilities as defined by the North Carolina Medical Board pursuant to G.S. 143-514.

(c) For EMS continuing education programs, Advanced EMS Educational Institutions shall meet the requirements defined in Paragraphs (a) and (b) of Rule .3001 of this Section.

(d) An application for credentialing as an Advanced EMS Educational Institution shall be submitted to the OEMS for review. The application shall demonstrate that the applicant

meets the requirements in Paragraphs (b) and (c) of this Rule. Advanced EMS Educational Institutions holding current accreditation by a national EMS educational accreditation agency that has been recognized by OEMS may use this accreditation as documentation toward meeting the requirements of Paragraphs (b) and (c) of this Rule.

(e) Advanced Educational Institution credentials shall be valid for a period not to exceed four years.

(f) For Advanced EMS Educational Institutions maintaining affiliation with a Model EMS System, credentials may be renewed without requirement for submission of an application.

Authority G.S. 143-508(d)(4).

10 NCAC 03D .3004 TRANSITION FOR APPROVED TEACHING INSTITUTIONS

Approved Teaching Institutions under contract with the OEMS as of December 31, 2001, shall be credentialed as an EMS Educational Institution consistent with the existing level of approval through December 31, 2002. These institutions may continue to offer courses currently allowed under the contract while preparing for credentialing under these Rules.

Authority G.S. 143-508(b).

SECTION .3100 – ENFORCEMENT

10 NCAC 03D .3101 DENIAL, SUSPENSION, AMENDMENT, OR REVOCATION

(a) The Department may deny, suspend, or revoke the permit of an ambulance or EMS nontransporting vehicle if the EMS provider:

- (1) Fails to substantially comply with the requirements of Section .2600 of this Subchapter;
- (2) Obtains or attempts to obtain a permit through fraud or misrepresentation; or
- (3) Fails to provide emergency medical care within the defined EMS service area in a timely and professional manner.

(b) In lieu of suspension or revocation, the Department may issue a temporary permit for an ambulance or EMS nontransporting vehicle whenever the Department finds that:

- (1) The EMS provider to which that vehicle is assigned has substantially failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article;
- (2) There is a reasonable probability that the EMS provider can remedy the permit deficiencies within a length of time determined by the Department; or
- (3) There is a reasonable probability that the EMS provider will be willing and able to remain in compliance with the rules regarding vehicle permits for the foreseeable future.

(c) The Department shall give the EMS provider written notice of the temporary permit. This notice shall be given personally or by certified mail and shall set forth:

- (1) The duration of the temporary permit not to exceed 60 days;
- (2) A copy of the vehicle inspection form;

- (3) The statutes or rules alleged to be violated; and
- (4) Notice to the EMS provider's right to a contested case hearing on the temporary permit.

(d) The temporary permit shall be effective immediately upon its receipt by the EMS provider and shall remain in effect until the Department:

- (1) Restores the vehicle to full permitted status; or
- (2) Suspends or revokes the vehicle's permit.

(e) The Department may deny, suspend, or revoke the credentials of EMS personnel or EMS instructors for any of the following reasons:

- (1) Failure to comply with the applicable performance and credentialing requirements as found in this Subchapter;
- (2) Immoral conduct;
- (3) Making false statements or representations to the OEMS or willfully concealing information in connection with an application for credentials;
- (4) Being unable to perform as a professional with reasonable skill and safety to patients and the public by reason of illness, use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality;
- (5) Unprofessional conduct, including but not limited to a failure to comply with the rules relating to the proper function of credentialed EMS personnel or EMS instructors contained in this Subchapter or the performance of or attempt to perform a procedure which is detrimental to the health and safety of any person or which is beyond the scope of practice of credentialed EMS personnel or EMS instructors;
- (6) Conviction in any court of a crime involving moral turpitude, a conviction of a felony, or conviction of a crime involving the function of credentialed EMS personnel or EMS instructors;
- (7) By false representations obtaining or attempting to obtain money or anything of value from a patient;
- (8) Adjudication of mental incompetence;
- (9) Lack of professional competence to practice with a reasonable degree of skill and safety for patients including but not limited to a failure to perform a prescribed procedure, failure to perform a prescribed procedure competently, or performance of a procedure which is not within the scope of practice of credentialed EMS personnel or EMS instructors;
- (10) Making false statements or representations, willfully concealing information, or failing to respond within a reasonable period of time and in a reasonable manner to inquiries from the OEMS;
- (11) Testing positive for any substance, legal or illegal, which could impair the physical or psychological ability of the credentialed EMS

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personnel or EMS instructor to perform all required or expected functions while on duty;

(12) Representing or allowing others to represent that the credentialed EMS personnel or EMS instructor has a credential that the credentialed EMS personnel or EMS instructor does not in fact have; or

(13) Inappropriate use or disclosure of records or data associated with EMS Systems, Specialty Care Transport Programs, or patients.

(f) The Department may amend any EMS provider license by reducing it from a full license to a provisional license whenever the Department finds that:

- (1) The licensee has substantially failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article;
- (2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and
- (3) There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

(g) The Department shall give the licensee written notice of the amendment to the EMS Provider License. This notice shall be given personally or by certified mail and shall set forth:

- (1) The length of the provisional EMS provider license;
- (2) The factual allegations;
- (3) The statutes or rules alleged to be violated; and
- (4) Notice to the EMS provider's right to a contested case hearing on the amendment of the EMS provider license.

(h) The provisional EMS provider license shall be effective immediately upon its receipt by the licensee and shall be posted in a prominent location at the primary business location of the EMS provider, accessible to public view, in lieu of the full license. The provisional license shall remain in effect until the Department:

- (1) Restores the licensee to full licensure status; or
- (2) Revokes the licensee's license.

(i) The Department may revoke or suspend an EMS Provider License whenever the Department finds that the licensee:

- (1) Has substantially failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article, and it is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time;
- (2) Has substantially failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article, and although the licensee may be able to remedy the deficiencies within a reasonable period of time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future;
- (3) Has failed to comply with the provision of G.S. 131E, Article 7, and the rules adopted under that article that endanger the health, safety, or welfare of the patients cared for or transported by the licensee; or

(4) Obtained or attempted to obtain an ambulance permit, EMS nontransporting vehicle permit, or EMS Provider License through fraud or misrepresentation.

(j) The issuance of a provisional EMS Provider License is not a procedural prerequisite to the revocation or suspension of a license pursuant to Paragraph (i) of this Rule.

(k) The Department may amend, deny, suspend, or revoke the credential of an EMS educational institution for any of the following reasons:

- (1) Failure to substantially comply with the requirements of Section .3000 of this Subchapter; or
- (2) Obtaining or attempting to obtain a credential through fraud or misrepresentation.

(l) The Department may amend, deny, suspend, or revoke the approval of an EMS System or designation of a Model EMS System for any of the following reasons:

- (1) Failure to substantially comply with the requirements of Section .2600 of this Subchapter; or
- (2) Obtaining or attempting to obtain designation through fraud or misrepresentation.

(m) The Department may amend, deny, suspend, or revoke the designation of a Specialty Care Transport Program for any of the following reasons:

- (1) Failure to substantially comply with the requirements of Section .2700 of this Subchapter; or
- (2) Obtaining or attempting to obtain designation through fraud or misrepresentation.

Authority G.S. 131E-155.1(d); 131E-157(c); 131E-159(a); 143-508(d)(10).

10 NCAC 03D .3102 PROCEDURES FOR DENIAL, SUSPENSION, AMENDMENT, OR REVOCATION

Denial, Suspension, Amendment, or Revocation of credentials, licenses, permits, approvals, or designations shall follow the law regarding contested cases found in G.S. 150B.

Authority G.S. 143-508(d)(10).

SECTION .3200 – TRAUMA SYSTEM DEFINITIONS

10 NCAC 03D .3201 TRAUMA SYSTEM DEFINITIONS

The following definitions apply throughout this Subchapter:

- (1) "Advanced Trauma Life Support (ATLS)" refers to the course sponsored by the American College of Surgeons.
- (2) "ACS" stands for the American College of Surgeons.
- (3) "Affiliated Hospital" means a non-trauma center hospital that is owned by the trauma center such that a contract or other agreement exists between these facilities to allow for the diversion or transfer of the trauma center's

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patient population to this non-trauma center hospital.

(4) "Bypass" means the transport of an emergency medical services patient past an emergency medical services receiving facility for the purposes of accessing a designated trauma center or a higher-level trauma center.

(5) "Contingencies" are conditions placed on a trauma center's designation which, if unmet, can result in the loss or amendment of a hospital's designation.

(6) "Trauma Performance Improvement Program (TPIP)" means a system in which outcome data is used to modify the process of patient care and prevent repetition of adverse events.

(7) "Deficiency" is the failure to meet essential criteria for a trauma center's designation as specified in Section .3300 of this Subchapter, which can serve as the basis for a focused review or denial of a trauma center designation.

(8) "Department" means the North Carolina Department of Health and Human Services.

(9) "Diversion" means that a hospital of its own volition reroutes a trauma patient to a trauma center from the scene or referring hospital.

(10) "E-Code" is a numeric identifier that defines the cause of injury, taken from the International Classification of Diseases (ICD).

(11) "Focused Review" is an evaluation of the trauma center's corrective actions to remove contingencies (as the result of deficiencies) placed upon it following a renewal site visit.

(12) "Hospital" means a licensed facility as defined in G.S. 131E-176.

(13) "Immediately Available" implies the physical presence of the health professional in an appropriate location at the time of need by the trauma patient.

(14) "Lead RAC Agency" is the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma planning in a region.

(15) "Level I Trauma Center" is a regional resource trauma center that has the capability of providing leadership, research, and total care for every aspect of injury from prevention to rehabilitation.

(16) "Level II Trauma Center" is a hospital that provides definitive trauma care regardless of the severity of the injury but may not be able to provide the same comprehensive care as a Level I trauma center and does not have trauma research as a primary objective.

(17) "Level III Trauma Center" is a hospital that provides prompt assessment, resuscitation, emergency operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma center.

(18) "OEMS" means the Office of Emergency Medical Services.

(19) "Post Graduate Year Four (PGY4)" means any surgery resident having completed three clinical years of general surgical training. A pure laboratory year will not constitute a clinical year.

(20) "Promptly Available" implies the physical presence of health professionals in an appropriate location within a short period of time, which is defined by the trauma system (director) and continuously monitored by the performance improvement program.

(21) "RAC" stands for "Regional Advisory Committee" which is comprised of a Lead RAC Agency and a group representing trauma care providers and the community, for the purpose of regional trauma planning, establishing, and maintaining a coordinated trauma system.

(22) "RFP" stands for "Request for Proposal" and is a standardized state document that must be completed by each hospital seeking initial or renewal trauma center designation.

(23) "Revocation" means the removal of a trauma center designation for concerns related to patient morbidity/mortality and/or failure to meet essential criteria and/or recurrent contingencies.

(24) "Transfer Agreement" means a formal written agreement between two agencies specifying the appropriate transfer of patient populations delineating the conditions and methods of transfer.

(25) "Trauma Center" is a hospital facility designated by the State of North Carolina and distinguished by its ability to immediately manage, on a 24-hour basis, the severely injured patient or those at risk for severe injury.

(26) "Trauma Center Criteria" means essential or desirable characteristics to define Level I, II, or III trauma centers.

(27) "Trauma Center Designation" means a formalized process of approval in which a hospital voluntarily seeks to have its trauma care capabilities and performance evaluated by experienced on-site reviewers.

(28) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the trauma statewide database.

(29) "Trauma Patient" is any patient with an ICD-9-CM discharge diagnosis 800.00-959.9 excluding 905-909 (late effects of injury), 9100-924 (blisters, contusions, abrasions, and insect bites), and 930-939 (foreign bodies).

(30) "Trauma Program" means an administrative entity that includes the trauma service and coordinates other trauma related activities. It must also include, at a minimum, the trauma medical director, trauma program

manager/trauma coordinator, and trauma registrar. This program's reporting structure must give it the ability to interact with at least equal authority with other departments providing patient care.

(31) "Trauma Protocols" are standards for practice in a variety of situations within the trauma system.

(32) "Trauma Guidelines" are suggested standards for practice in a variety of situations within the trauma system.

(33) "Trauma Registry" is an OEMS-maintained database to provide information for analysis and evaluation of the quality of patient care, including epidemiological and demographic characteristics of trauma patients.

(34) "Trauma Service" means a clinical service established by the medical staff that has oversight of and responsibility for the care of the trauma patient.

(35) "Trauma System" means an integrated network that ensures that acutely injured patients are expeditiously taken to hospitals appropriate for their level of injury.

(36) "Trauma Team" means a group of health care professionals organized to provide coordinated and timely care to the trauma patient.

(37) "Triage" is a predetermined schematic for patient distribution based upon established medical needs.

(e) Remain a current provider in the ACS' Advanced Trauma Life Support Course and in the provision of trauma-related instruction to other health care personnel; and

(f) Be involved with trauma research and the publication of results and presentations;

(4) A full-time trauma nurse coordinator (TNC)/program manager (TPM) who is a registered nurse, licensed by the North Carolina Board of Nursing;

(5) A full-time trauma registrar (TR) who has a working knowledge of medical terminology, is able to operate a personal computer, and has demonstrated the ability to extract data from the medical record;

(6) A hospital department/division/section for general surgery, neurological surgery, emergency medicine, anesthesiology, and orthopaedic surgery, with designated chair or physician liaison to the trauma program for each;

(7) Clinical capabilities in general surgery with two separate posted call schedules. One shall be for trauma, one for general surgery. In those instances where a physician may simultaneously be listed on both schedules, there must be a defined back-up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. The trauma service director shall specify, in writing, the specific credentials that each back-up surgeon must have. These, at a minimum, must state that the back-up surgeon has surgical privileges at the trauma center and is boarded or eligible in general surgery (with board certification in general surgery within five years of completing residency). If a trauma surgeon is simultaneously on call at more than one hospital, there shall be a defined, posted trauma surgery back-up call schedule composed of surgeons credentialed to serve on the trauma panel;

(8) Response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:

(a) An in-house Post Graduate Year 4 or senior general surgical resident, at a minimum, who is a member of that hospital's surgical residency program and responds within 20 minutes of notification;

(b) A trauma attending whose presence at the patient's bedside within 20 minutes of notification is documented and who participates in therapeutic decisions and is present at all operative procedures;

(c) An emergency physician who is present in the emergency department

Authority G.S. 131E-162.

SECTION .3300 – TRAUMA CENTER STANDARDS AND APPROVAL

10 NCAC 03D .3301 LEVEL I TRAUMA CENTER CRITERIA

To receive designation as a Level I Trauma Center, a hospital shall have the following:

(1) A trauma program and a trauma service which have been operational for at least six months prior to application for designation;

(2) Membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry for at least six months prior to submitting a Request for Proposal;

(3) Trauma medical director who is a board-certified general surgeon. The trauma medical director must:

(a) Have a minimum of three years clinical experience on a trauma service or trauma fellowship training;

(b) Serve on the center's trauma service;

(c) Participate in providing care to patients with life-threatening or urgent injuries;

(d) Participate in the North Carolina Chapter of the ACS Committee on Trauma as well as other regional and national trauma organizations;

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24 hours per day who is either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine). Emergency physicians caring only for pediatric patients may, as an alternative, be boarded in pediatric emergency medicine. These physicians must be board-certified within five years after successful completion of a residency and serve as a designated member of the trauma team until the arrival of the trauma surgeon;

(d) Neurosurgery and orthopaedic surgery specialists who are never simultaneously on-call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, unless there is either an in-house attending neurosurgeon/orthopaedic surgeon, a Post Graduate Year 2 or higher in-house neurosurgery/orthopaedic surgery resident or an in-house trauma surgeon or emergency physician as long as the institution can document management guidelines and annual continuing medical education for neurosurgical/orthopaedic emergencies. There must be a specified written back-up on the call schedule whenever the neurosurgical/orthopaedist is simultaneously on-call at a hospital other than the trauma center;

(e) An in-house anesthesiologist or a Clinical Anesthesiology Year 3 (CA3) resident as long as an anesthesiologist on-call is advised and promptly available if requested by the trauma team leader, and;

(f) Registered nursing personnel trained in the care of trauma patients;

(9) A written credentialing process established by the department of surgery to approve physician assistants and attending general surgeons covering the trauma service. The surgeons must have a minimum of board certification in general surgery within five years of completing residency;

(10) Standard written protocols relating to trauma management must be formulated and routinely updated;

(11) Criteria to ensure team activation prior to arrival of trauma/burn patients to include, at a minimum, the following:

(a) Shock;

(b) Respiratory distress;

(c) Airway compromise;

(d) Unresponsiveness (Glasgow Coma Scale less than 8) with potential for multiple injuries; and

(e) Gunshot wound to head, neck, or torso;

(12) Prompt surgical evaluation shall be considered based upon the following criteria:

(a) Proximal amputations;

(b) Burns meeting institutional transfer criteria;

(c) Vascular compromise;

(d) Crush to chest or pelvis;

(e) Two or more proximal long bone fractures; and

(f) Spinal cord injury;

(13) Prompt surgical consults shall be considered based upon the following criteria:

(a) Falls greater than 20 feet;

(b) Pedestrian struck by motor vehicle;

(c) Motor vehicle crash with:

(i) Ejection (includes motorcycle);

(ii) Rollover;

(iii) Speed greater than 40 mph; or

(iv) Death at the scene; and

(d) Extremes of age, < 5 or > 70 years;

(14) Clinical capabilities (promptly available if requested by the trauma team leader, with a posted on-call schedule), to include individuals credentialed in the following:

(a) Cardiac surgery;

(b) Critical care;

(c) Hand surgery;

(d) Microvascular/replant surgery;

(e) Neurosurgery (The neurosurgeon must be dedicated to one hospital or a back-up call schedule must be available. If fewer than 25 emergency neurosurgical trauma operations are done in a year, and the neurosurgeon is dedicated only to that hospital, then a published back-up call list is not necessary.);

(f) Obstetrics/gynecologic surgery;

(g) Ophthalmic surgery;

(h) Oral/maxillofacial surgery;

(i) Orthopaedics (dedicated to one hospital or a back-up call schedule must be available);

(j) Pediatric surgery;

(k) Plastic surgery;

(l) Radiology;

(m) Thoracic surgery; and

(n) Urologic surgery;

(15) An emergency department which has at a minimum:

(a) A designated physician director who is board-certified or prepared in emergency medicine (by the

American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);

(b) 24-hour-per-day staffing by physicians physically present in the Emergency Department such that:

(i) At least one physician on every shift in the Emergency Department is either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) to serve as the designated member of the trauma team at least until the arrival of the trauma surgeon. Emergency physicians caring only for pediatric patients may, as an alternative, be boarded in pediatric emergency medicine. All these physicians must be board-certified within five years after successful completion of a residency;

(ii) All remaining emergency physicians, if not board-certified or prepared in emergency medicine as outlined in Sub-item (15)(b)(i) of this Rule, are board-certified, or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine, with each being board-certified within five years after successful completion of a residency; and

(iii) All emergency physicians practice emergency medicine as their primary specialty;

(c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;

(d) Equipment for patients of all ages to include:

(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);

(ii) Pulse oximetry;

(iii) End-tidal carbon dioxide determination equipment;

(iv) Suction devices;

(v) Electrocardiograph-oscilloscope-defibrillator with internal paddles;

(vi) Apparatus to establish central venous pressure monitoring;

(vii) Intravenous fluids and administration devices to include large bore catheters and intraosseous infusion devices;

(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, and thoracostomy, peritoneal lavage, and central line insertion;

(ix) Apparatus for gastric decompression;

(x) 24-hour-per-day x-ray capability;

(xi) Two-way communication equipment for communication with the emergency transport system;

(xii) Skeletal traction devices, including capability for cervical traction;

(xiii) Arterial catheters;

(xiv) Thermal control equipment for patients;

(xv) Thermal control equipment for blood and fluids;

(xvi) Rapid infuser system;

(xvii) Broselow tape;

(xviii) Sonography; and

(xix) Doppler;

(16) An operating suite which is immediately available 24 hours per day and has at a minimum:

(a) 24-hour-per-day immediate availability of in-house staffing;

(b) Equipment for patients of all ages to include:

(i) Cardiopulmonary bypass capability;

(ii) Operating microscope;

(iii) Thermal control equipment for patients

(iv) Thermal control equipment for blood and fluids;

(v) 24-hour-per-day x-ray capability including c-arm image intensifier;

(vi) Endoscopes and bronchoscopes;

(vii) Craniotomy instruments;

(viii) Capability of fixation of long-bone and pelvic fractures; and

(ix) Rapid infuser system;

(17) A postanesthetic recovery room or surgical intensive care unit which has at a minimum:

(a) 24-hour-per-day in-house staffing by registered nurses;

(b) Equipment for patients of all ages to include:

(i) Capability for resuscitation and continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Capability for continuous monitoring of intracranial pressure;

(iii) Pulse oximetry;

(iv) End-tidal carbon dioxide determination capability;

(v) Thermal control equipment for patients; and

(vi) Thermal control equipment for blood and fluids;

(18) An intensive care unit for trauma patients which has at a minimum:

(a) A designated surgical director for trauma patients;

(b) A physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on-call for the Emergency Department;

(c) Ratio of one nurse per two patients on each shift;

(d) Equipment for patients of all ages to include:

(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, and pocket masks);

(ii) Oxygen source with concentration controls;

(iii) Cardiac emergency cart;

(iv) Temporary, transvenous pacemaker;

(v) Electrocardiograph-oscilloscope-defibrillator with internal paddles;

(vi) Cardiac output monitoring capability;

(vii) Electronic pressure monitoring capability;

(viii) Mechanical ventilator;

(ix) Patient weighing devices;

(x) Pulmonary function measuring devices;

(xi) Temperature control devices; and

(xii) Intracranial pressure monitoring devices;

(e) Within 30 minutes of request, be able to perform blood gas measurements, hematocrit level, and chest x-ray studies;

(19) Acute hemodialysis capability;

(20) Physician-directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;

(21) Acute spinal cord management capability or written transfer agreement with a hospital capable of caring for a spinal cord injured patient;

(22) Radiological capabilities which has at a minimum:

(a) 24-hour-per-day in-house radiology technologist;

(b) 24-hour-per-day in-house computerized tomography technologist;

(c) Sonography;

(d) Computed tomography;

(e) Angiography;

(f) Magnetic resonance imaging; and

(g) Resuscitation equipment to include: airway management and IV therapy;

(23) Respiratory therapy services available in-house 24 hours per day;

(24) 24-hour-per-day clinical laboratory service, which must include at a minimum:

(a) Standard analysis of blood, urine, and other body fluids, including micro-sampling when appropriate;

(b) Blood-typing and cross-matching;

(c) Coagulation studies;

(d) Comprehensive blood bank or access to community central blood bank with storage facilities;

(e) Blood gases and pH determination; and

(f) Microbiology;

(25) A rehabilitation service which provides at a minimum:

(a) A professional staff trained in rehabilitation care of critically injured patients;

(b) For major trauma patients, functional assessment and recommendations regarding short and long term rehabilitation needs within one week of the patient's admission to the

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hospital or as soon as hemodynamically stable;

(c) Full in-house rehabilitation service or a written transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;

(d) Physical, occupational, speech therapies, and social services; and

(e) Substance evaluation and counseling capability;

(26) A performance improvement program, as outlined in the document "Performance Improvement Guidelines for North Carolina Trauma Centers," which is incorporated by reference and includes:

(a) A state-approved trauma registry whose data is submitted to the OEMS at least quarterly, which includes all trauma patients seen at the trauma center itself or those that are routinely diverted or transferred to its affiliated hospital;

(b) Morbidity and mortality reviews to include all trauma deaths;

(c) Trauma performance committee that meets at least quarterly, to include physicians, nurses, pre-hospital personnel, and a variety of other healthcare providers which reviews policies, procedures, and system issues and whose members or designee attends at least 50% of the regular meetings;

(d) Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, neurosurgery, orthopaedics, emergency medicine, anesthesiology, and other specialty physicians, as needed, specific to the case, and the trauma nurse coordinator/program manager and whose members or designee attends at least 50% of the regular meetings;

(e) Identification of discretionary and non-discretionary audit filters;

(f) Documentation and review of times and reasons for trauma-related diversion of patients from the scene or referring hospital;

(g) Documentation and review of response times for trauma surgeons (who must demonstrate 80% compliance), neurosurgeons, anesthesiologists or airway managers, and orthopaedists;

(h) Appropriate trauma team notification;

(i) Review of pre-hospital trauma care to include dead-on-arrivals; and

(j) Review of times and reasons for transfer of injured patients;

(27) An outreach program to include:

(a) Written transfer agreements to address the transfer and receipt of trauma patients;

(b) Programs for physicians within the community and within the referral area (to include telephone and on-site consultations) about how to access the trauma center resources and refer patients within the system;

(c) Development of a Regional Advisory Committee (RAC) as specified in Rule .3502 of this Subchapter;

(d) Development of regional criteria for coordination of trauma care;

(e) Assessment of trauma system operations at the regional level; and

(f) ATLS;

(28) A program of injury prevention and public education to include:

(a) Epidemiology research to include studies in injury control, collaboration with other institutions on research, monitoring progress of prevention programs, and consultation with qualified researchers on evaluation measures;

(b) Surveillance methods to include trauma registry data, special Emergency Department and field collection projects;

(c) Designation of a injury prevention coordinator; and

(d) Outreach activities, program development, information resources, and collaboration with existing national, regional, and state trauma programs;

(29) A trauma research program designed to produce new knowledge applicable to the care of injured patients to include:

(a) Identifiable institutional review board process;

(b) Extramural educational presentations which must include 12 education/outreach presentations over a three-year period; and

(c) 10 peer-reviewed publications over a three-year period that could come from any aspect of the trauma program;

(30) A documented continuing education program for staff physicians, nurses, allied health personnel, and community physicians to include:

(a) A general surgery residency program;

(b) Current board certification for neurosurgeons and orthopaedics;

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(c) 20 hours of Category I or II trauma-related continuing medical education every two years for all attending general surgeons on the trauma service, orthopaedists, and neurosurgeons, with at least 50% of this being extramural;

(d) 20 hours of Category I or II trauma-related continuing medical education every two years for all emergency physicians, with at least 50% of this being extramural;

(e) Advanced Trauma Life Support (ATLS) completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS;

(f) 20 hours of Category I trauma-related continuing medical education (beyond in-house in-services) every two years for the trauma nurse coordinator/program manager;

(g) 16 hours of trauma-registry-related or trauma-related continuing education every two years, as deemed appropriate by the trauma nurse coordinator/program manager for the trauma registrar;

(h) At least an 80% compliance rate for 16 hours of trauma-related continuing education (as approved by the trauma nurse coordinator/program manager) every two years related to trauma care for RN's and LPN's in transport programs, Emergency Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator/program manager; and

(i) 16 hours of trauma-registry-related or trauma-related continuing education every two years for physician assistants and mid-level practitioners routinely caring for trauma patients.

(3) A trauma medical director who is a board-certified general surgeon. The trauma medical director must:

- (a) Have a minimum of three years clinical experience on a trauma service and/or trauma fellowship training;
- (b) Serve on the center's trauma service;
- (c) Participate in providing care to patients with life-threatening urgent injuries;
- (d) Participate in the North Carolina Chapter of the ACS' Committee on Trauma as well as other regional and national trauma organizations; and
- (e) Remain a current provider in the ACS' Advanced Trauma Life Support Course and in the provision of trauma-related instruction to other health care personnel;

(4) A full-time trauma nurse coordinator (TNC)/program manager (TPM) who is a registered nurse, licensed by the North Carolina Board of Nursing;

(5) A full-time trauma registrar (TR) who has a working knowledge of medical terminology, is able to operate a personal computer, and has demonstrated the ability to extract data from the medical record;

(6) A hospital department/division/section for general surgery, neurological surgery, emergency medicine, anesthesiology, and orthopaedic surgery, with designated chair or physician liaison to the trauma program for each;

(7) Clinical capabilities in general surgery with two separate posted call schedules. One shall be for trauma, one for general surgery. In those instances where a physician may simultaneously be listed on both schedules, there must be a defined back-up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. The trauma service director shall specify, in writing, the specific credentials that each back-up surgeon must have. These, at a minimum, must state that the back-up surgeon has surgical privileges at the trauma center and is boarded or eligible in general surgery (with board certification in general surgery within five years of completing residency). If a trauma surgeon is simultaneously on call at more than one hospital, there shall be a defined, posted trauma surgery back-up call schedule composed of surgeons credentialed to serve on the trauma panel;

(8) Response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:

- (a) A trauma attending whose presence at the patient's bedside within 20

Authority G.S. 131E-162.

10 NCAC 03D .3302 LEVEL II TRAUMA CENTER CRITERIA

To receive designation as a Level II Trauma Center, a hospital shall have the following:

- (1) A trauma program and a trauma service which have been operational for at least six months prior to application for designation;
- (2) Membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry for at least six months prior to submitting a Request for Proposal;

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minutes of notification is documented and who participates in therapeutic decisions and is present at all operative procedures;

(b) An emergency physician who is present in the Emergency Department 24 hours per day who is either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board-certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This physician must be board-certified within five years after successful completion of a residency and serves as a designated member of the trauma team until the arrival of the trauma surgeon;

(c) Neurosurgery and orthopaedic surgery specialists who are never simultaneously on-call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, as long as there is either an in-house attending neurosurgeon/orthopaedic surgeon; a Post Graduate Year 2 or higher in-house neurosurgery/orthopaedic surgery resident; or in-house emergency physician or the on-call trauma surgeon as long as the institution can document management guidelines and annual continuing medical education for neurosurgical/orthopaedic emergencies. There must be a specified written back-up on the call schedule whenever the neurosurgeon/orthopaedic surgeon is simultaneously on-call at a hospital other than the trauma center; and

(d) An in-house anesthesiologist or a Clinical Anesthesiology Year 3 (CA3) resident unless an anesthesiologist on-call is advised and promptly available after notification or an in-house CRNA under physician supervision, practicing in accordance with G.S. 90-171.20(7)e., pending the arrival of the anesthesiologist;

(9) A written credentialing process established by the Department of Surgery to approve physician assistants and attending general surgeons covering trauma service. The surgeons must have a minimum of board certification in general surgery within five years of completing residency;

(10) Standard written protocols relating to trauma care management must be formulated and routinely updated;

(11) Criteria to ensure team activation prior to arrival of trauma/burn patients, to include at a minimum, the following:

- (a) Shock;
- (b) Respiratory distress;
- (c) Airway compromise;
- (d) Unresponsiveness (Glasgow Coma Scale less than 8) with potential for multiple injuries; and
- (e) Gunshot wound to head, neck, or torso;

(12) Prompt surgical evaluation shall be considered based upon the following criteria:

- (a) Proximal amputations;
- (b) Burns meeting institutional transfer criteria;
- (c) Vascular compromise;
- (d) Crush to chest or pelvis;
- (e) Two or more proximal long bone fractures; and
- (f) Spinal cord injury;

(13) Prompt surgical consults shall be considered based upon the following criteria:

- (a) Falls greater than 20 feet;
- (b) Pedestrian struck by motor vehicle;
- (c) Motor vehicle crash with:
 - (i) Ejection (includes motorcycle);
 - (ii) Rollover;
 - (iii) Speed greater than 40 mph; or
 - (iv) Death at the scene;
- (d) Extremes of age, < 5 or > 70 years;

(14) Clinical capabilities (promptly available if requested by the trauma team leader, with a posted on-call schedule), to include individuals credentialed in the following:

- (a) Critical care;
- (b) Hand surgery;
- (c) Neurosurgery (The neurosurgeon must be dedicated to one hospital or a back-up call schedule must be available. If fewer than 25 emergency neurosurgical trauma operations are done in a year, and the neurosurgeon is dedicated only to that hospital, then a published back-up call list is not necessary.)
- (d) Obstetrics/gynecologic surgery;
- (e) Ophthalmic surgery;
- (f) Oral maxillofacial surgery;
- (g) Orthopaedics (dedicated to one hospital or a back-up call schedule must be available);
- (h) Plastic surgery;
- (i) Radiology;

(j) Thoracic surgery; and
(k) Urologic surgery;

(15) An Emergency Department which has at a minimum:

- (a) A designated physician director who is board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);
- (b) 24-hour-per-day staffing by physicians physically present in the Emergency Department who:
 - (i) Are either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine or board-certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine). This physician must be board-certified within five years after successful completion of a residency;
 - (ii) Are designated members of the trauma team; and
 - (iii) Practice emergency medicine as their primary specialty;
- (c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;
- (d) Equipment for patients of all ages to include:
 - (i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);
 - (ii) Pulse oximetry;
 - (iii) End-tidal carbon dioxide determination equipment;
 - (iv) Suction devices;
 - (v) Electrocardiograph-oscilloscope-defibrillator with internal paddles;
 - (vi) Apparatus to establish central venous pressure monitoring;

(vii) Intravenous fluids and administration devices to include large bore catheters and intraosseous infusion devices;

(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, and thoracostomy, peritoneal lavage, and central line insertion;

(ix) Apparatus for gastric decompression;

(x) 24-hour-per-day x-ray capability;

(xi) Two-way communication equipment for communication with the emergency transport system;

(xii) Skeletal traction devices, including capability for cervical traction;

(xiii) Arterial catheters;

(xiv) Thermal control equipment for patients; and

(xv) Thermal control equipment for blood and fluids;

(xvi) Rapid infuser system;

(xvii) Broselow tape;

(xviii) Sonography; and

(xix) Doppler;

(16) An operating suite which is immediately available 24 hours per day and which has at a minimum:

- (a) 24-hour-per-day immediate availability of in-house staffing;
- (b) Equipment for patients of all ages to include:
 - (i) Thermal control equipment for patients;
 - (ii) Thermal control equipment for blood and fluids;
 - (iii) 24-hour-per-day x-ray capability, including c-arm image intensifier;
 - (iv) Endoscopes and bronchoscopes;
 - (v) Craniotomy instruments; and
 - (vi) Capability of fixation of long-bone and pelvic fractures;
 - (vii) Rapid infuser system;

(17) A postanesthetic recovery room or surgical intensive care unit which has at a minimum:

- (a) 24-hour-per-day in-house staffing by registered nurses;
- (b) Equipment for patients of all ages to include:
 - (i) Capability for resuscitation and continuous monitoring

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of temperature, hemodynamics, and gas exchange;

(ii) Capability for continuous monitoring of intracranial pressure;

(iii) Pulse oximetry;

(iv) End-tidal carbon dioxide determination capability;

(v) Thermal control equipment for patients; and

(vi) Thermal control equipment for blood and fluids;

(18) An intensive care unit for trauma patients which has at a minimum:

(a) A designated surgical director of trauma patients;

(b) A physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on-call for the Emergency Department;

(c) Ratio of one nurse per two patients on each shift;

(d) Equipment for patients of all ages to include:

(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, and pocket masks);

(ii) Oxygen source with concentration controls;

(iii) Cardiac emergency cart;

(iv) Temporary transvenous pacemaker;

(v) Electrocardiograph-oscilloscope-defibrillator with internal paddles;

(vi) Cardiac output monitoring capability;

(vii) Electronic pressure monitoring capability;

(viii) Mechanical ventilator;

(ix) Patient weighing devices;

(x) Pulmonary function measuring devices;

(xi) Temperature control devices; and

(xii) Intracranial pressure monitoring devices;

(e) Within 30 minutes of request, be able to perform blood gas measurements, hematocrit level, and chest x-ray studies;

(19) Acute hemodialysis capability or utilization of a written transfer agreement;

(20) Physician-directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;

(21) Acute spinal cord management capability or written transfer agreement with a hospital capable of caring for a spinal cord injured patient;

(22) Radiological capabilities which has at a minimum:

(a) 24-hour-per-day in-house radiology technologist;

(b) 24-hour-per-day in-house computerized tomography technologist;

(c) Sonography;

(d) Computed tomography;

(e) Angiography; and

(f) Resuscitation equipment to include airway management and IV therapy;

(23) Respiratory therapy services available in-house 24 hours per day;

(24) 24-hour-per-day clinical laboratory service which must include at a minimum:

(a) Standard analysis of blood, urine, and other body fluids, including micro-sampling when appropriate;

(b) Blood-typing and cross-matching;

(c) Coagulation studies;

(d) Comprehensive blood bank or access to a community central blood bank with storage facilities;

(e) Blood gases and pH determination; and

(f) Microbiology;

(25) A rehabilitation service which provides at a minimum:

(a) A professional staff trained in rehabilitation care of critically injured patients;

(b) For major trauma patients, functional assessment and recommendation regarding short- and long-term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable;

(c) Full in-house rehabilitation service or a written transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;

(d) Physical, occupational, speech therapies, and social services; and

(e) Substance abuse evaluation and counseling capability;

(26) A performance improvement program, as outlined in the document "Performance Improvement Guidelines for North Carolina Trauma Centers," which is incorporated by reference and includes:

(a) A state-approved trauma registry whose data is submitted to the OEMS at least quarterly, which includes all trauma patients seen at the trauma center itself or those that are routinely diverted or transferred to its affiliated hospital;

(b) Morbidity and mortality reviews to include all trauma deaths;

(c) Trauma performance committee that meets at least quarterly, to include physicians, nurses, pre-hospital personnel, and a variety of other healthcare providers which reviews policies, procedures, and system issues and whose members or designee attends at least 50% of the regular meetings;

(d) Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, neurosurgery, orthopaedics, emergency medicine, anesthesiology, and other specialty physicians, as needed, specific to the case, and the trauma nurse coordinator/program manager and whose members or designee attends at least 50% of the regular meetings;

(e) Identification of discretionary and non-discretionary audit filters;

(f) Documentation and review of times and reasons for trauma-related diversion of patients from the scene or referring hospital;

(g) Documentation and review of response times for trauma surgeons (who must demonstrate 80% compliance), neurosurgeons, anesthesiologist or airway managers, and orthopaedists;

(h) Appropriate trauma team notification;

(i) Review of pre-hospital trauma care to include dead-on-arrivals; and

(j) Review of times and reasons for transfer of injured patients;

(27) An outreach program to include:

(a) Written transfer agreements to address the transfer and receipt of trauma patients;

(b) Programs for physicians within the community and within the referral area (to include telephone and on-site consultations) about how to access the trauma center resources and refer patients within the system;

(c) Development of a Regional Advisory Committee (RAC) as specified in Rule .3502 of this Subchapter;

(d) Development of regional criteria for coordination of trauma care; and

(e) Assessment of trauma system operations at the regional level;

(28) A program of injury prevention and public education to include:

(a) Designation of an injury prevention coordinator; and

(b) Outreach activities, program development, information resources, and collaboration with existing national, regional, and state trauma programs;

(29) A documented continuing education program for staff physicians, nurses, allied health personnel, and community physicians to include:

(a) Current board certification for neurosurgeons and orthopaedists;

(b) 20 hours of Category I or II trauma-related continuing medical education every two years for all attending general surgeons on the trauma service, orthopaedics, and neurosurgeons, with at least 50% of this being extramural;

(c) 20 hours of Category I or II trauma-related continuing medical education every two years for all emergency physicians, with at least 50% of this being extramural;

(d) Advanced Trauma Life Support (ATLS) completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS.

(e) 20 hours of Category I trauma-related continuing medical education (beyond in-house in-services) every two years for the trauma nurse coordinator/program manager;

(f) 16 hours of trauma-registry-related or trauma-related continuing education every two years, as deemed appropriate by the trauma nurse coordinator/program manager, for the trauma registrar;

(g) at least 80% compliance rate for 16 hours of trauma-related continuing education (as approved by the trauma nurse coordinator/program manager) every two years related to trauma care for RN's and LPN's in transport programs, Emergency Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator/program manager; and

(h) 16 contact hours of trauma-related continuing education every two years for physician assistants and mid-level

practitioners routinely caring for trauma patients.

Authority G.S. 131E-162.

10 NCAC 03D .3303 LEVEL III TRAUMA CENTER CRITERIA

To receive designation as a Level III Trauma Center, a hospital shall have the following:

- (1) A trauma program and a trauma service which have been operational for at least six months prior to application for designation;
- (2) Membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry for at least six months prior to submitting a Request for Proposal application;
- (3) A trauma medical director who is a board-certified general surgeon. The trauma medical director must:
 - (a) Serve on the center's trauma service;
 - (b) Participate in providing care to patients with life-threatening or urgent injuries;
 - (c) Participate in the North Carolina Chapter of the ACS' Committee on Trauma;
 - (d) Remain a current provider in the ACS' Advanced Trauma Life Support Course in the provision of trauma-related instruction to other health care personnel;
- (4) A designated trauma nurse coordinator (TNC)/program manager (TPM) who is a registered nurse, licensed by the North Carolina Board of Nursing;
- (5) A trauma registrar (TR) who has a working knowledge of medical terminology, is able to operate a personal computer, and has demonstrated the ability to extract data from the medical record;
- (6) A hospital department/division/section for general surgery, emergency medicine, anesthesiology, and orthopaedic surgery, with designated chair or physician liaison to the trauma program for each;
- (7) Clinical capabilities in general surgery with a written posted call schedule that indicates who is on call for both trauma and general surgery. If a trauma surgeon is simultaneously on call at more than one hospital, there must be a defined, posted trauma surgery back-up call schedule composed of surgeons credentialed to serve on the trauma panel. The trauma service director shall specify, in writing, the specific credentials that each back-up surgeon must have. These, at a minimum, must state that the back-up surgeon has surgical privileges at the trauma center and is boarded or eligible in general surgery (with board certification in general surgery within five years of completing residency);
- (8) Response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:
 - (a) A trauma attending whose presence at the patient's bedside within 30 minutes of notification is documented and who participates in therapeutic decisions and is present at all operative procedures;
 - (b) An emergency physician who is present in the Emergency Department 24 hours per day who is either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board-certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This physician must be board-certified within five years after successful completion of a residency and serve as a designated member of the trauma team until the arrival of the trauma surgeon;
 - (c) An anesthesiologist who is on-call and promptly available after notification by the trauma team leader or an in-house CRNA under physician supervision, practicing in accordance with G.S. 90-171.20(7)e., pending the arrival of the anesthesiologist within 20 minutes of notification;
- (9) A written credentialing process established by the department of surgery to approve physician assistants and attending general surgeons covering the trauma service. These surgeons must have a minimum of board certification in general surgery within five years of completing residency;
- (10) Standard written protocols relating to trauma care management must be formulated and routinely updated;
- (11) Criteria to ensure team activation prior to arrival of trauma/burn patients, to include at a minimum, the following:
 - (a) Shock;
 - (b) Respiratory distress;
 - (c) Airway compromise;
 - (d) Unresponsiveness (Glasgow Coma Scale less than 8) with potential for multiple injuries; and
 - (e) Gunshot wound to head, neck, or torso;
- (12) Prompt surgical evaluation shall be considered based upon the following criteria:
 - (a) Proximal amputations;

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(b) Burns meeting institutional transfer criteria;
(c) Vascular compromise;
(d) Crush to chest or pelvis;
(e) Two or more proximal long bone fractures; and
(f) Spinal cord injury;

(13) Prompt surgical consults shall be considered based upon the following criteria:
(a) Falls greater than 20 feet;
(b) Pedestrian struck by motor vehicle;
(c) Motor vehicle crash with:
(i) Ejection (includes motorcycle);
(ii) Rollover;
(iii) Speed greater than 40 mph; or
(iv) Death at the scene;
(d) Extremes of age, < 5 or > 70 years;

(14) Clinical capabilities (promptly available within 30 minutes if requested by the trauma team leader, with a posted on-call schedule) to include individuals credentialed in the following:
(a) Orthopaedics; and
(b) Radiology;

(15) An Emergency Department which has at a minimum:
(a) A designated physician director who is board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);
(b) 24-hour-per-day staffing by physicians physically present in the Emergency Department who:
(i) Are either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board-certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine. This physician must be board-certified within five years after successful completion of a residency;
(ii) Are designated members of a trauma team; and
(iii) Practice emergency medicine as their primary specialty;

(c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;

(d) Resuscitation equipment for patients of all ages to include:
(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);
(ii) Pulse oximetry;
(iii) End-tidal carbon dioxide determination equipment;
(iv) Suction devices;
(v) Electrocardiograph-oscilloscope-defibrillator with internal paddles;
(vi) Apparatus to establish central venous pressure monitoring;
(vii) Intravenous fluids and administration devices to include large bore catheters and intraosseous infusion devices;
(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, and thoracostomy, peritoneal lavage, and central line insertion;
(ix) Apparatus for gastric decompression;
(x) 24-hour-per-day x-ray capability;
(xi) Two-way communication equipment for communication with the emergency transport system;
(xii) Skeletal traction devices;
(xiii) Thermal control equipment for patients; and
(xiv) Thermal control equipment for blood and fluids;
(xv) Rapid infuser system;
(xvi) Broselow tape; and
(xvii) Doppler;

(16) An operating suite which has at a minimum:
(a) Personnel available 24 hours a day, on-call, and available within 30 minutes of notification unless in-house;
(b) Age-specific equipment to include:
(i) Thermal control equipment for patients;

(ii) Thermal control equipment for blood and fluids;

(iii) 24-hour-per-day x-ray capability, including c-arm image intensifier;

(iv) Endoscopes and bronchoscopes;

(v) Equipment for long bone and pelvic fracture fixation; and

(vi) Rapid infuser system;

(17) A postanesthetic recovery room or surgical intensive care unit which has at a minimum:

(a) 24-hour-per-day availability of registered nurses within 30 minutes from inside or outside the hospital;

(b) Equipment for patients of all ages to include:

(i) Capability for resuscitation and continuous monitoring of temperature, hemodynamics, and gas exchange;

(ii) Pulse oximetry;

(iii) End-tidal carbon dioxide determination;

(iv) Thermal control equipment for patients; and

(v) Thermal control equipment for blood and fluids;

(18) An intensive care unit for trauma patients which has at a minimum:

(a) A designated surgical director of trauma patients;

(b) A physician on duty in the intensive care unit 24-hours-per-day or immediately available from within the hospital (which may be a physician who is the sole physician on-call for the Emergency Department);

(c) Equipment for patients of all ages to include:

(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators and pocket masks);

(ii) Oxygen source with concentration controls;

(iii) Cardiac emergency cart;

(iv) Temporary transvenous pacemaker;

(v) Electrocardiograph-oscilloscope-defibrillator;

(vi) Cardiac output monitoring capability;

(vii) Electronic pressure monitoring capability;

(viii) Mechanical ventilator;

(ix) Patient weighing devices;

(x) Pulmonary function measuring devices; and

(xi) Temperature control devices;

(d) Within 30 minutes of request, be able to perform blood gas measurements, hematocrit level, and chest x-ray studies;

(19) Acute hemodialysis capability or utilization of a written transfer agreement;

(20) Physician-directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;

(21) Acute spinal cord management capability or written transfer agreement with a hospital capable of caring for a spinal cord injured patient;

(22) Acute head injury management capability or written transfer agreement with a hospital capable of caring for a head injury;

(23) Radiological capabilities which have at a minimum:

(a) Radiology technologist available within 30 minutes of notification or documentation that procedures are available within 30 minutes;

(b) If the capability of computed tomography exists in the hospital, the computed tomography technologist must be available within 30 minutes of notification;

(c) Sonography; and

(d) Resuscitation equipment to include airway management and IV therapy;

(24) Respiratory therapy services on-call 24 hours per day;

(25) 24-hour-per-day clinical laboratory service which must include at a minimum:

(a) Standard analysis of blood, urine, and other body fluids, including micro-sampling when appropriate;

(b) Blood-typing and cross-matching;

(c) Coagulation studies;

(d) Comprehensive blood bank or access to a community central blood bank with storage facilities;

(e) Blood gases and pH determination; and

(f) Microbiology;

(26) Full in-house rehabilitation service or written transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;

(27) Physical therapy and social services;

(28) A performance improvement program, as outlined in the document "Performance Improvement Guidelines for North Carolina Trauma Centers," which is incorporated by reference and includes:

PROPOSED RULES

<ul style="list-style-type: none">(a) A state-approved trauma registry whose data is submitted to the OEMS at least quarterly, which includes all trauma patients seen at the trauma center itself or those that are routinely diverted or transferred to its affiliated hospital;(b) Morbidity and mortality reviews to include all trauma deaths;(c) Trauma performance committee that meets at least quarterly, to include physicians, nurses, pre-hospital personnel, and a variety of other healthcare providers, which reviews policies, procedures, and system issues and whose members or designee attends at least 50% of the regular meetings;(d) Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, emergency medicine, and other specialty physicians as needed specific to the case, and the trauma nurse coordinator/program manager and whose members or designee attends at least 50% of the regular meetings;(e) Identification of discretionary and non-discretionary audit filters;(f) Documentation and review of times and reasons for trauma-related diversion of patients from the scene or referring hospital;(g) Documentation and review of response times for trauma surgeons (who must demonstrate 80% compliance) and orthopaedists;(h) Appropriate trauma team notification;(i) Documentation (unless in-house) and review of Emergency Department response times for anesthesiologists or airway managers and computerized tomography technologist;(j) Documentation of availability of the surgeon on-call for trauma, such that compliance is 90% or greater where there is no trauma surgeon back-up call schedule;(k) Trauma performance and multidisciplinary peer review committees may be incorporated together or included in other staff meetings as appropriate for the facility performance improvement rules;(l) Review of pre-hospital trauma care to include dead-on-arrivals; and(m) Review of times and reasons for transfer of injured patients;(29) An outreach program to include:	<ul style="list-style-type: none">(a) Written transfer agreements to address the transfer and receipt of trauma patients;(b) Participation in a Regional Advisory Committee (RAC);(30) Coordination and/or participation in community prevention activities;(31) A documented continuing education program for staff physicians, nurses, allied health personnel, and community physicians to include:<ul style="list-style-type: none">(a) 20 hours of Category I or II trauma-related continuing medical education every two years for all attending general surgeons on the trauma service, with at least 50% of this being extramural;(b) 20 hours of Category I or II trauma-related continuing medical education every two years for all emergency physicians, with at least 50% of this being extramural;(c) Advanced Trauma Life Support (ATLS) completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS;(d) 20 hours of Category I trauma-related continuing medical education (beyond in-house in-services) every two years for the trauma nurse coordinator/program manager;(e) 16 hours of trauma-registry-related or trauma-related continuing education every two years, as deemed appropriate by the trauma nurse coordinator/program manager, for the trauma registrar;(f) At least an 80% compliance rate for 16 hours of trauma-related continuing education (as approved by the trauma nurse coordinator/program manager) every two years related to trauma care for RN's and LPN's in transport programs, Emergency Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator/program manager; and(g) 16 hours of trauma-registry-related or trauma-related continuing education every two years for physician assistants and mid-level practitioners routinely caring for trauma patients.
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Authority G.S. 131E-162.

**10 NCAC 03D .3304
PROCESS**

INITIAL DESIGNATION

(a) For initial trauma center designation, the hospital shall request a consult visit by OEMS and have the consult within one year prior to submission of the RFP.

(b) A hospital interested in pursuing trauma center designation shall submit a letter of intent 180 days prior to the submission of an RFP to the OEMS. The letter shall also define the hospital's primary trauma catchment area. Simultaneously, Level I or II applicants shall also demonstrate the need for the trauma center designation by submitting one original and three copies of documents which include at a minimum:

- (1) The population to be served and the extent to which the population is underserved for trauma care with the methodology used to reach this conclusion;
- (2) Geographic considerations to include trauma primary and secondary catchment area and distance from other trauma centers; and
- (3) Trauma patient volume and severity of injury for the facility for the 24-month period of time preceding the application. The trauma center shall show that its trauma service will be taking care of at least 200 trauma patients with an Injury Severity Score (ISS) greater than or equal to 15 during the first two year period of its designation. This criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II trauma center sharing all or part of its catchment area or by jeopardizing the existing trauma center's ability to meet this same 200-patient minimum.

(c) Following receipt of the letter of intent by OEMS, any designated Level I or II trauma center(s) sharing all or part of the applicant's catchment area must provide to OEMS a trauma registry download for the same two-year period used by the applicant. This download shall be provided within 30 days of the request of OEMS.

(d) OEMS shall review the regional data, from both the applicant and the existing trauma center(s), and ascertain the applicant's ability to satisfy the justification of need information required in Paragraphs (b) (1-3) of this Rule. Simultaneously, the applicant's primary RAC shall be notified of the application and be provided the regional data as required in Paragraphs (b) (1-3) of this Rule submitted by the applicant for review and comment. The RAC shall be given a minimum of 30 days to submit any concerns in writing for OEMS' consideration. If no comments are received, OEMS shall proceed.

(e) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. The RAC shall also be notified so that any necessary changes in protocols can be considered.

(f) OEMS shall also notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for initial designation to allow for comment.

(g) Hospitals desiring to be considered for initial trauma center designation shall complete and submit an original and five copies of bound, page-numbered RFP to the OEMS at least 90 days prior to the proposed site visit date.

(h) For Level I, II, and III applicants, the RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in Rule .3301, .3302, or .3303 of this Section and shall include information which supports

compliance with the criteria contained in "North Carolina's Trauma Center Criteria," dated January 1, 2002, which is incorporated by reference.

(i) If OEMS does not recommend a site visit, the reasons shall be forwarded to the hospital in writing within 30 days of the decision. The hospital may reapply for designation within six months following the submission of an updated RFP. If the hospital fails to respond within six months, the hospital shall reapply following the process outlined in Paragraphs (a) – (h) of this Rule.

(j) If the OEMS recommends the hospital for a site visit, the hospital shall be notified within 30 days and the site visit shall be conducted within six months of the recommendation. The site visit shall be scheduled on a date mutually agreeable to the hospital and the OEMS.

(k) Any in-state reviewer for a Level I or II visit (except the OEMS representatives) shall be from outside the planning region in which the hospital is located. The composition of a Level I or II state site survey team shall be as follows:

- (1) One out-of-state Fellow of the ACS, experienced as a site surveyor, who shall be designated the primary reviewer;
- (2) One emergency physician who currently works in a designated trauma center, is a member of the North Carolina College of Emergency Physicians, and is boarded in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);
- (3) One in-state trauma surgeon who is a member of the North Carolina Committee on Trauma;
- (4) One out-of-state trauma nurse coordinator/program manager;
- (5) The medical director of the OEMS; and
- (6) The Hospitals Specialist of the OEMS.

(l) All site team members for a Level III visit shall be from in-state, and all (except for the OEMS representatives) shall be from outside the planning region in which the hospital is located. The composition of a Level III state site survey team shall be as follows:

- (1) One Fellow of the ACS, who is a member of the North Carolina Committee on Trauma and shall be designated the primary reviewer;
- (2) One emergency physician who currently works in a designated trauma center, is a member of the North Carolina College of Emergency Physicians, and is boarded in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);
- (3) A trauma nurse coordinator/program manager;
- (4) The medical director of the OEMS; and
- (5) The Hospitals Specialist of the OEMS.

(m) On the day of the site visit the hospital shall make available all required patient medical charts.

(n) A post-conference report based on the consensus of the site review team will be given verbally during a summary conference. A written consensus report will be completed, to include a peer review report, by the primary reviewer and submitted to OEMS within 30 days of the site visit.

(o) The report of the site survey team and the staff recommendations shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting which is more than 45 days following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for trauma center designation be approved or denied.

(p) All criteria defined in Rules .3301, .3302, or .3303 of this Section shall be met for initial designation at the level requested. Initial designation shall not be granted if deficiencies exist.

(q) Hospitals with a deficiency(ies) may be given up to 12 months to demonstrate compliance. Satisfaction of deficiency(ies) may require an additional site visit. If compliance is not demonstrated within the time period, to be defined by OEMS, the hospital shall be required to submit a new application and updated RFP and follow the process outlined in Paragraphs (a) – (h) of this Rule.

(r) The final decision regarding trauma center designation shall be rendered by the OEMS.

(s) The hospital shall be notified, in writing, of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(t) If a trauma center changes its trauma program administrative structure (such that the trauma service, trauma medical director, trauma nurse coordinator/program manager and/or trauma registrar are relocated on the hospital's organizational chart) at any time, it shall notify OEMS of this change in writing within 30 days of the occurrence.

(u) Initial designation as a trauma center is valid for a period of three years.

Authority G.S. 131E-162; 143-509(3).

10 NCAC 03D .3305 RENEWAL DESIGNATION PROCESS

(a) One of two options may be utilized to achieve trauma center renewal:

- (1) Undergo a site visit conducted by OEMS to obtain a four-year renewal designation; or
- (2) Undergo a verification visit arranged by the ACS, in conjunction with OEMS, to obtain a three- year renewal designation;

(b) For hospitals choosing option number (a)(1) of this Rule:

- (1) Prior to the end of the designation period, the OEMS shall forward to the hospital an RFP for completion. The hospital shall, within 10 days of receipt of the RFP, define for OEMS the trauma center's trauma primary catchment area. Upon this notification, OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for renewal to allow for comment;
- (2) Hospitals seeking a renewal of trauma center designation shall complete and submit an original and five copies of a bound, page-numbered RFP as directed by the OEMS to the OEMS and the specified site surveyors at least 30 days prior to the site visit. The RFP shall

include information that supports compliance with the criteria contained in Rules .3301, .3302, or .3303 of this Section as it relates to the trauma center's level of designation;

- (3) All criteria defined in Rules .3301, .3302, or .3303 of this Section, as relates to the trauma center's level of designation, shall be met for renewal designation.
- (4) A site visit shall be conducted within 120 days prior to the end of the designation period. The site visit shall be scheduled on a date mutually agreeable to the hospital and the OEMS.
- (5) The composition of a Level I or II site survey team shall be the same as that specified in Rule .3304(k) of this Section.
- (6) The composition of a Level III site survey team shall be the same as that specified in Rule .3304(l) of this Section.
- (7) On the day of the site visit, the hospital shall make available all required patient medical charts.
- (8) A post-conference report based on consensus of the site review team will be given verbally during the summary conference. A written consensus report will be completed, to include a peer review report, by the primary reviewer and submitted to OEMS within 30 days of the site visit.
- (9) The report of the site survey team and a staff recommendation shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting which is more than 45 days following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for trauma center renewal be approved or denied.
- (10) Hospitals with a deficiency(ies) have two weeks to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in two weeks, the hospital, instead of a renewal, may be given a time period (up to 12 months) to demonstrate compliance and undergo a focused review, which may require an additional site visit. If compliance is not demonstrated within the time period, as specified by OEMS, the trauma center designation shall not be renewed. To become redesignated, the hospital shall be required to submit an updated RFP and follow the initial applicant process outlined in Rule .3304 of this Section;
- (11) The final decision regarding trauma center renewal shall be rendered by the OEMS;
- (12) The hospital shall be notified in writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting;

PROPOSED RULES

(13) The four-year renewal date that may be eventually granted will not be extended due to the focused review period; and

(14) Hospitals in the process of satisfying contingencies placed on them prior to December 31, 2001, shall be evaluated based on the rules that were in effect at the time of their renewal visit.

(c) For hospitals choosing Subparagraph (a)(2) of this Rule:

(1) At least six months prior to the end of the trauma center's designation period, the trauma center must notify the OEMS of its intent to undergo an ACS verification visit. It must simultaneously define in writing to the OEMS its trauma primary catchment area. Trauma centers choosing this option must then comply with all the ACS' verification procedures, as well as any additional state criteria as outlined in Rules .3301, .3302, or .3303, as apply to their level of designation;

(2) If a trauma center currently using the ACS' verification process chooses not to renew using this process, it must notify the OEMS at least six months prior to the end of its state trauma center designation period of its intention to exercise Subparagraph (a)(1) of this Rule;

(3) When completing the ACS' documentation for verification, the trauma center must simultaneously submit two identical copies to OEMS. The trauma center must simultaneously complete documents supplied by OEMS to verify compliance with additional North Carolina criteria (i.e., criteria that exceed the ACS criteria) and forward these to OEMS and the ACS;

(4) The OEMS shall notify the Board of County Commissioners within the trauma center's trauma primary catchment area of the trauma center's request for renewal to allow for comments;

(5) The trauma center must make sure the site visit is scheduled to ensure that the ACS' final written report, accompanying medical record reviews and cover letter are received by OEMS at least 30 days prior to a regularly scheduled State Emergency Medical Services Advisory Council meeting to ensure that the trauma center's state designation period does not terminate without consideration by the State Emergency Medical Services Advisory Council;

(6) The composition of the Level I or Level II site team must be as specified in Rule .3304(k) of this Section, except that both the required trauma surgeons and the emergency physician may be from out-of-state. Neither North Carolina Committee on Trauma nor North Carolina College of Emergency Physician membership will be required of the surgeons or emergency physician, respectively, if from out-of-state;

(7) The composition of the Level III site team must be as specified in Rule .3304(l) of this Section, except that the trauma surgeon, emergency physician, and trauma nurse coordinator/program manager may be from out-of-state. Neither North Carolina Committee on Trauma nor North Carolina College of Emergency Physician membership will be required of the surgeon or emergency physician, respectively, if from out-of-state;

(8) All state trauma center criteria must be met as defined in Rules .3301, .3302, and .3303, for renewal of state designation. An ACS' verification is not required for state designation. An ACS' verification does not ensure a state designation;

(9) The final written report issued by the ACS' verification review committee, the accompanying medical record reviews (from which all identifiers may be removed), and cover letter must be forwarded to OEMS within 10 working days of its receipt by the trauma center seeking renewal;

(10) The written reports from the ACS and the OEMS staff recommendation shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting. The State EMS Advisory Council shall recommend to OEMS that the request for trauma center renewal be approved or denied;

(11) The hospital shall be notified in writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting;

(12) Hospitals with contingencies, as the result of a deficiency(ies), as determined by OEMS, may undergo a focused review (to be conducted by the OEMS) whereby the trauma center may be given up to 12 months to demonstrate compliance. Satisfaction of contingency(ies) may require an additional site visit. If compliance is not demonstrated within the time period, as specified by OEMS, the trauma center designation shall not be renewed. To become redesignated, the hospital shall be required to submit a new RFP and follow the initial applicant process outlined in Rule .3304 of this Section.

Authority G.S. 131E-162; 143-509(3).

SECTION .3400 – TRAUMA CENTER DESIGNATION ENFORCEMENT

10 NCAC 03D .3401 DENIAL, FOCUSED REVIEW, VOLUNTARY WITHDRAWAL, OR REVOCATION OF TRAUMA CENTER DESIGNATION

PROPOSED RULES

(a) The OEMS may deny the initial or renewal designation (without first allowing a focused review) of a trauma center for any of the following reasons:

- (1) Failure to comply with G.S. 131E-162 and the rules adopted under that article; or
- (2) Attempting to obtain a trauma center designation through fraud or misrepresentation; or
- (3) Failure to comply with G.S. 131E-162 and the rules adopted under that article endangers the health, safety, or welfare of patients cared for in the hospital; or
- (4) Repetition of contingencies placed on the trauma center in previous site visits.

(b) When a trauma center is required to have a focused review, an option only for a trauma center seeking renewal, it must be able to demonstrate compliance with the provisions of G.S.131E-162 and the rules adopted under that article within one year or less as required and delineated in writing by OEMS.

(c) The OEMS may revoke a trauma center designation at any time or deny a request for renewal of designation, whenever the OEMS finds that the trauma center has failed to comply with the provisions of G.S. 131E-162 and the rules adopted under that article; and

- (1) It is not probable that the trauma center can remedy the deficiencies within one year or less; or
- (2) Although the trauma center may be able to remedy the deficiencies within a reasonable period of time, it is not probable that the trauma center shall be able to remain in compliance with designation rules for the foreseeable future; or
- (3) The trauma center fails to meet the requirements of a focused review; or
- (4) Failure to comply endangers the health, safety, or welfare of patients cared for in the trauma center.

(d) The OEMS shall give the trauma center written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

- (1) The factual allegations;
- (2) The statutes or rules alleged to be violated; and
- (3) Notice of the hospital's right to a contested case hearing on the amendment of the designation.

(e) Focused review is not a procedural prerequisite to the revocation of a designation pursuant to Paragraph (d) of this Rule.

(f) With the OEMS' approval, a trauma center may voluntarily withdraw its designation for a maximum of one year by submitting a written request. This request shall include the reasons for withdrawal and a plan for resolution of the issues. To reactivate the designation, the facility shall provide written documentation of compliance that is acceptable to the OEMS. Voluntary withdrawal shall not affect the original expiration date of the trauma center's designation.

(g) If the trauma center fails to resolve the issues which resulted in a voluntary withdrawal within the specified time period for resolution, the OEMS may revoke the trauma center designation.

(h) In the event of a revocation or voluntary withdrawal, the OEMS shall provide written notification to all hospitals and emergency medical services providers within the trauma center's defined trauma primary catchment area. The OEMS shall provide written notification to same if, and when, the voluntary withdrawal reactivates to full designation.

Authority G.S. 131E-162.

10 NCAC 03D .3402 PROCEDURES FOR APPEAL OF DENIAL, FOCUSED REVIEW OR REVOCATION

Appeal of denial or revocation of a trauma center designation shall follow the law regarding contested cases found in G.S. 150B.

Authority G.S. 131E-162.

10 NCAC 03D .3403 MISREPRESENTATION OF DESIGNATION

(a) Hospitals shall not represent themselves as a trauma center unless they are currently designated by the Department pursuant to Section .3300 of this Subchapter.

(b) Designation applies only to the hospital that submitted the RFP and underwent the formal site survey and does not extend to its satellite facilities or affiliates.

Authority G.S. 131E-162.

SECTION .3500 – TRAUMA SYSTEM DESIGN

10 NCAC 03D .3501 STATE TRAUMA SYSTEM

(a) The state trauma system consists of regional plans, policies, guidelines, and performance improvement initiatives by the RACs and monitored by the OEMS.

(b) The OEMS shall require that each hospital select a Regional Advisory Committee (RAC). If a hospital does not exist in a given county, the EMS system for the county shall select the RAC. Each RAC shall include at least one Level I or II trauma center. Any hospital changing its affiliation shall report the change in writing to the OEMS within 30 days of the date of the change.

(c) The OEMS shall notify each RAC of its hospital and county membership.

Authority G.S. 131E-162.

10 NCAC 03D .3502 REGIONAL TRAUMA SYSTEM PLAN

(a) A Level I and/or II trauma center shall facilitate development of and provide RAC staff support which shall include, at a minimum, the following:

- (1) The trauma medical director(s) from the Lead RAC Agency; and
- (2) Trauma nurse coordinator(s) or program manager(s) from the Lead RAC Agency;

(b) The RAC membership shall include, at a minimum, the following:

- (1) The trauma medical director(s) and the trauma nurse coordinator(s) or program manager(s) from The Lead RAC Agency;

- (2) If on staff, an outreach coordinator(s) or designee(s), as well as an identified RAC registrar or designee(s) from the Lead RAC Agency;
- (3) A senior level hospital administrator;
- (4) An emergency physician;
- (5) An Emergency Medical Services representative;
- (6) A representative from each hospital participating in the RAC;
- (7) Community representatives; and
- (8) An EMS System physician involved in medical oversight.

(c) The RAC shall develop and submit a plan within one year of notification of the RAC membership, or for existing RACs within six months of the implementation date of this rule, to the OEMS containing at a minimum:

- (1) Organizational structure to include the roles of the members of the system;
- (2) Goals and objectives to include the orientation of the providers to the regional system;
- (3) RAC membership list, rules of order, terms of office, meeting schedule (held at a minimum of two times per year);
- (4) Copies of documents and information required by the OEMS as defined in Rule .3503 of this Section;
- (5) System evaluation tools to be utilized;
- (6) Written documentation of regional support for the plan; and
- (7) Performance improvement activities to include the RAC Registry.

(d) The RAC shall submit to the OEMS an annual progress report that assesses compliance with the regional trauma system plan and specifies any updates to the plan.

(e) Upon OEMS' receipt of a letter of intent for initial Level I or II trauma center designation pursuant to Rule .3304(b) of this Subchapter, the applicant's RAC shall be provided the applicant's data from OEMS to review and comment. This data which should demonstrate the need for the trauma center designation must include at a minimum:

- (1) The population to be served and the extent to which the population is underserved for trauma care with the methodology used to reach this conclusion;
- (2) Geographic considerations to include trauma primary and secondary catchment area and distance from other trauma centers; and
- (3) Trauma patient volume and severity of injury for the facility for the 24-month period of time preceding the application. The trauma center shall show that its trauma service will be taking care of at least 200 trauma patients with an Injury Severity Score (ISS) greater than or equal to 15 during the first two year period of its designation. This criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II trauma center sharing all or part of its catchment area or by jeopardizing the

existing trauma center's ability to meet this same 200-patient minimum.

- (f) The RAC has 30 days to comment on the request for initial designation.
- (g) The RAC shall also be notified of the OEMS approval to submit an RFP so that necessary changes in protocols can be considered.

Authority G.S. 131E-162.

10 NCAC 03D .3503 REGIONAL TRAUMA SYSTEM POLICY DEVELOPMENT

The RAC shall oversee the development, implementation, and evaluation of the regional trauma system to include:

- (1) Public information and education programs to include system access and injury prevention;
- (2) Written trauma system guidelines to address the following:
 - (A) Regional communications;
 - (B) Triage;
 - (C) Treatment at the scene and in the pre-hospital, inter-hospital, and Emergency Department to and include: guidelines to facilitate the rapid assessment and initial resuscitation of the severely injured patient, including primary and secondary survey. Criteria addressing management during transport should include continued assessment and management of airway, cervical spine, breathing, circulation, neurologic and secondary parameters, communication, and documentation;
 - (D) Transport to determine the appropriate mode of transport and level of care required to transport, considering patient condition, requirement for trauma center resources, family requests, and capability of transferring entity;
 - (E) Bypass procedures which define:
 - (i) Circumstances and criteria for bypass decisions;
 - (ii) Time and distance criteria; and
 - (iii) Mode of transport which bypasses closer facilities;
 - (F) Scene and inter-hospital diversion procedures which shall include delineation of specific factors such as hospital census and/or acuity, physician availability, staffing issues, disaster status, or transportation which would require routing of a patient to another trauma center;
- (3) Transfer agreements (to include those with other hospitals, as well as specialty care facilities such as burn, pediatrics, spinal cord, and rehabilitation) which shall outline mutual understandings between facilities to

transfer/accept certain patients. These shall specify responsible parties, documentation requirements, and minimum care requirements;

(4) A performance improvement plan which includes:

(A) A performance improvement committee of the RAC;

(i) Whose membership only includes health care professionals, as defined and protected by G.S. 131E-95 or in G.S. 90-21.222A; and

(ii) Continuously evaluates the regional trauma system through structured review of process of care and outcomes;

(B) A RAC registry database, once operational, that reports quarterly or as requested by the OEMS.

Fiscal Impact

State
 Local
 Substantive ($\geq \$5,000,000$)
 None

SUBCHAPTER 32H - EMERGENCY MEDICAL SERVICES ADVANCED LIFE SUPPORT

SECTION .0100 – GENERAL INFORMATION

21 NCAC 32H .0102 DEFINITIONS

The following definitions apply in this Subchapter:

(1) "Audit and review panel" means a committee composed of representatives of the medical, nursing, administrative, county government, and prehospital care service elements of an advanced life support (ALS) program that has the responsibility for the on-going monitoring and evaluation of the program. The chairman of the panel shall be a physician and a majority of the voting members shall be physicians.

(2) "Medical Crew Member" means a physician, registered nurse, EMT paramedic, EMT intermediate, EMT defibrillation technician, or EMT who holds a current North Carolina license or certification and who has completed additional training in altitude physiology, EMS communications, in flight emergencies, and aircraft and flight safety conducted under the direct guidance of the medical director.

(3) "Emergency medical technician defibrillation (EMT-D)" means a person specially educated in a program approved by the Office of Emergency Medical Services who has been certified or recertified by the North Carolina Medical Board as qualified to render the services enumerated in Rule .0407 of this Subchapter.

(4) "Emergency medical technician intermediate (EMT-I)" means a person specially educated in a program approved by the Office of Emergency Medical Services who has been certified or recertified by the North Carolina Medical Board as qualified to render the services enumerated in Rule .0403 of this Subchapter.

(5) "Emergency medical technician paramedic (EMT-P)" means a person specially educated in a program approved by the Office of Emergency Medical Services who has been certified or recertified by the North Carolina Medical Board as qualified to render the services enumerated in Rule .0402 of this Subchapter.

(6) "Advanced Life Support Professional (ALS Professional)" means a certified emergency medical dispatcher, emergency medical technician defibrillation, emergency medical technician intermediate, or emergency medical

Authority G.S. 131E-162.

TITLE 21 – OCCUPATIONAL LICENSING BOARDS

CHAPTER 32 – NORTH CAROLINA MEDICAL BOARD

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC Medical Board intends to repeal the rules cited as 21 NCAC 32H .0102, .0201-.0203, .0301-.0303, .0401-.0405, .0407-.0409, .0501-.0503, .0505-.0508, .0601-.0602, .0701, .0801-.0802, .0901-.0903, .1001-.1004; 32I .0101-.0104. Notice of Rule-making Proceedings was published in the Register on January 15, 2001 and September 17, 2001.

Proposed Effective Date: April 1, 2003

Public Hearing:

Date: June 18, 2002

Time: 4:00 p.m.

Location: NC Medical Board, 1201 Front Street, Suite 100, Raleigh, NC

Reason for Proposed Action: The NC General Assembly recently ratified House Bill 452 (Session Law 2001-220) and House Bill 453 (Session Law 2001-211). These two pieces of legislation amended G.S. 143-56 and G.S. 143-450 to update existing Emergency Medical Services (EMS) terminology, definitions, roles and responsibilities. As such, changes are needed to ensure compliance with the new laws. The Commission is proposing to permanently repeal existing EMS rules and replace them with new permanent rules.

Comment Procedures: Written comments concerning this rule-making action must be submitted to Diane Meelheim, Assistant Executive Director, NC Medical Board, P.O. Box 20007, Raleigh, NC 27619. Comments will be received through June 18, 2002.

technician paramedic whether working on a paid or volunteer basis.

(7) "Medical control" means the management and accountability for the medical care aspects of an ALS program. It entails physician direction and oversight of the initial education and continuing education of the ALS professionals; development and monitoring of both operational and treatment protocols; evaluation of the medical care rendered by ALS professionals; participation in system evaluation; and directing, by radio or telephone, the medical care rendered by the ALS professionals.

(8) "Medical director" means the physician responsible for the medical aspects of the management of an ALS program.

(9) "Mobile intensive care nurse (MICN)" means a registered nurse who has been approved or reapproved by the North Carolina Medical Board to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

(10) "Advanced life support program (ALS program)" means a program of prehospital emergency medical care whereby definitive medical care is delivered to a victim of sudden injury or illness by appropriately educated and certified ALS professionals operating under the direction of a sponsor hospital. All ALS programs shall conform to the criteria established in the rules contained in this Subchapter and shall be approved by the Office of Emergency Medical Services.

(11) "Mobile intensive care unit" means any emergency vehicle staffed by ALS professionals and equipped in accordance with standards established by the North Carolina Medical Care Commission as found in 10 NCAC 3M .0202, .0203, .0204, and .0207 to provide remote intensive care to sick and injured persons at the scene of a medical emergency and during transport to a health care facility.

(12) "Oral interview panel" means a committee composed of physicians, ALS professionals certified at or above the level of application and may include other medical personnel such as registered nurses and mobile intensive care nurses involved in the ALS program. The responsibility of the oral interview panel is to interview each applicant for certification, either collectively or individually, and evaluate the suitability to perform successfully at the certification level sought. The panel shall be approved by the medical director and consist of a minimum of three members including one physician and one ALS professional.

(13) "Office of Emergency Medical Services" means an official agency of the State of North Carolina, Department of Health and Human Services, that serves in an administrative capacity to the North Carolina Medical Board.

(14) "Physician" means an individual licensed by the North Carolina Medical Board to practice medicine in the State of North Carolina.

(15) "Sponsor hospital" means a hospital and its medical staff which participates in an ALS program and has responsibility for providing or ensuring the provision of initial education, continuing education, and medical control to the ALS professionals. The sponsor hospital shall meet criteria adopted by the North Carolina Medical Board and be approved by the Office of Emergency Medical Services.

(16) "Study project" means a proposal involving exceptions to the provisions of this Subchapter for the purpose of evaluating the efficiency and effectiveness of alternate means of providing ALS services to the citizens of North Carolina.

(17) "Blind insertion airway device" means an airway adjunct designed to be used as a pharyngotracheal or esophageal device which is inserted without the use of direct visualization. For the purposes of these Rules, this definition does not include esophageal obturator airways, esophageal gastric tube airways, or endotracheal tubes.

(18) "Coding" means the selection and assignment of an alphanumeric classification to a call for medical assistance by an EMD.

(19) "Emergency Medical Dispatcher (EMD)" means a trained public safety telecommunicator with additional training and specific emergency medical knowledge essential for the efficient management of emergency medical service communications who has successfully completed an education and training program meeting the criteria established by the Office of Emergency Medical Services and who functions as an agent or constituent of an Emergency Medical Dispatch Program approved by the Office of Emergency Medical Services.

(20) "Emergency Medical Dispatching" means the reception and management of requests for emergency medical assistance.

(21) "Emergency Medical Dispatch Program" means the approved program with procedures established for the management and delivery of emergency medical assistance by a public or private agency that sends emergency medical assistance to requesting persons and provides pre arrival instructions for a victim of sudden injury or illness.

(22) "Emergency Medical Dispatch Priority Reference System (EMDPRS)" means a medically approved written or computer generated reference system used by an emergency medical dispatching agency to

provide medical direction, and to dispatch aid to medical emergencies.

(23) "EMD selection" means the process which establishes criteria to identify a candidate for education and training as an Emergency Medical Dispatcher (EMD).

(24) "Pre arrival instructions" means telephone rendered, medically approved written instructions read by emergency medical dispatchers to callers, which help provide aid to the victim and control the situation prior to patient access by pre hospital care providers.

(25) "Public Safety Telecommunicator" means an individual trained to communicate by electronic means with persons seeking emergency assistance and with public or private agencies and individuals providing such assistance.

(26) "Approved Teaching Institution" means an agency with a current contract with the Office of Emergency Medical Services to provide emergency medical services educational programs. Approved teaching institutions must meet the criteria in accordance with 10 NCAC 03D-1201.

(27) "Physician Assistant (PA)" means a physician assistant who has been licensed by the North Carolina Medical Board and approved by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

(28) "Nurse Practitioner (NP)" means a nurse who is licensed by the North Carolina Board of Nursing and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing and approved by the Office of Emergency Medical Services to issue instructions to ALS professionals in accordance with protocols approved by the sponsor hospital and under the direction of the medical director.

Authority G.S. 143-514.

SECTION .0200 - PROGRAM STANDARDS AND APPROVAL

21 NCAC 32H .0201 ADVANCED LIFE SUPPORT PROGRAM CRITERIA

ALS programs shall cover a defined service area and shall have the following:

(1) a plan, as specified in Rule .0302 of this Subchapter, for the coordination of the sponsor hospitals participating in the program;

(2) a designated medical director who shall be responsible either directly or by delegation to the other licensed physicians at the sponsor hospital(s) for the following:

PROPOSED RULES

- (b) making recommendations to the medical director for the continuing education program for ALS personnel;
- (c) reviewing the policies, procedures and protocols of the ALS program and making recommendations for improvement; and
- (d) making recommendations for consideration by the sponsor hospital administratively responsible for the program regarding the appointment of the medical director.

Authority G.S. 143-514.

21 NCAC 32H .0202 PROGRAM APPROVAL

- (a) A complete proposal to establish or expand an ALS program must be submitted to the Office of Emergency Medical Services at least 60 days prior to the planned field implementation or expansion of the program, and be re-approved every four years following initial approval.
- (b) The proposal must demonstrate that the program meets the standards found in Rule .0201 of this Section and must follow the format specified by the Office of Emergency Medical Services.

Authority G.S. 143-514.

21 NCAC 32H .0203 APPROVAL REQUIREMENTS: EMERGENCY MEDICAL DISPATCHER PROGRAM

- (a) All emergency medical dispatching agencies applying the principles of EMD or offering EMD services, procedures, or programs to the public shall conform to the criteria established in the rules contained in this Subchapter and shall submit a proposal for program approval to the Office of Emergency Medical Services at least 60 days prior to program implementation. The proposal must document that the EMD program has:
 - (1) a defined service area;
 - (2) a designated medical director responsible for medical supervision of the program in accordance with Rule .0201(2)(a)-(e) of this Section;
 - (3) adopted, maintains, and updates on a regular basis, a written or computer-based emergency medical dispatch priority reference system (EMDPRS) approved by the EMD medical director including at least the minimum incident protocols set forth in the "Guidelines for the Development and Operation of Emergency Medical Dispatch Programs";
 - (4) adequate personnel certified in accordance with the requirements of this Subchapter to ensure that the program will be continuously available on a 24 hour a day basis;
 - (5) an organized and defined system of communications that provides for public access through a central emergency communications center using a single seven

digit telephone number for the service area or an emergency 9-1-1 telephone system;

(6) the ability to dispatch and coordinate all resources, such as manpower, vehicles and equipment that are essential to the effective and efficient management of requests for emergency medical assistance;

(7) an audit and review panel which meets at a minimum on a quarterly basis;

(8) a formal risk management program including written procedures that provide:

(A) The chain of command for establishment of policies, procedures, and resolution of conflicts relating to the EMD Program;

(B) Administrative procedures and written protocols for resource allocation and alternative response assignments of emergency response units;

(C) EMD responsibilities in special situations, such as disasters, multi-causality incidents, or situations requiring referral to specialty hotlines;

(D) Complete written and recorded documentation of EMD operations that permit timely medical audit and review;

(E) Procedures for selection and processing of cases for EMD audit and review.

(9) adopted and maintains a dispatch coding system consistent with the incident protocol types in the EMDPRS which categorizes the problem determination through the EMDs evaluation of the problem or situation;

(10) provides, maintains, and upgrades on a regular basis, all necessary protocols, educational equipment, and quality assurance/case review equipment and supplies required for operation of the EMD program.

(b) EMD programs shall make application to the Office of Emergency Medical Services and be re-approved every four years following initial EMD program approval.

Authority G.S. 143-514.

SECTION .0300 - HOSPITAL UTILIZATION

21 NCAC 32H .0301 HOSPITAL INVOLVEMENT

Hospital and hospital medical staff participation in the establishment, operation and ongoing evaluation of ALS programs is essential. The role of each participating hospital within the service area of an ALS program shall be defined, and the operational procedures outlined and agreed to by all participants so as to help ensure proper coordination. Sponsor Hospitals may provide services utilizing ALS professionals for the delivery of emergency medical care to the sick and injured at the scene of an emergency and during education of the ALS professionals. While functioning pursuant to these Rules, the

PROPOSED RULES

ALS professionals shall be under the control and supervision of the physician, approved MICN, physician assistant or nurse practitioner of the sponsor hospital from which they are receiving instructions.

Authority G.S. 143-514.

21 NCAC 32H .0302 PLAN FOR PARTICIPATING HOSPITALS

(a) Each ALS program shall have a written plan which outlines the roles and responsibilities of each of the sponsor hospitals that will function in the program. The plan shall allow for the participation of all hospitals within the service area of the ALS program that meet the sponsor hospital criteria even though one or more hospitals may choose not to participate at the initiation of the program. One hospital shall be designated in the plan as being administratively responsible for the ALS program and as such have overall responsibility for administration and coordination of the program and ensuring compliance with the requirements of this Subchapter. Changes in this designation shall be approved by the Office of Emergency Medical Services. If participating hospitals cannot reach an agreement regarding the designation of the administratively responsible sponsor hospital, the Office of Emergency Medical Services shall designate one of the hospitals as administratively responsible for the program. This designation shall be for one year or until such time as the participating hospitals can reach an agreement on the designation, whichever is shorter. The Office of Emergency Medical Services shall continue an annual appointment of the administratively responsible sponsor hospital until the participating hospitals can reach an agreement on this designation.

(b) The plan shall be approved by the chief of staff and chief executive officer of each participating hospital and shall include at a minimum:

- (1) a description of the role each hospital is to have in the ALS program;
- (2) a description of the operational procedures to be followed by the ALS professionals, MICN, physician assistant or nurse practitioner personnel to obtain medical direction;
- (3) the treatment protocols to be utilized in the program and a description of the procedure to be followed to modify them;
- (4) a description of how the audit and review function will be established and carried out;
- (5) a description of the methodology for providing continuing education for the ALS professionals, MICN, physician assistant or nurse practitioner personnel; and
- (6) a description of the mechanism for providing physician backup to the MICN, physician assistant or nurse practitioner personnel in programs where they are utilized.

(c) The plan shall be approved for a period not to exceed four years. At the end of the approval period, the ALS program must submit an updated plan meeting the criteria specified in Paragraphs (a) and (b) of this Rule.

Authority G.S. 143-514.

21 NCAC 32H .0303

SPONSOR HOSPITAL

(a) To be approved by the Office of Emergency Medical Services as a sponsor hospital, a hospital shall:

- (1) demonstrate that it will function as part of an ALS program in accordance with a plan meeting the requirements of Rule .0302 of this Section;
- (2) meet all of the following criteria:
 - (A) have physician, MICN, physician assistant or nurse practitioner coverage available 24 hours per day in the emergency department or critical care unit for communication with the ALS professionals;
 - (B) ensure 24 hour availability of a registered nurse who is primarily responsible to meet ALS patients upon arrival at the emergency department;
 - (C) have a physician available to provide backup to the MICN, physician assistant or nurse practitioner issuing instructions to the ALS professionals;
 - (D) appoint a registered nurse to act as a liaison between the ALS professionals and the hospital. The nurse liaison shall meet the requirements set forth in the "Guidelines for the Selection and Performance of the Emergency Medical Services Nurse Liaison";
 - (E) appoint a physician to serve as a medical director or liaison to the medical director of the ALS program after consideration of the recommendation made by the audit and review panel;
 - (F) have written support letters for the program from both the chief executive officer and chief of staff of the hospital;
 - (G) establish or participate in an audit and review panel that meets at a minimum quarterly;
 - (H) have access to and operate a communications system that will provide, at a minimum, two way voice communications to ALS professionals anywhere in the service area of the ALS program. The medical director shall verify that the communications system is satisfactory for on line medical control. The communications system shall provide for communication from the onset of patient treatment through the delivery of the patient at the medical treatment facility. The communications system shall be operational 24 hours per day and shall allow for initiation of communication

by either the ALS professionals or by the sponsor hospital that is directing the patient care procedures and treatment. Approved first responder organizations functioning at the EMT-D level of care as part of approved ALS programs are exempt from the requirements of this Paragraph unless utilizing medications authorized under locally approved protocols requiring voice communication;

(H) provide orientation regarding the ALS program to medical and nursing personnel at the hospital who participate in the program;

(I) have treatment protocols adopted by the medical staff covering the performance of ALS professionals which are consistent with those being used throughout the ALS program;

(K) provide or ensure provision of a continuing education program approved by the Office of Emergency Medical Services for ALS professionals, MICN, physician assistant or nurse practitioner personnel; and

(L) provide or ensure provision of supervised clinical experience for those participating in the educational program.

(M) In addition, the sponsor hospital designated as administratively responsible for the ALS program shall have a physician in the emergency department 24 hours a day who is available to give orders and medical direction to the ALS professionals. For ALS programs that do not have a participating hospital within their area with a physician in the emergency department 24 hours a day, this requirement may be met by the sponsor hospital designated as administratively responsible for the program defining a mechanism to provide physician backup to the MICN, physician assistant or nurse practitioner and medical control to the ALS professionals.

Authority G.S. 143-514.

SECTION .0400 - EDUCATION AND PERFORMANCE OF ADVANCED LIFE SUPPORT PERSONNEL

21 NCAC 32H .0401 EDUCATIONAL PROGRAMS

(a) An educational program intended to qualify personnel as ALS professionals, MICNs, physician assistants or nurse practitioners authorized to issue orders to ALS personnel shall be approved by the Office of Emergency Medical Services. Proposals for educational programs shall be submitted for approval at least 20 days prior to the date on which the program is scheduled to start.

(b) ALS professional students may perform the services and functions permitted by the rules contained in this Subchapter for their certification level during:

(1) the clinical portion of an approved educational program while caring for patients in the sponsor hospital or other facility approved by the medical director and the Office of Emergency Medical Services, provided that the related didactic work has been completed and that they are under the direct supervision of a physician, physician assistant, nurse practitioner, or registered nurse;

(2) a field internship provided that:

(A) the related didactic work of an approved educational program has been completed;

(B) they are directly supervised and accompanied by an ALS professional certified at a like or higher certification level or a physician; and

(C) the internship is conducted within an ALS program approved at the same or higher certification level of the educational program.

Authority G.S. 143-514.

21 NCAC 32H .0402 EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC PERFORMANCE

EMT-Ps educated in approved programs, certified by the North Carolina Medical Board to perform medical acts, and functioning in an approved ALS program may do any of the following in accordance with the protocols established by their sponsor hospital:

(1) While at the scene of a medical emergency where the capability of continuous two way voice communication is maintained with a physician, approved MICN, physician assistant or nurse practitioner located in the sponsor hospital, and upon order of such physician, MICN, physician assistant or nurse practitioner:

(a) establish an intravenous line in a peripheral vein;

(b) obtain blood for laboratory analysis;

(c) administer in a fashion via a route approved by the program medical director any intravenous fluid or medication specified for use by EMT-Ps found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services;

(d) perform pulmonary ventilation by means of a blind insertion airway device or endotracheal tube;

(e) perform defibrillation or cardioversion;

(f) perform chest decompression by needle thoracotomy;

(g) use positive end expiratory pressure respirators;

(h) perform cricothyrotomy;

(i) perform gastric suction by intubation;

- (j) perform urinary catheterization;
- (k) perform external cardiac pacing;
- (l) establish an intraosseous infusion line in patients under 6 years of age and use it to administer any intravenous fluid or medication specified for use by EMT Ps found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services and approved by the program medical director for intraosseous infusion;
- (m) using previously established indwelling semi permanent central venous catheters, administer any intravenous fluid or medication specified for use by EMT Ps found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services;
- (n) place and maintain heparin or saline locks; and
- (o) perform rapid sequence endotracheal intubation.

(2) When confronted with serious or life threatening clinical situations as defined in the patient care protocols established by the sponsor hospital of the ALS program and approved by the Office of Emergency Medical Services, perform as necessary under standing orders any of the following prior to contacting the sponsor hospital:

- (a) cardiopulmonary resuscitation;
- (b) defibrillation, cardioversion, or external cardiac pacing;
- (c) pulmonary ventilation by means of a blind insertion airway device or endotracheal tube;
- (d) establish an intravenous line in a peripheral vein;
- (e) establish an intraosseous infusion line in patients under 6 years of age and use it to administer any intravenous fluid or medication specified for use by EMT Ps found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services and approved by the program medical director for intraosseous infusion;
- (f) administer any intravenous fluid or medication specified for use by EMT Ps on the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services and approved by the medical director for use under standing orders;
- (g) perform chest decompression by needle thoracotomy;
- (h) perform cricothyrotomy; and

(3) When transferring a patient who is receiving intravenous therapy begun at the transferring agency, and where the capability of continuous two way voice communication is maintained with a physician, approved MICN, physician assistant or nurse practitioner located in the sponsor hospital, or when meeting the requirements of Rule .1003 of this Subchapter and upon order of such physician, MICN, physician assistant or nurse practitioner, EMT Ps may maintain intravenous lines for any fluid or medication specified for use by EMT Ps during patient transfers on the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services and approved by the program medical director for use in patient transfers.

(4) When providing emergency care to a patient who has been physically evaluated by a physician, physician assistant or nurse practitioner and who has critical or life threatening clinical situations as defined in the patient care protocols established by the sponsor hospital of the ALS program, an air ambulance program meeting the criteria specified in Rule .1004 of this Subchapter, or a critical care transport program as defined in 10 NCAC 03D .0807, and where the capability of continuous two way voice communication is maintained with a physician, MICN, physician assistant or nurse practitioner approved by the program medical director, EMT P's may:

- (a) upon order of said physician, MICN, physician assistant or nurse practitioner:
 - (i) insert a femoral venous line;
 - (ii) obtain arterial blood gas samples via peripheral artery or pre existing arterial line;
 - (iii) maintain invasive monitoring devices to include central venous pressure lines, swan ganz catheters, arterial lines, intra ventricular catheters, and epidural catheters; and
 - (iv) administer any fluid or medication specified for use by EMT Ps during critical care transports on the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services and approved by the program medical director for use in critical care transfers.
- (b) perform all the skills of an EMT P and administer all medications

approved for use by EMT P's enumerated in Items (1), (2), and (3) of this Rule.

Authority G.S. 143-514.

21 NCAC 32H .0403 EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE PERFORMANCE

~~EMT Is educated in approved programs, certified by the North Carolina Medical Board to perform medical acts, and functioning in an approved ALS program may do any of the following in accordance with the protocols established by their sponsor hospital:~~

- (1) ~~While at the scene of a medical emergency where the capability of continuous two way voice communication is maintained with a physician, approved MICN, physician assistant or nurse practitioner located in the sponsor hospital, and upon order of such physician, MICN, physician assistant or nurse practitioner:~~
 - (a) ~~establish an intravenous line in a peripheral vein;~~
 - (b) ~~perform pulmonary ventilation by means of a blind insertion airway device or endotracheal tube;~~
 - (c) ~~obtain blood for laboratory analysis;~~
 - (d) ~~administer in a fashion via a route approved by the medical director any intravenous fluid or medication specified for use by EMT Is found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services; and~~
 - (e) ~~place and maintain heparin or saline locks.~~
- (2) ~~When confronted with serious or life threatening clinical situations as defined in the patient care protocols established by the sponsor hospital of the ALS program and approved by the Office of Emergency Medical Services, perform as necessary under standing orders any of the following prior to contacting the sponsor hospital:~~
 - (a) ~~cardiopulmonary resuscitation;~~
 - (b) ~~defibrillation by means of an automatic or semi automatic defibrillator;~~
 - (c) ~~pulmonary ventilation by means of a blind insertion airway device or endotracheal tube;~~
 - (d) ~~establish an intravenous line in a peripheral vein;~~
 - (e) ~~administer any fluid or medication specified for use by EMT Is found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services;~~
- (3) ~~When in the presence of an EMT P perform any act listed in this Rule upon direction of the EMT P as defined by the patient care~~

~~protocols of the ALS program and approved by the Office of Emergency Medical Services.~~
~~(4) When transferring a patient who is receiving intravenous therapy begun at the transferring agency, and where the capability of continuous two way voice communication is maintained with a physician, approved MICN, physician assistant or nurse practitioner located in the sponsor hospital, or when meeting the requirements of Rule .1003 of this Subchapter and upon order of such physician, MICN, physician assistant or nurse practitioner, EMT Is may maintain intravenous lines for any fluid or medication specified for use by EMT Is during patient transfers on the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services and approved by the program medical director for use in patient transfers.~~

Authority G.S. 143-514.

21 NCAC 32H .0404 MOBILE INTENSIVE CARE NURSE PERFORMANCE

~~MICNs currently approved by the North Carolina Medical Board, while functioning under the direction of a physician in the sponsor hospital of an approved ALS program, may direct ALS professionals to perform actions as defined in Rules .0402, .0403 and .0407 of this Subchapter by the sponsor hospital for that ALS program. All orders issued to ALS professionals by MICNs shall be countersigned by a physician.~~

Authority G.S. 143-514.

21 NCAC 32H .0405 ALS PROFESSIONAL PERFORMANCE IN THE PRESENCE OF A PHYSICIAN

~~When there is a physician licensed to practice medicine present at the scene of a medical or traumatic emergency and that physician chooses to assume medical responsibility for the patient, the ALS professionals at the scene shall:~~

- (1) ~~require and allow that physician to contact the sponsor hospital and the physician who receives the call at the sponsor hospital shall make the decision as to whether or not the physician on the scene is to be allowed to take charge of the patient and give orders;~~
- (2) ~~if the physician on the scene is allowed to take charge, permit that physician's orders to take precedence over all other procedures or protocols normally utilized within that ALS program; and~~
- (3) ~~follow the orders of the physician within the limits enumerated in Rules .0402, .0403, and .0407 of this Section.~~

Authority G.S. 143-514.

21 NCAC 32H .0407 EMERGENCY MEDICAL TECHNICIAN-DEFIBRILLATION PERFORMANCE

~~EMT Ds educated in approved programs, certified by the North Carolina Medical Board to perform medical acts, and~~

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functioning in an approved ALS program may perform any of the following in accordance with the protocols established by their sponsor hospital:

- (1) When confronted with a pulseless non breathing patient, perform as necessary under standing orders any of the following prior to contacting the sponsor hospital:
 - (a) defibrillation by means of an automatic or semi-automatic defibrillator;
 - (b) pulmonary ventilation by means of a blind insertion airway device; and
 - (c) cardiopulmonary resuscitation.
- (2) When confronted with serious or life threatening clinical situations as defined in the patient care protocols established by the sponsor hospital of the ALS program and approved by the Office of Emergency Medical Services, administer under standing orders prior to contacting the sponsor hospital any fluid or medication specified for use by EMT Ds found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services.
- (3) While at the scene of a medical emergency where the capability of continuous two way voice communication is maintained with a physician, approved MICN, physician assistant or nurse practitioner located in the sponsor hospital, and upon order of such physician, MICN, physician assistant or nurse practitioner, administer in a fashion approved by the program medical director any fluid or medication specified for use by EMT Ds found in the North Carolina EMS Medication Formulary approved by the Office of Emergency Medical Services.

Authority G.S. 143-514.

21 NCAC 32H .0408 EMERGENCY MEDICAL DISPATCHER PERFORMANCE

EMDs educated in approved programs, when certified by the North Carolina Medical Board, and while functioning in an approved Emergency Medical Dispatch program, may do the following in compliance with the protocols established in the emergency medical dispatch priority reference protocol system approved by the medical director:

- (1) Receive and process calls for medical assistance in a standardized manner, using the approved EMDPRS protocol to elicit required information for evaluating, advising, and treating sick or injured individuals, and dispatching an appropriate EMS response.
- (2) Provide pre arrival instructions to the patient through the caller when possible and appropriate to do so while functioning in compliance with the EMDPRS.

Authority G.S. 143-514.

21 NCAC 32H .0409 PHYSICIAN ASSISTANT OR NURSE PRACTITIONER PERFORMANCE

Physician assistants and nurse practitioners while functioning under the direction of a physician in the sponsor hospital of an approved ALS program, may direct ALS professionals to perform actions as defined in Rules .0402, .0403 and .0407 of this Section and approved by the sponsor hospital for that ALS program. All orders issued to ALS professionals by physician assistants or nurse practitioners shall be countersigned by a physician.

Authority G.S. 143-514.

SECTION .0500 - CERTIFICATION AND APPROVAL REQUIREMENTS FOR ADVANCED LIFE SUPPORT PERSONNEL

21 NCAC 32H .0501 CERTIFICATION REQUIREMENTS: EMT-PARAMEDIC

(a) To become certified as an EMT P, a person shall meet the following criteria within one year of the approved educational program completion date:

- (1) be currently certified as an emergency medical technician in the State of North Carolina;
- (2) be affiliated on a continuous basis with an ambulance provider that has been issued a permit by the Office of Emergency Medical Services, or an approved first responder organization which functions as part of an approved ALS program;
- (3) successfully complete an EMT P educational program meeting the requirements of the "North Carolina EMT P Curriculum Outline." If the educational program was completed over one year prior to application, a person shall submit evidence of completion of pertinent continuing education in emergency medicine taken in the past year and have the continuing education approved by the Office of Emergency Medical Services;
- (4) successfully complete a performance evaluation conducted under the direction of the medical director of the ALS program assessing the ability to perform the skills and procedures specified in Rule 0402 of this Subchapter;
- (5) be recommended for certification upon examination by an oral interview panel established by the ALS program in which the person is proposing to function;
- (6) pass a basic life support practical examination approved or administered by the Office of Emergency Medical Services; and
- (7) pass the EMT P written examination administered by the Office of Emergency Medical Services.

(b) Persons holding current certification as an EMT P with the National Registry of Emergency Medical Technicians or in another state where the educational and certification requirements have been approved for legal recognition by the Office of Emergency Medical Services may become certified by:

(1) presenting evidence of such certification for verification by the Office of Emergency Medical Services; and

(2) meeting the criteria specified in Subparagraphs (a)(1), (a)(2), (a)(4), and (a)(5) of this Rule.

(e) Certification obtained through legal recognition shall be valid for four years or the unexpired term of the certification that was used to obtain a certification in this state, whichever is shorter. All certifications shall be valid for the period stated on the certificate issued to the applicant. This period shall not exceed four years. Persons shall be recertified by presenting documentation to the Office of Emergency Medical Services that they have successfully completed the following:

(1) an ongoing continuing education program under the direction of the medical director, meeting the requirements of "Guidelines for Continuing Education and Performance Evaluation of Emergency Medical Services Advanced Life Support Personnel;"

(2) an ALS performance evaluation conducted under the direction of the medical director meeting the requirements of "Guidelines for Continuing Education and Performance Evaluation of Emergency Medical Services Advanced Life Support Personnel" assessing the ability to perform the skills specified in Rule .0402 of this Subchapter;

(3) basic life support practical examination approved or administered by the Office of Emergency Medical Services; and

(4) an EMT P written examination approved or administered by the Office of Emergency Medical Services.

Authority G.S. 143-514.

21 NCAC 32H .0502 CERTIFICATION REQUIREMENTS: EMT-INTERMEDIATE

(a) To become certified as an EMT I a person shall meet the following criteria within one year of the approved educational program completion date:

(1) be currently certified as an emergency medical technician in the State of North Carolina;

(2) be affiliated on a continuous basis with an ambulance provider that has been issued a permit by the Office of Emergency Medical Services, or an approved first responder organization which functions as part of an approved ALS program;

(3) successfully complete an EMT I educational program meeting the requirements of the "North Carolina EMT I Curriculum Outline." If the educational program was completed over one year prior to application, a person shall submit evidence of completion of pertinent continuing education in emergency medicine taken in the past year and have the continuing education approved by the Office of Emergency Medical Services;

(4) successfully complete a performance evaluation conducted under the direction of the

medical director of the ALS program assessing his the ability to perform the skills and procedures specified in Rule .0403 of this Subchapter;

(5) be recommended for certification upon examination by an oral interview panel established by the ALS program in which the person is proposing to function;

(6) pass a basic life support practical examination approved or administered by the Office of Emergency Medical Services; and

(7) pass the EMT I written examination administered by the Office of Emergency Medical Services.

(b) Persons holding current certification as an EMT I with the National Registry of Emergency Medical Technicians or in another state where the educational and certification requirements have been approved for legal recognition by the Office of Emergency Medical Services may become certified by:

(1) presenting evidence of such certification for verification by the Office of Emergency Medical Services; and

(2) meeting the criteria specified in Subparagraphs (a)(1), (a)(2), (a)(4), and (a)(5) of this Rule.

(c) Certification obtained through legal recognition shall be valid for four years or the unexpired term of the certification that was used to obtain a certification in this state, whichever is shorter. All certifications shall be valid for the period stated on the certification issued to the applicant. This period shall not exceed four years. Persons shall be recertified by presenting documentation to the Office of Emergency Medical Services that they have successfully completed the following:

(1) an ongoing continuing education program under the direction of the medical director, meeting the requirements of "Guidelines for Continuing Education and Performance Evaluation of Emergency Medical Services Advanced Life Support Personnel;"

(2) an ALS performance evaluation conducted under the direction of the medical director meeting the requirements of "Guidelines for Continuing Education and Performance Evaluation of Emergency Medical Services Advanced Life Support Personnel" assessing the ability to perform the skills specified in Rule .0403 of this Subchapter;

(3) basic life support practical examination approved or administered by the Office of Emergency Medical Services; and

(4) an EMT I written examination approved or administered by the Office of Emergency Medical Services.

Authority G.S. 143-514.

21 NCAC 32H .0503 APPROVAL REQUIREMENTS: MOBILE INTENSIVE CARE NURSE

(a) To be approved as a MICN, a person must meet the following criteria within one year of the approved educational program completion date:

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- (1) be currently licensed as a registered nurse in the State of North Carolina;
- (2) be affiliated on a continuous basis with a sponsor hospital which is part of an approved ALS program;
- (3) have a minimum of two years emergency or critical care nursing experience, or a combination of this experience;
- (4) present evidence of successful completion of a MICN educational program meeting the requirements of the "North Carolina MICN Curriculum Outline." If the educational program was completed over one year prior to application, a person must submit evidence of completion of pertinent continuing education in emergency medicine taken in the past year and have the continuing education approved by the Office of Emergency Medical Services; and
- (5) be recommended by the medical director of the ALS program after determining that the applicant is adequately familiar with the patient care and operational protocols of the ALS program.

(b) Approval shall be valid for a period not to exceed four years at which time the person may be reapproved by successfully completing an approved MICN reapproval program under the direction of the medical director, meeting the requirements of "Guidelines for Approval/Reapproval of Mobile Intensive Care Nurses."

Authority G.S. 143-514.

21 NCAC 32H .0505 CERTIFICATION REQUIREMENTS: EMT-DEFIBRILLATION

(a) To become certified as an EMT-D a person shall meet the following criteria within one year of the approved educational program completion date:

- (1) be currently certified as an emergency medical technician in the State of North Carolina;
- (2) be affiliated on a continuous basis with an ambulance provider that has been issued a permit by the Office of Emergency Medical Services, or an approved first responder organization which functions as part of an approved ALS program;
- (3) successfully complete an EMT-D educational program meeting the requirements of the "North Carolina EMT-D Curriculum Outline." If the educational program was completed over one year prior to application, a person shall submit evidence of completion of pertinent continuing education in emergency medicine taken in the past year and have the continuing education approved by the Office of Emergency Medical Services;
- (4) successfully complete a performance evaluation conducted under the direction of the medical director of the ALS program assessing the ability to perform the skills and procedures specified in Rule .0407 of this Subchapter;

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course including adult and infant CPR or equivalent;

(4) successfully complete an approved EMD educational program meeting the requirements of the "Guidelines for Development and Operation of Emergency Medical Dispatch Programs." If the educational program was completed over one year prior to application, a person shall submit evidence of completion of pertinent continuing education in emergency medical dispatch taken in the past year and have the continuing education approved by the Office of Emergency Medical Services;

(5) successfully complete an evaluation conducted under the direction of the medical director of the EMD program assessing the ability to perform the skills and procedures specified in Rule .0408 of this Subchapter; and be recommended for certification examination;

(6) pass the EMD written examination administered or approved by the Office of Emergency Medical Services.

(b) Persons holding current certification equivalent to EMD where the educational and certification requirements have been approved for legal recognition by the Office of Emergency Medical Services may become certified by:

(1) presenting evidence of such certification for verification by the Office of Emergency Medical Services; and

(2) meeting the criteria specified in Subparagraphs (a)(1), (a)(2), (a)(3), and (a)(5) of this Rule.

(c) Certification obtained through legal recognition shall be valid for four years or the unexpired term of the certification that was used to obtain a certification in this state, whichever is shorter. All certifications shall be valid for the period stated on the certificate issued to the applicant by the Office of Emergency Medical Services. This period shall not exceed four years. Persons shall be recertified by presenting documentation to the Office of Emergency Medical Services that they have successfully completed the following:

(1) an ongoing continuing education program under the direction of the medical director, meeting the requirements of "Guidelines for Development and Operation of Emergency Medical Dispatch Programs";

(2) an EMD performance evaluation conducted under the direction of the medical director meeting the requirements of "Guidelines for Development and Operation of Emergency Medical Dispatch Programs" assessing the ability to perform the skills specified in Rule .0408 of this Subchapter; and

(3) an EMD written examination approved or administered by the Office of Emergency Medical Services.

(a) To be approved as a physician assistant or nurse practitioner functioning under these Rules, a person must meet the following criteria within one year of the approved educational program completion date:

(1) be currently approved and licensed as a physician assistant or nurse practitioner in the State of North Carolina;

(2) be affiliated on a continuous basis with a sponsor hospital which is part of an approved ALS program;

(3) have a minimum of two years emergency or critical care experience, or a combination of this experience;

(4) present evidence of successful completion of a physician assistant or nurse practitioner educational program meeting the requirements of the "North Carolina Physician Assistant and Nurse Practitioner EMS Curriculum Outline." If the educational program was completed over one year prior to application, a person shall submit evidence of completion of pertinent continuing education in emergency medicine taken in the past year and have the continuing education approved by the Office of Emergency Medical Services; and

(5) be recommended by the medical director of the ALS program after determining that the applicant is adequately familiar with the patient care and operational protocols of the ALS program.

(b) Approval shall be valid for a period not to exceed four years at which time the person may be reapproved by successfully completing an approved physician assistant or nurse practitioner reapproval program under the direction of the medical director, meeting the requirements of "Guidelines for Approval/Reapproval of Physician Assistants and Nurse Practitioners Functioning In EMS Programs."

Authority G.S. 143-514.

21 NCAC 32H .0508 AEROMEDICAL MEDICAL CREW MEMBERS

All medical crew members, including speciality teams shall meet, at a minimum, the following criteria:

(1) Fly an average of at least five missions per month per six month period or complete refresher education in aircraft safety every six months; and

(2) Complete refresher education in aircraft safety on an annual basis.

Authority G.S. 143-514.

SECTION .0600 - ENFORCEMENT

21 NCAC 32H .0601 GROUNDS FOR DENIAL, SUSPENSION, OR REVOCATION

(a) The North Carolina Medical Board may deny, suspend or revoke the approval of an ALS program, EMD program, or sponsor hospital for any of the following reasons:

Authority G.S. 143-514.

21 NCAC 32H .0507 APPROVAL REQUIREMENTS: PHYSICIAN ASSISTANT AND NURSE PRACTITIONER

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(1) failure to comply with the requirements as found in Sections .0200 and .0300 of this Subchapter; or

(2) obtaining approval through fraud or misrepresentation.

(b) The North Carolina Medical Board may deny, suspend or revoke the certification of an ALS professional or the approval of a MICN, physician assistant or nurse practitioner for any of the following reasons:

(1) failure to comply with the applicable performance and certification and approval requirements as found in this Subchapter;

(2) immoral or dishonorable conduct;

(3) making false statements or representations to the North Carolina Medical Board or the Office of Emergency Medical Services or willfully concealing of material information in connection with an application for certification or approval;

(4) being unable to perform as an ALS professional, MICN, physician assistant or nurse practitioner with reasonable skill and safety to patients and the public by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality;

(5) unprofessional conduct, including but not limited to a failure to comply with the rules relating to the proper function of an ALS professional, MICN, physician assistant or nurse practitioner contained in this Subchapter or the performance of or attempt to perform a procedure which is detrimental to the health and safety of a patient or which is beyond the scope and responsibility of the ALS professional, MICN, physician assistant or nurse practitioner;

(6) conviction in any court of a crime involving moral turpitude, a conviction of a felony, or conviction of a crime involving the function of an ALS professional, MICN, physician assistant or nurse practitioner;

(7) by false representations obtaining or attempting to obtain money or anything of value from a patient;

(8) adjudication of mental incompetence;

(9) lack of professional competence to practice with a reasonable degree of skill and safety for patients including but not limited to a failure to perform a prescribed procedure, failure to perform a prescribed procedure competently or performance of a procedure which is not within the scope of official duties of the ALS professional, MICN, physician assistant or nurse practitioner;

(10) failure to respond within a reasonable period of time and in a reasonable manner to inquiries from the North Carolina Medical Board or the Office of Emergency Medical Services concerning any matter relating to the practice of an ALS professional, MICN, physician assistant or nurse practitioner;

(11) testing positive for substance abuse by blood, urine or breath testing while on duty as an ALS professional, MICN, physician assistant or nurse practitioner; or

(12) representing or allowing others to represent that the ALS professional, MICN, physician assistant or nurse practitioner is a physician or otherwise has a certification or approval that the ALS professional, MICN, physician assistant or nurse practitioner does not in fact have.

Authority G.S. 143-514.

21 NCAC 32H .0602 PROCEDURES FOR DENIAL, SUSPENSION, OR REVOCATION

(a) The North Carolina Medical Board may deny, suspend or revoke the certification of an ALS professional or the approval of a MICN, physician assistant, nurse practitioner, sponsor hospital, EMD program or ALS program in accordance with G.S. 150B Article 3A.

(b) Notwithstanding Paragraph (a) of this Rule, the North Carolina Medical Board may summarily suspend the certification of an ALS professional, the approval of a MICN, physician assistant, nurse practitioner, sponsor hospital, EMD program or ALS program as specified in G.S. 150B 3(c).

Authority G.S. 143-514.

SECTION .0700 - EXCEPTIONS

21 NCAC 32H .0701 CONDITIONS

Upon application of interested citizens in North Carolina, the North Carolina Medical Board may approve the furnishing and providing of ALS programs in North Carolina by persons who have been approved to provide these services by an agency of a state or federal jurisdiction adjoining North Carolina. This approval may be granted where the North Carolina Medical Board finds and concludes that the requirements enumerated in Rule .0201 of this Subchapter for ALS programs cannot be reasonably obtained by reason of lack of geographical access.

Authority G.S. 143-514.

SECTION .0800 - FORMS

21 NCAC 32H .0801 INCORPORATION BY REFERENCE

The following documents are required for educational and evaluation programs and incorporated herein by reference including subsequent amendments and editions. Copies of these documents are available free of charge from the Office of Emergency Medical Services, PO Box 29530, Raleigh, NC 27626-0530:

(1) "North Carolina EMT-P Curriculum Outline";

(2) "North Carolina EMT-I Curriculum Outline";

(3) "North Carolina EMT-D Curriculum Outline";

(4) "North Carolina MICN Curriculum Outline";

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- (5) "Guidelines for Continuing Education and Performance Evaluation of Emergency Medical Services Advanced Life Support Personnel";
- (6) "Guidelines for Approval/Reapproval of Mobile Intensive Care Nurses";
- (7) "Guidelines for the Selection and Performance of the Emergency Medical Services Nurse Liaison";
- (8) "Guidelines for Development and Operation of Emergency Medical Dispatch Programs";
- (9) "North Carolina Physician Assistant and Nurse Practitioner Emergency Medical Services Curriculum Outline";
- (10) "Guidelines for Approval/Reapproval of Physician Assistants and Nurse Practitioners Functioning In EMS Programs";
- (11) "North Carolina EMS Medication Formulary."

Authority G.S. 143-514.

21 NCAC 32H .0802 SOURCE OF FORMS AND DOCUMENTS

Forms and documents may be secured free of charge from the Office of Emergency Medical Services, Division of Facility Services, Department of Human Resources, P.O. Box 29530, Raleigh, N. C. 27626-0530, (919) 733-2285.

Authority G.S. 143-514.

SECTION .0900 – STUDY PROJECTS

21 NCAC 32H .0901 CONDITIONS

(a) Persons proposing to undertake a study project shall have a project director who is a physician licensed to practice medicine in the State of North Carolina and shall submit a written proposal to the Office of Emergency Medical Services for presentation to the North Carolina Medical Board. The proposal shall include the following:

- (1) a description of the purpose of the project, an explanation of the proposed project, the methodology to be used in implementing the project, and the geographical area to be covered by the proposed project;
- (2) a list of the ALS programs, EMD programs, ambulance providers, and hospitals participating in the project;
- (3) a signed statement of endorsement from the medical director of each participating ALS program, EMD program, the chief executive officer of each participating hospital, and the director of each participating ambulance provider;
- (4) a description of the skills to be utilized by the ALS professionals if different from those specified in this Subchapter, the provisions for training and supervising the personnel who are to utilize these skills and the names of such personnel; and
- (5) the name and signature of the project director attesting to the approval of the proposal.

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- (b) The hospitals and ambulance providers participating in the project shall be a part of an approved ALS program.
- (c) The time period for the project shall not exceed three years.

Authority G.S. 143-514.

21 NCAC 32H .0902 STUDY PROJECT APPROVAL

(a) The North Carolina Medical Board may grant approval to any project which is found to comply with the conditions specified in this Section.

(b) Project approval shall be granted for a period of one year from the date of approval by the North Carolina Medical Board. Approval for continuation beyond this period by the North Carolina Medical Board shall be based on the achievement of satisfactory progress as evidenced in written progress reports to be submitted to the Office of Emergency Medical Services at least 90 days prior to the end of the approved year.

(c) Approval of a project by the North Carolina Medical Board shall constitute approval of the personnel listed in the proposal to exercise the specified skills as participants in the project. The project director shall submit the names of additional personnel to the Office of Emergency Medical Services for approval by the North Carolina Medical Board prior to using additional personnel in the project.

(d) The North Carolina Medical Board may rescind approval of the study project at any time.

Authority G.S. 143-514.

21 NCAC 32H .0903 STUDY RECOMMENDATIONS

At least six months prior to the planned completion of the study project, the project director shall submit to the Office of Emergency Medical Services a report of the preliminary findings of the project and any recommendations for changes in this Subchapter.

Authority G.S. 143-514.

SECTION .1000 – MEDICAL CONTROL

21 NCAC 32H .1001 MEDICAL CONTROL PROCEDURES

Each ALS program must have procedures established to ensure medical control over the medical care rendered in the ALS program. This shall include, at a minimum:

- (1) a designated medical director to carry out the tasks as specified in Rule .0201(2)(a)-(e) of this Subchapter;
- (2) treatment protocols or approved emergency medical dispatch priority reference system (EMDPRS);
- (3) operational protocols for obtaining medical direction from the sponsor hospital(s); and
- (4) audit and review of the medical care rendered in the program.

Authority G.S. 143-514.

21 NCAC 32H .1002 MEDICAL CONTROL FROM HOSPITAL OUTSIDE SERVICE AREA

ALS professionals transporting patients to a facility other than their own sponsor hospital may receive orders from the facility to perform the skills allowed in Section .0400 of this Subchapter provided that:

- (1) the facility is a sponsor hospital;
- (2) the care level of the ALS orders issued is consistent with the hospital's approved level of sponsorship;
- (3) the patient care protocols used by the receiving facility are consistent with those of the provider;
- (4) the respective audit and review committees establish a mechanism for the routine exchange of information;
- (5) the ALS professionals establish and maintain two-way voice communications with the receiving facility; and
- (6) the Office of Emergency Medical Services has received and approved documentation from the administrator and medical director of each facility specifying how Paragraphs (1) through (5) of this Rule have been met.

Authority G.S. 143-514.

21 NCAC 32H .1003 MEDICAL CONTROL FOR TRANSPORTS BETWEEN FACILITIES

ALS professionals transporting patients between facilities may accept orders from sponsor hospitals other than their own sponsor hospital provided that:

- (1) the care level of the ALS orders issued is consistent with the hospital's approved level of sponsorship;
- (2) the patient is transported to the hospital issuing the orders; and
- (3) the ALS professionals establish and maintain two-way voice communications with the hospital issuing the orders.

Authority G.S. 143-514.

21 NCAC 32H .1004 AIR AMBULANCE PROGRAM CRITERIA

(a) Air ambulance programs operating under the authority of 10 NCAC 03D .0801(b)(4)(B) must submit a proposal for program approval to the Office of Emergency Medical Services at least 60 days prior to field implementation. The proposal must document that the program has:

- (1) a defined service area;
- (2) a physician medical director responsible for:
 - (A) the establishment and updating of treatment and transfer protocols;
 - (B) medical supervision of the selection, education, and performance of medical crew members as defined in Rule .0102(2) of this Subchapter;
 - (C) the medical review of patient care; and
 - (D) medical management of the program. The medical director may temporarily suspend, pending due process review,

any medical crew member whose actions or medical care are determined to be detrimental to patient care;

- (3) adequate medical crew members educated, in accordance with Rule .0508 of this Subchapter, to ensure that the program will be continuously available on a 24 hour a day basis;
- (4) an audit and review panel which meets at a minimum on a quarterly basis to:
 - (A) review cases and determine the appropriateness of medical care rendered;
 - (B) make recommendations to the medical director about the continuing education needed by medical crew members; and
 - (C) review and revise policies, procedures, and protocols for the program;
- (5) patient transfer protocols that have been reviewed and approved by the Office of Emergency Medical Services.

(b) Air ambulance programs based outside of North Carolina may be granted approval by the Office of Emergency Medical Services to operate in North Carolina under 10 NCAC 03D .0801(b)(4)(B) by submitting a proposal for program approval. The proposal must document that the program meets all criteria specified in Paragraph (a) of this Rule, and has been issued a Certificate of Need by the Department.

Authority G.S. 143-514.

SUBCHAPTER 32I - EPINEPHRINE FOR ADVERSE REACTIONS TO INSECT STINGS

21 NCAC 32I .0101 REQUIREMENTS FOR APPROVAL

Individuals who desire to be considered for approval by the Board of Medical Examiners to administer epinephrine to persons who suffer adverse reaction to insect stings shall present evidence to the satisfaction of the Board that such individual possesses and has met the following requirements:

- (1) completed a training program designed to instruct individuals in the appropriate use of procedures for the administration of epinephrine to persons who suffer adverse reactions to insect stings as outlined in 21 NCAC 32I .0002 hereof;
- (2) be 18 years of age or older; and
- (3) be of good moral character, not having violated any law of Chapter 90 of the General Statutes or any Rule adopted under that Chapter.

Authority G.S. 143-509(9).

21 NCAC 32I .0102 TRAINING PROGRAMS

PROPOSED RULES

~~Programs shall be taught by a physician licensed to practice medicine in the State of North Carolina, to include but not be limited to the following:~~

- ~~(1) definition of anaphylaxis;~~
- ~~(2) agents which might cause anaphylaxis and the distinction between them, including:~~
 - ~~(a) drugs;~~
 - ~~(b) insects;~~
 - ~~(c) foods;~~
 - ~~(d) inhalants;~~
- ~~(3) recognition of symptoms of anaphylaxis;~~
- ~~(4) appropriate emergency treatment of anaphylaxis as a result of insect stings;~~
- ~~(5) availability and nature of packages containing equipment for administering to anaphylaxis as a result of insect stings;~~
- ~~(6) pharmacology of epinephrine:~~
 - ~~(a) indications;~~
 - ~~(b) contraindications;~~
 - ~~(c) side effects;~~
- ~~(7) discussion of legal implications of rendering aid; and~~
- ~~(8) instruction that treatment is to be utilized only in the absence of the availability of physicians~~

~~or other practitioners who are authorized to administer the treatment.~~

Authority G.S. 143-509(9).

21 NCAC 32I .0103 APPROVAL

~~A certification by the physician from whom the individual has received instruction as required in Rule .0002 of this Subchapter, certifying that such individual has satisfactorily completed such training program shall be filed with the N.C. Office of Emergency Medical Services. Upon recommendation of the Office of Emergency Medical Services, the Board will approve applicants to administer epinephrine for the treatment of adverse reactions to insect stings. This approval will be effective for four years.~~

Authority G.S. 143-509(9).

21 NCAC 32I .0104 FORMS

~~Forms may be obtained from the Office of Emergency Medical Services, Division of Facility Services, Department of Human Resources, P.O. Box 29530, Raleigh, N.C. 27626-0530.~~

Authority G.S. 143-509(9).

This Section includes temporary rules reviewed by the Codifier of Rules and entered in the North Carolina Administrative Code and includes, from time to time, a listing of temporary rules that have expired. See G.S. 150B-21.1 and 26 NCAC 02C .0500 for adoption and filing requirements. Pursuant to G.S. 150B-21.1(e), publication of a temporary rule in the North Carolina Register serves as a notice of rule-making proceedings unless this notice has been previously published by the agency.

TITLE 10 - DEPARTMENT OF HEALTH AND HUMAN SERVICES**Rule-making Agency:** *Division of Facility Services***Rule Citation:** *10 NCAC 03R .6352***Effective Date:** *April 8, 2002***Findings Reviewed and Approved by:** *Beecher R. Gray***Authority for the rulemaking:** *G.S. 131E-176(25); 131E-177(1); 131E-183*

Reason for Proposed Action: *The annual State Medical Facilities Plan (SMFP) contains an inventory of facilities/beds/equipment in addition to various dates that CON applications are due. As the inventory of facilities, beds and equipment is updated throughout the year, amendments to the SMFP temporary rules are sometimes necessary. Rule 10 NCAC*

03R.6383 was recently amended to reflect a change in chemical dependency adult detox-only beds in Mental Health Planning Area 17. Specifically, that amendment identified a need for 10 beds in Planning Area 17. There was no need in Area 17 prior to this amendment. An amendment to this Rule is now necessary to comply with the recent change to 10 NCAC 03R.6383. This Rule identifies the beginning review dates for all CON applications. Subitem 18 of this Rule identifies the schedule for Chemical Dependency Adult Detox-only Beds "in accordance with 10 NCAC 03R.6383." Because 10 NCAC 03R.6383 now identifies a need for Area 17, a beginning review date for CON applications from that area must now be included in this Rule. Without the amendment, a need would exist in one rule without a corresponding date to submit an application in the other.

Comment Procedures: *Questions or comments concerning the rules should be directed to Mark Benton, Rule-making Coordinator, Division of Facility Services, 701 Barbour Drive, 2701 Mail Service Center, Raleigh, NC 27699-2701.*

CHAPTER 03 – FACILITY SERVICES**SUBCHAPTER 03R - CERTIFICATE OF NEED REGULATIONS****SECTION .6300 - PLANNING POLICIES AND NEED DETERMINATION FOR 2001****10 NCAC 03R .6352 CERTIFICATE OF NEED REVIEW SCHEDULE**

The Department of Health and Human Services (DHHS) has established the following review schedules for certificate of need applications.

(1) Acute Care Beds (in accordance with the need determination in 10 NCAC 03R .6356)

Hospital Service System	CON Beginning Review Date
Brunswick County Hospital	July 1, 2002

(2) Operating Rooms (in accordance with the need determination in 10 NCAC 03R .6358)

Ambulatory Surgery Service Area (Constituent Counties)	Certificate of Need Beginning Review Date
8 (Bladen, Cumberland, Robeson, Sampson)	March 1, 2002
10 (Buncombe, Haywood, Madison, Mitchell, Yancey)	March 1, 2002
24 (Greene, Lenoir, Martin, Pitt)	July 1, 2002
27 (Hoke, Lee, Montgomery, Moore, Richmond, Scotland)	March 1, 2002

(3) Open Heart Surgery Services (in accordance with the need determination in 10 NCAC 03R .6359)

County	CON Beginning Review Date
Robeson	May 1, 2002

(4) Heart-Lung Bypass Machines (in accordance with the need determination in 10 NCAC 03R .6360)

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Hospital Service System	CON Beginning Review Date
Pitt County Memorial NorthEast Medical Center	May 1, 2002 August 1, 2002

(5) Fixed Cardiac Catheterization Equipment (in accordance with the need determination in 10 NCAC 03R .6361)

County	CON Beginning Review Date
Gaston Wake	April 1, 2002 September 1, 2002

(6) Shared Fixed Cardiac Catheterization Equipment (in accordance with the need determination in 10 NCAC 03R .6362)

Hospital Service System	CON Beginning Review Date
Columbus County	September 1, 2002

(7) Radiation Oncology Treatment Center (in accordance with the need determination in 10 NCAC 03R .6368)

Radiation Oncology Treatment Center Service Area	CON Beginning Review Date
6 (Cleveland, Gaston, Lincoln, Rutherford)	June 1, 2002

(8) Mobile Dedicated Positron Emission Tomography (PET) Scanners (in accordance with the need determination in 10 NCAC 03R .6369)

Positron Emission Tomography (PET) Scanners Planning Region	CON Beginning Review Date
1 (HSAs I, II, III)	August 1, 2002
2 (HSAs IV, V, VI)	November 1, 2002

(9) Magnetic Resonance Imaging Scanners (in accordance with the need determinations in 10 NCAC 03R .6370)

Magnetic Resonance Imaging Scanners Service Areas (Constituent Counties)	CON Beginning Review Date
4 (Ashe, Avery, Watauga)	August 1, 2002
6 (Rutherford, Cleveland)	April 1, 2002
8 (Gaston)	June 1, 2002
9 (Cabarrus, Montgomery, Rowan, Stanly)	June 1, 2002
10 (Iredell)	December 1, 2002
11 (Alleghany, Davie, Forsyth, Stokes, Surry, Wilkes, Yadkin)	April 1, 2002
13 (Caswell, Durham, Granville, Person, Vance, Warren)	May 1, 2002
17 (Anson, Mecklenburg, Union)	October 1, 2002
18 (Cumberland, Hoke, Moore, Robeson, Sampson)	May 1, 2002
19 (Franklin, Harnett, Johnston, Wake)	November 1, 2002
23 (Beaufort, Bertie, Greene, Hyde, Martin, Pitt, Washington)	November 1, 2002

(10) Dedicated Fixed Breast Magnetic Resonance Imaging (MRI) Scanner Need Determination (in accordance with 10 NCAC 03R .6371)

Magnetic Resonance Imaging Scanners Service Area	CON Beginning Review Date
17 (Anson, Mecklenburg, Union)	December 1, 2002

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(11) Magnetic Resonance Imaging Scanners (in accordance with the need determination in 10 NCAC 03R .6372)

Magnetic Resonance Imaging Scanners Service Area	CON Beginning Review Date
3 (Buncombe, Madison, McDowell, Mitchell, Yancey)	August 1, 2002
10 (Iredell)	April 1, 2002
15 (Davidson, Guilford, Randolph & Rockingham)	October 1, 2002
21 (Bladen, Brunswick, Columbus, Duplin, New Hanover, Pender)	September 1, 2002

(12) Adult Care Home Beds (in accordance with the need determination in 10 NCAC 03R .6374)

County	CON Beginning Review Date
Ashe	August 1, 2002
Cherokee	June 1, 2002
Dare	May 1, 2002
Gates	November 1, 2002
Graham	April 1, 2002
Greene	September 1, 2002
Halifax	November 1, 2002
Jones	September 1, 2002
Macon	April 1, 2002
Madison	June 1, 2002
Mitchell	August 1, 2002
Pender	September 1, 2002
Tyrrell	May 1, 2002
Washington	May 1, 2002

(13) Medicare-Certified Home Health Agencies or Offices (in accordance with the need determination in 10 NCAC 03R .6375)

County	CON Beginning Review Date
Montgomery	March 1, 2002
Pamlico	December 1, 2002

(14) Hospice Home Care Programs (in accordance with the need determination in 10 NCAC 03R .6378)

County	CON Beginning Review Date
Beaufort	March 1, 2002
Craven	March 1, 2002
Johnston	December 1, 2002
Robeson	December 1, 2002
Rowan	June 1, 2002
Wilson	March 1, 2002

(15) Single County New Hospice Inpatient Beds (in accordance with the need determination in 10 NCAC 03R .6379)

County	CON Beginning Review Date
Cleveland	October 1, 2002
Cumberland	July 1, 2002
Gaston	June 1, 2002
Richmond	July 1, 2002
Rutherford	October 1, 2002

(16) Adolescent Residential Chemical Dependency (Substance Abuse) Treatment Beds (in accordance with the need determination in 10 NCAC 03R .6382)

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Mental Health Planning Region	CON Beginning Review Date
North Central Region	July 1, 2002

(17) Adult Chemical Dependency (Substance Abuse) Treatment Beds, (in accordance with the need determination in 10 NCAC 03R .6382)

Mental Health Planning Region	CON Beginning Review Date
North Central Region	July 1, 2002

(18) Chemical Dependency (Substance Abuse) Beds – Adult Detox-Only Beds (in accordance with the need determination in 10 NCAC 03R .6383)

Mental Health Planning Area	CON Beginning Review Date
1 (Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain)	July 1, 2002
2 (Buncombe, Madison, Mitchell, Yancey)	July 1, 2002
4 (Henderson, Transylvania)	July 1, 2002
5 (Alexander, Burke, Caldwell, McDowell)	July 1, 2002
6 (Rutherford, Polk)	July 1, 2002
7 (Cleveland, Gaston, Lincoln)	July 1, 2002
10 (Rowan, Stanly, Cabarrus, Union)	July 1, 2002
11 (Surry, Yadkin, Iredell)	July 1, 2002
13 (Rockingham)	July 1, 2002
15 (Alamance, Caswell)	July 1, 2002
16 (Orange, Person, Chatham)	July 1, 2002
<u>17 Durham</u>	<u>July 1, 2002</u>
18 (Vance, Granville, Franklin, Warren)	July 1, 2002
19 (Davidson)	July 1, 2002
21 (Bladen, Columbus, Robeson, Scotland)	July 1, 2002
24 (Johnston)	July 1, 2002
25 (Wake)	July 1, 2002
26 (Randolph)	July 1, 2002
29 (Wayne)	July 1, 2002
30 (Wilson, Greene)	July 1, 2002
31 (Edgecombe, Nash)	July 1, 2002
32 (Halifax)	July 1, 2002
33 (Carteret, Craven, Jones, Pamlico)	July 1, 2002
34 (Lenoir)	July 1, 2002
36 (Bertie, Gates, Hertford, Northampton)	July 1, 2002
37 (Beaufort, Hyde, Martin, Tyrrell, Washington)	July 1, 2002
38 (Camden, Chowan, Currituck, Dare, Pasquotank, Perquimans)	July 1, 2002
39 (Duplin, Sampson)	July 1, 2002

(19) There are ten categories of projects for certificate of need review. The DHHS shall determine the appropriate review category or categories for all applications submitted pursuant to 10 NCAC 03R .0304. For proposals which include more than one category, the DHHS may require the applicant to submit separate applications. If it is not practical to submit separate applications, the DHHS shall determine in which category the application shall be reviewed. The review of an application for a certificate of need shall

commence in the next applicable review schedule after the application has been determined to be complete. The ten categories are:

(A) Category A. Proposals submitted by acute care hospitals, except those proposals included in Categories B through H and Category J, including but not limited to the following types of projects: renovation, construction, equipment, and acute care services.

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(B) Category B. Proposals for nursing care beds; adult care home beds; new continuing care retirement communities applying for exemption under 10 NCAC 03R .6389(b) or .6390; and relocations of nursing care beds under 10 NCAC 03R .6389(d) or 10 NCAC 03R .6389(f).

(C) Category C. Proposals for new psychiatric facilities; psychiatric beds in existing health care facilities; new intermediate care facilities for the mentally retarded (ICF/MR) and ICF/MR beds in existing health care facilities; new substance abuse and chemical dependency treatment facilities; substance abuse and chemical dependency treatment beds in existing health care facilities; transfers of nursing care beds from State Psychiatric Hospitals to local communities pursuant to 10 NCAC 03R .6389(e); transfers of ICF/MR beds from State Mental Retardation Centers to community facilities pursuant to Chapter 858 of the 1983 Sessions Laws.

(D) Category D. Proposals for new dialysis stations in response to the "county need" or "facility need" methodologies; and relocations of existing dialysis stations to another county.

(E) Category E. Proposals for inpatient rehabilitation facilities; inpatient rehabilitation beds; licensed ambulatory surgical facilities; new operating rooms and relocations of existing operating rooms as defined in 10 NCAC 03R .6358(b).

(F) Category F. Proposals for new Medicare-certified home health agencies or offices; new hospices; new hospice inpatient facility beds; and new hospice residential care facility beds.

(G) Category G. Proposals for conversion of hospital beds to nursing care under 10 NCAC 03R .6389(a); and conversion of acute care hospitals to long-term acute care hospitals.

(H) Category H. Proposals for bone marrow transplantation services, burn intensive care services, neonatal intensive care services, open heart surgery services, solid organ transplantation services, air ambulance equipment, cardiac angioplasty equipment, cardiac catheterization equipment, heart-lung bypass machines, gamma knives, lithotriptors, magnetic resonance imaging scanners, positron emission tomography scanners, major medical equipment as defined in G.S. 131E-176 (14f), diagnostic centers as defined in G.S. 131E-176 (7a), and oncology treatment centers as defined in G.S. 131E-176 (18a).

(I) Category I. Proposals involving cost overruns; expansions of existing continuing care retirement communities which are licensed by the Department of Insurance at the date the application is filed and are applying under 10 NCAC 03R .6389(b) for exemption from need determinations in 10 NCAC 03R .6373 or 10 NCAC 03R .6390 for exemption from need determinations in 10 NCAC 03R .6374; relocations within the same county of existing health service facilities, beds or dialysis stations (excluding relocation of operating rooms as defined in 10 NCAC 03R .6358(b)) which do not involve an increase in the number of health service facility beds or stations; reallocation of beds or services; Category A proposals submitted by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990; proposals submitted pursuant to 10 NCAC 03R .6385(c) by Academic Medical Center Teaching Hospitals designated prior to January 1, 1990; acquisition of replacement equipment that does not result in an increase in the inventory; and any other proposal not included in Categories A through H and Category J.

(J) Category J. Proposals for demonstration projects.

(20) A service, facility, or equipment for which a need determination is identified in Items (1) through (18) of this Rule shall have only one scheduled review date and one corresponding application filing deadline in the calendar year as specified in these items, even though the following review schedule shows multiple review dates for the broad category. Applications for certificates of need for new institutional health services not specified in Items (1) through (18) of this Rule shall be reviewed pursuant to the following review schedule, with the exception that no reviews are scheduled if the need determination is zero. Need determinations for additional dialysis stations pursuant to the "county need" or "facility need" methodologies shall be

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reviewed in accordance with 10 NCAC 03R

.6376 or 10 NCAC 03R .6377.

CON Beginning Review Date	Review Categories for HSA I, II, III	Review Categories for HSA IV, V, VI
January 1, 2002	--	--
February 1, 2002	--	--
March 1, 2002	A, E, G, I, J	A, C, E, F, G, H, I, J
April 1, 2002	B, C, D, H, I	D
May 1, 2002	--	B, C, H, I
June 1, 2002	A, B, C, F, H, I	--
July 1, 2002	C	A, C, E, F, I
August 1, 2002	B, H, I	--
September 1, 2002	--	B, C, H, I
October 1, 2002	A, C, D, E, F, H, I	D
November 1, 2002		A, B, C, H, I
December 1, 2002	C, H, I	F

For purposes of Magnetic Resonance Imaging (MRI) scanners reviews only, Anson County in MRI Area 17 is considered to be in HSA III and Caswell County in MRI Area 13 is considered to be in HSA IV.

(21) In order to give the DHHS sufficient time to provide public notice of review and public notice of public hearings as required by G.S. 131E-185, the deadline for filing certificate of need applications is 5:00 p.m. on the 15th day of the month preceding the "CON Beginning Review Date." In instances when the 15th day of the month falls on a weekend or holiday, the filing deadline is 5:00 p.m. on the next business day. The filing deadline is absolute and applications received after the deadline shall not be reviewed in that review period.

individual will receive services when the Division determines that it does not have the resources to serve all eligible individuals. These modifications affect the public and must be included in rules. Temporary rule action is necessary to implement these modifications as soon as possible to allow the Division to manage its resources.

10 NCAC 20C .0119 – *To control expenditures in post secondary education, professional schools, proprietary and trade schools and other training programs, Division staff have modified the rates of payment for providing training services to clients. This modification affects the public and must be included in rules. Temporary rule action is necessary to implement this modification as soon as possible.*

10 NCAC 20C .0205-.0206 – *To control expenditures in services provided to clients the Division has modified the services covered by or exempt from the financial needs test and the financial needs test. These modifications affect the public and must be included in rules. Temporary rule action is necessary to implement these modifications as soon as possible to allow the Division to manage its resources.*

Comment Procedures: Written comments concerning this rule-making action may be submitted within 60 days after the date of publication in this issue of the North Carolina Register. Comments must be submitted to Steven E. Hairston, Rule-making Coordinator, Division of Vocational Rehabilitation Services, 2801 Mail Services Center, Raleigh, NC 27699-2801.

CHAPTER 20 - VOCATIONAL REHABILITATION

SUBCHAPTER 20A - GENERAL INFORMATION

SECTION .0100 - INFORMATION REGARDING RULES

10 NCAC 20A .0102 DEFINITIONS

As used in this Chapter, the following terms have the meaning specified:

(1) "Acceptance for services" means that the category to which an eligible individual is assigned is being served by the Division.

Rule-making Agency: DHHS – Division of Vocational Rehabilitation Services

Rule Citation: 10 NCAC 20A .0102; 20C .0119, .0205-.0206, .0603-.0604, .0606

Effective Date: May 1, 2002

Findings Reviewed and Approved by: Beecher R. Gray

Authority for the rulemaking: G.S. 143-545.1; 143-546.1

Reason for Proposed Action:

10 NCAC 20A .0102; 20C .0603-.0604, .0606 – *To control expenditures in services provided to clients the Division has modified the priority categories that determine when an*

(2) "Designated State Unit" means the state vocational rehabilitation division that is primarily concerned with vocational rehabilitation or vocational and other rehabilitation of individuals with disabilities and that is responsible for the administration of the vocational rehabilitation program of the State agency.

(4)(3) "Division" means the Division of Vocational Rehabilitation Services of the Department of Health and Human Services.

(2)(4) "Division Director" or "Director" means the Director of the Division of Vocational Rehabilitation Services.

(3)(5) "Division's Modification Review Committee" means a committee of Division staff from the State Office appointed by the Division Director and chaired by the Chief of Operations to review for approval or disapproval:

(a) amounts for residence or job site modifications that exceed standard amounts specified in 10 NCAC 20C .0316; and

(b) purchase of vehicles as set forth in 10 NCAC 20C .0316.

(6) "Eligible individual" means an applicant for vocational rehabilitation services who meets the eligibility requirements under 34 C.F.R 361.42(a).

(7) "Extended period of time" means that the individual will require at least nine months to complete the services on the Individualized Plan for Employment (IPE) or will require one of the following services permanently in order to accomplish their job choice and maintain employment:

(a) Personal Assistance Services; or

(b) Rehabilitation Technology; or

(c) Extended Services.

The required minimum of nine months does not include the standard amount of time required to complete a post-secondary training curriculum, but does include extra time required to complete the training curriculum due to disability related reasons.

(8) "Extended Services" means ongoing support services and other appropriate services that are needed to support and maintain an individual with a most significant disability in supported employment and that are provided by a State agency, a private nonprofit organization, employer, or any other appropriate resource, from funds other than funds received by the designated state unit to provide supported employment training and after the individual has made the transition from support provided by the designated State unit.

(4) "Functional Capacity" means the ability to perform in the following areas:

(a) communication;

(b) interpersonal skills;

(c) mobility;

(d) self-care;

(e) self direction;

(f) work skills; and

(g) tolerance.

(9) "Functional Capacity Areas" means the areas of ability which are impacted by an individual's disability and used to determine serious limitations to employment for an eligible individual with a disability. For the purposes of this Section:

(a) "Communication" means the ability to use, give and/or receive information.

(b) "Interpersonal skills" means the ability to establish and/or maintain appropriate interactions with others.

(c) "Mobility" means the ability to move from place to place.

(d) "Self-care" means the ability to plan and/or perform activities of daily living.

(e) "Self direction" means the ability to plan, initiate, organize, or carry out goal-directed activities or solve problems related to self-care, socialization, and working independently.

(f) "Work skills" means the ability to learn and/or perform work functions.

(g) "Work Tolerance" means the ability to sustain the required level of work function.

(5)(10) "Individual with a severe significant disability" "significant disability" has the meaning specified in P.L. 102-569, Section 7(15) which is incorporated by reference.

(6)(11) "Individual with the most severe disability" "Individual with a most significant disability" means an individual with a severe with a significant disability who meets all aspects of the definition for significant disability, and whose impairment seriously limits three or more functional capacity areas in terms of an employment outcome.

(12) "Individualized Plan for Employment" (IPE) means a written document prepared on forms provided by the designated state unit for each eligible individual accepted for services which outlines what is required to achieve an employment outcome.

(13) "Intercurrent illness" means an acute medical condition that arises during the rehabilitation process and constitutes a barrier to the achievement of an employment outcome.

(14) "Multiple services" means two or more primary services.

(15) "Order of Selection" means the priority system under which the Division provides vocational rehabilitation services to eligible individuals

with disabilities when sufficient resources are not available for the Division to serve all eligible individuals with disabilities.

(7)(16) "Permanent disability" means any physical or mental condition which is expected to be lasting regardless of medical or psychological intervention, and which is highly unlikely to go into full or permanent remission.

(17) "Permanent functional limitation" means restrictions in activity or function related to employment imposed by the disability that:

(a) is not likely to be corrected through surgical intervention or medical treatment; and

(b) will require on-going treatment because impediments related to the disability will not be removed through the provision of physical and mental restoration services.

(18) "Personal Assistance Services" means a range of services provided by one or more persons designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability.

(19) "Primary Services" means any one of the following services:

(a) Physical and mental restoration services: Diagnosis and treatment services of impairments excluding treatment of intercurrent illnesses.

(b) Counseling and guidance: Substantial counseling and guidance that addresses separate and specific objectives with documentation of regular appointments and progress towards objectives distinct from the general counseling relationship that exists between the rehabilitation counselor and the eligible individual with a disability throughout the rehabilitation process.

(c) Vocational and other training: Personal and vocational adjustment training, post-secondary, and on-the-job training.

(d) Job Related Services: Job search, placement assistance, job retention services, follow-up services, and follow-along services.

(e) Rehabilitation Technology: Rehabilitation engineering, assistive technology devices, and assistive technology services.

(20) "Priority category" means the order in which eligible individuals with disabilities will be served. These categories are based on refinement of the three criteria in the definition of "individual with a significant disability".

(8)(21) "Post-employment services" means one or more services that are provided subsequent to the achievement of an employment outcome that are necessary for an individual to maintain, regain, or advance in employment, consistent with the individual's abilities, capabilities, and interests.

(22) "Rehabilitation technology" means services that systematically apply technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by an eligible individual with a disability.

(23) "Seriously limits" means that due to a significant physical or mental impairment, one or more of an eligible individual's functional capacity areas is restricted to the degree that the individual requires accommodations not routinely made for other individuals and/or interventions that cannot be easily achieved, and that will be required permanently in order for the individual to obtain and maintain successful employment.

(9)(24) Transferable work skills means skills, educational level, talents, abilities, and knowledge that will allow employment consistent with the individual's strengths, resources, priorities, concerns, capabilities, interest and informed choice.

The section of the Public Law incorporated by reference in this Rule shall automatically include any later amendments thereto as allowed by G.S. 150B-21.6. Copies of the section of the Public Law so incorporated may be obtained at no cost from the Division.

History Note: Authority G.S. 143-545.1; 150B-21.6; P.L. 102-569, s. 7(15); s. 101(a)(5)(A); Eff. February 1, 1976; Amended Eff. February 1, 1996; October 1, 1994; April 1, 1988; Temporary Amendment Eff. May 1, 2002; July 3, 2001.

SUBCHAPTER 20C - PROGRAM RULES

SECTION .0100 - GENERAL POLICIES

10 NCAC 20C .0119 RATES OF PAYMENT

(a) Policies governing rates of payment for all purchases, vocational rehabilitation services, and current rates of payment may be reviewed 8 a.m. to 5 p.m., Monday through Friday, at the Division's State Office, 805 Ruggles Drive, Dorothea Dix Campus, Raleigh, North Carolina. Vendors providing any services authorized by the state agency shall agree not to make any charge to, or accept payment from, the handicapped individual-the individual receiving services from the Division or the individual's family for such services unless the amount for such service charge or payment is previously known to, and where applicable, approved by the Division.

(b) The Division's rate for payment for post secondary education and professional schools will not exceed the median annual rate charged for the public university and professional schools system and the median rate charged for the community

college system as approved by the North Carolina General Assembly October, 2001.

- (1) Proprietary for profit vocational and trade schools or other training programs that offer curriculums comparable to those offered through the community college system will not exceed the median annual rate for payment established for the community college system.
- (2) Proprietary for profit vocational and trade schools or other training programs that offer an accelerated or condensed curriculum or those training programs that offer training in areas not readily accessible to the client offered through the community college system will not exceed the median annual rate established for the public university system.
- (3) Proprietary for profit vocational and trade schools and any other vocational or trade program that does not operate on a semester system or has varying program lengths will have a prorated monthly rate established based on the annual median rate for payment as defined in Subparagraphs (b)(1) and (b)(2) of this Rule.
- (4) For those individuals who are North Carolina residents and choose to attend training programs out-of-state, the Division's rate of payment is limited to the rate specified in Paragraph (b) of this Rule.

(c) No training or training services in an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) as noted in Rule .0205, Paragraph (a)(9) of this Section may be paid for with vocational rehabilitation funds until maximum efforts have been made by the designated state unit and the individual to secure grant assistance in whole or part from other resources to pay for training and such assistance is applied to the cost of training.

History Note: Authority G.S. 143-546; 34 C.F.R. 361.46;

Eff. February 1, 1976;

Amended Eff. May 1, 1990;

Temporary Amendment Eff. May 1, 2002.

SECTION .0200 - ELIGIBILITY

10 NCAC 20C .0205 SERVICES COVERED BY OR EXEMPT FROM FINANCIAL NEEDS TEST

(a) The financial need of a client, as determined by the financial needs test specified in Rule .0206 of this Section, shall apply as a condition for furnishing the following vocational rehabilitation services to clients eligible for services or to clients eligible for extended ~~evaluation~~: evaluation or trial work experiences:

- (1) physical and mental restoration;
- (2) maintenance;
- (3) transportation;
- (4) occupational license;
- (5) tools, equipment, and initial stock (including livestock), supplies and necessary shelters in connection with these items;

- (6) books, training supplies, and materials required for courses in postsecondary educational facilities;
- (7)(6) services to members of the individual's family necessary to the adjustment or rehabilitation of the individual with disabilities;
- (8)(7) ~~rehabilitation technology including~~ telecommunications, sensory, and other technological aids and devices;
- (9) ~~recruiting and training to provide new employment opportunities in rehabilitation, health, welfare, public safety, law enforcement, and other public service employment;~~
- (10)(8) post-employment services necessary to assist individuals with disabilities in maintaining suitable employment (other than those services in Paragraph (b) Paragraphs (b) and (c) of this Rule which are provided without regard to financial need); ~~and~~
- (9) vocational and other training services, ~~including personal and vocational adjustment training, books, tools, and other training materials;~~
- (11)(10) other goods and services expected to benefit an individual with disabilities in obtaining employment or achieving the individual's independent living goals; ~~and~~
- (11) ~~non-assessment services for eligible individuals receiving vocational rehabilitation services through trial work experiences or extended evaluation.~~

(b) No training or training services in an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) as noted in Paragraph (a)(9) of this Rule may be paid for with vocational rehabilitation funds until maximum efforts have been made by the designated state unit and the individual to secure grant assistance in whole or part from other resources to pay for training and such assistance is applied to the cost of training.

(b)(c) The financial needs test shall not apply as a condition for furnishing the following:

- (1) services exempt from the financial needs test under 34 C.F.R. 361.47; 34 C.F.R. 361.54;
- (2) interpreter services ~~for the deaf and~~ foreign language interpreter/translator services for individuals who are unable to understand either verbal or written information presented by the Division;
- (3) ~~notetaker services for individuals enrolled in post secondary training programs: ;~~
- (4) ~~tuition for:~~
 - (A) ~~on the job training;~~
 - (B) ~~community rehabilitation program training;~~
 - (C) ~~community college/college parallel programs up to the catalog rate;~~
 - (D) ~~vocational training at:~~

(i) community college vocational programs up to the catalog rate; and

(ii) proprietary for profit vocational and trade schools up to a limit of four thousand dollars (\$4,000) per training program; and

(E) post secondary education up to the maximum rate charged for the public university system.

(5) fees required in post secondary educational facilities up to the maximum rate charged for the public university system;

(6) training supplies and materials required for training in division operated facilities and the training programs listed in Paragraphs (b)(4)(A) and (B) of this Rule; and

(3) as a condition for furnishing any vocational rehabilitation service to individuals determined eligible for Social Security benefits under Titles II or XVI of the Social Security Act; and

(7)(4) in addition, for individuals in the independent living program, independent living skills training, attendant management training, and recreational therapy when these services are provided by staff of the Division's Independent Living Program.

(e) The Division may grant an exception to the rate for tuition and required fees for post secondary education specified in Paragraphs (b)(4)(E) and (b)(5) of this Rule when necessary to accommodate the special training needs of individuals with severe disabilities who must be enrolled in high cost, special programs designed for students with severe physical disabilities.

(c) The Division may grant an exception to the rate for tuition for post-secondary education specified in Rule .0119 of this Section when accommodations for the special training needs of individuals with significant disabilities are included in the tuition rate.

History Note: Authority G.S. 143-545A; 143-546A; 34 C.F.R. 361.40; 34 C.F.R. 361.41; 34 C.F.R. 361.47; 34 C.F.R. 364.59; Eff. February 1, 1976; Amended Eff. February 1, 1996; October 1, 1994; March 1, 1990; Temporary Amendment Eff. May 1, 2002.

10 NCAC 20C .0206 FINANCIAL NEEDS TEST

(a) A client's financial need shall be determined by application of the General Assembly's financial eligibility scale for non-medicaid medical programs which sets the limit of net annual income for families of various sizes and by consideration of other available assets that could be used to pay for the cost of rehabilitation services. The General Assembly's eligibility financial scale is contained in the annual appropriation bill. In applying the General Assembly's financial eligibility scale, the Division shall follow the provisions of this Rule to determine net monthly income and family size. The General Assembly's eligibility financial scale is usually found in the current appropriations bill as follows: S.L. 1998, c. 212, s. 12.33.

Financial information is obtained to determine the client's financial eligibility to receive services listed in Paragraph (a) of Rule .0205 of this Section. Financial information obtained may include check stubs, State and Federal income tax forms and other information to document income or other financial resources. If the client does not have check stubs or tax returns, the client will be required to complete a verification form signed by their last employer, the individual who supports them, or the agency representative who processes the client's public support. Whenever the financial situation of the client is unclear or there is a question regarding the resources of the client, the Unit Manager will be consulted for analysis or application of client financial information.

(b) The time period to be used as the basis for computing net monthly family income is the month prior to the planning of any service which is based on the individual's financial eligibility. Net monthly family income shall be recomputed at any time there is a change in the family's income: income but at least annually.

(c) A client's family shall include only the client if any of the following conditions apply:

(1) The client is 23 years of age;

(2) The client is a ward of the court;

(3) The client is an emancipated minor;

(4) The client is a veteran of the United States Armed Forces; or

(5) The client is under 23 years of age and can produce a tax return from the year prior to application for services indicating self-support, or receipts, records for basic living expenses such as rent and utilities for a minimum of three consecutive months, pay stubs, or other information such as receipts of medical payments, payment of health insurance premiums, child care payment receipts, and legally mandated payments that indicate that he or she is independently self-supporting.

(e)(d) A client's family shall include the client and the following persons living in the same household as the client if the client is 18 years of age or older and is not being claimed as a dependent by the parents for tax purposes or if the client is less than 18 years of age and is married: if the client is married:

(1) the client's spouse;

(2) the client's children under 18 23 years of age; or

(3) other individuals related to the client by blood, marriage, or adoption if the other individuals have no income; and

(4) the client's children of any age who are temporarily living away from the household while attending school if they are being claimed as dependents by the client for tax purposes.

(d)(e) A client's family shall include the client and the following persons living in the same household as the client if the client is less than 18 23 years of age and is not married or if the client is 18 23 years of age or older and is being claimed as a dependent by the parents for tax purposes: purposes regardless of place of residence:

(1) the client's parents, not including step-parents;

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- (2) siblings or half-siblings of the client, but not step-siblings, if the siblings are unmarried and less than ~~18-23~~ years of age;
- (3) siblings or half-siblings of the client, but not step-siblings, if the siblings are ~~18 23~~ years of age or older and have no income; and
- (4) other individuals related to the client by blood, marriage, or adoption if the other individuals have no income.

~~(e) If a client is 18 years of age or older and is temporarily living away from the permanent home while attending school and is being claimed as a dependent by the parents for tax purposes, the client's family shall be determined according to Paragraph (d) of this Rule.~~

~~(f) In Paragraphs (d)(2) and (3) of this Rule, siblings who are temporarily living away from the household while attending school may be considered as living in the same household if they are being claimed as dependents by their parents for tax purposes and the parents are in the same household as the client.~~

~~(g) Net monthly family income shall be computed by subtracting the deductions allowed in Paragraph (h) of this Rule from the gross monthly family income as computed according to Paragraph (g) of this Rule.~~

~~(h) Gross Monthly Family Income.~~

- (1) Gross monthly family income shall mean the combined cash income received by the client's family from the following sources:
 - (A) wages and salaries;
 - (B) earnings from self-employment;
 - (C) earnings from stocks, bonds, savings accounts, rentals, and all other investments;
 - (D) Social Security benefits and Supplemental Security Income benefits; received by family members;
 - (E) public assistance benefits;
 - (F) retirement and pension payments;
 - (G) Veterans Administration benefits; and
 - (H) all other sources of cash income.
- (2) If the income received from any of the sources listed in Paragraph (g)(1) of this Rule is not received on a monthly basis, the monthly pro rata share of the most recent receipt of the income shall be included in the computation.
- (3) Gross family income shall not include:
 - (A) income that children may earn from babysitting, lawn mowing, or other miscellaneous tasks;
 - (B) gifts;
 - (C) inheritances; ~~or~~
 - (D) life insurance proceeds; proceeds; or
 - (E) Social Security benefits and Supplemental Security Income benefits of the client.

~~(h) Any of the following expenses, which are paid by a member of the client's family, shall be allowed as deductions in determining net monthly income:~~

- (1) state, federal, and Social Security taxes and any mandatory deductions for retirement contributions;

- (2) medical and dental payments not covered by a third-party payer;
- (3) health insurance premiums;
- (4) disability related expenses, not covered by a third-party payor, paid for the client or a member of the client's family except for expenses for those participants or clients who require personal assistance services in order to achieve independent living or an employment outcome and for whom the Division is contributing or is considering contributing to the cost of the personal assistance services;
- (5) child care payments up to one hundred and seventy-five dollars (\$175.00) per child per month for any child in the family unit who is 14 years of age or younger and the parents or other responsible adults are not able to care for the child;
- (6) post-secondary training expenses for family members not to exceed the rate specified in Rule ~~.0205 (b)(4) and (5) .0119, Paragraphs (b)(1)-(b)(4)~~ of this Section; and
- (7) legally mandated payments such as alimony, child support or Social Security paybacks.

~~(i) In addition to net monthly family income, other assets that are available to the client's family shall be considered in determining a client's financial need. Available assets shall mean cash or property which could be used to pay for the cost of rehabilitation services and shall include:~~

- (1) cash in checking or savings accounts which exceeds an amount three times the net monthly income allowed for the family size; and
- (2) real property considering the following provisions:
 - (A) Real property, other than the family homesite, shall be considered if the fair market value less encumbrances exceeds twenty-five thousand dollars (\$25,000).
 - (B) The equity shall be determined by subtracting the amount owed on mortgages or liens from the purchase price or the fair market value, whichever is less.
 - (C) The family homesite for the purposes of this Rule shall be defined as the family's principle place of residence and includes:
 - (i) the house and lot plus all buildings on the lot if the residence is in the city; or
 - (ii) the house and the land on which the house is located up to a maximum of one acre plus all buildings on the acre if the residence is in a rural area.
 - (D) Real property shall be regarded as an available asset to the extent that it can be converted to cash, either by sale or by use as collateral for a loan, in a

timely manner to meet the cost of rehabilitation services.

~~(4)(j)~~ If the client's family has excess resources in either net monthly family income or available assets, the excess resources shall be applied to the cost of the client's rehabilitation. The unit manager shall approve the plan to apply excess resources to the cost of the client's rehabilitation. When the Division is contributing or is considering contributing to the cost of personal assistance services for an individual who has been determined financially eligible according to this Rule, the individual's financial contribution toward the cost of the personal assistance services shall be one-half the excess net monthly family income. The counselor shall determine the amounts to be paid and the method of payment. The unit manager shall approve the payment plan.

~~(4)(k)~~ If there are extenuating circumstances, that prohibit the client's application of the excess resources toward the cost of rehabilitation, the Division may waive the application of part or all of the excess resources toward the rehabilitation. Such circumstances may include the inability to sell property, the fact that the amount of funds would be so small that it would provide little substantial help with the rehabilitation program, and the fact that the conversion of the excess resources may result in undue delay in proceeding with the rehabilitation program. Written approval of the unit manager or facility director shall be required for the waiver. Documentation of the particular circumstances shall be provided by the client and shall be maintained in the client's record.

History Note: Authority G.S. 143-545.1; 143-546.1; 34 C.F.R. 361.47;

Eff. February 1, 1976;

Amended Eff. April 1, 1999; March 1, 1990;

Temporary Amendment Eff. May 1, 2002.

SECTION .0600 - ORDER OF SELECTION FOR SERVICES

10 NCAC 20C .0603 PRIORITY CATEGORIES

(a) The Division shall determine each client's priority category at the time the individual is determined eligible for services. The client shall be placed in the highest category (beginning with Category One) for which he/she qualifies.

(b) The Division shall notify each eligible individual of his/her priority classification in writing at the same time the notification of eligibility is provided.

~~(c) The priority categories for the order of selection for services for eligible individuals are as follows:~~

~~(1) Category One. Individuals who have the most severe disabilities;~~

~~(2) Category Two. Individuals with severe disabilities~~

~~(3) Category Three. Individuals with non-severe and permanent disability who will need multiple vocational rehabilitation services to attain a suitable employment outcome; and~~

~~(4) Category Four. Any eligible individual who does not qualify for placement in a higher priority category.~~

~~(c) The priority categories for order of selection for services for eligible individuals are as follows:~~

(1) Category One: Individuals with a most significant (MSD) disability who are seriously limited in four functional capacity areas;

(A) Individuals with a most significant disability (MSD) who are seriously limited in four functional capacity areas and who receive SSI/SSDI;

(B) Individuals with a most significant disability (MSD) who are seriously limited in four functional capacity areas and who cannot be placed into category 1-A;

(2) Category Two: Individuals with a most significant disability (MSD) who are seriously limited in three functional capacity areas;

(A) Individuals with a most significant disability (MSD) who are seriously limited in three functional areas and who receive SSI/SSDI;

(B) Individuals with a most significant disability (MSD) who are seriously limited in three functional capacity areas and who cannot be placed into category 2-A;

(3) Category Three: Individuals with a significant disability (SD) who are seriously limited in two functional capacity areas;

(A) Individuals with a significant disability (SD) who are seriously limited in two functional capacity areas and who receive SSI/SSDI;

(B) Individuals with a significant disability (SD) who are seriously limited in two functional capacity areas and who cannot be placed into category 3-A;

(4) Category Four: Individuals with a significant disability (SD) who are seriously limited in one functional capacity area;

(A) Individuals with a significant disability (SD) who are seriously limited in one functional capacity area and who receive SSI or SSDI;

(B) Individuals with a significant disability (SD) who are seriously limited in one functional capacity area and who cannot be placed into category 4-A;

(5) Category Five: Individuals with a non-significant and permanent disability that results in permanent functional limitations and who will require multiple vocational rehabilitation services to obtain a suitable employment outcome;

(6) Category Six: Any eligible individual who does not qualify for placement in a higher category.

~~(d) The Division shall follow the provisions of P.L. 102-569, Section 101(a)(13)(B) which is incorporated by reference regarding public safety officers when applicable in its order of selection. This incorporation by reference shall automatically~~

~~include any later amendments to the cited section of the public law as allowed by G.S. 150B-21.6. A copy of the cited section of the public law may be obtained at no cost from the Division.~~

~~(e)(d) The Division shall change a client's priority classification immediately if there are changes in the client's circumstances that warrant a change, significance of disability as evidenced by a review of medical information that warrants a change in their priority category classification. The Division shall notify the client in writing of any change in priority classification.~~

History Note: Authority G.S. 143-545A; 143-546A; P.L. 102-569, s. 101(a)(5)(A); 34 C.F.R. 361.36; Eff. October 1, 1994; Amended Eff. July 1, 1998; April 1, 1997; Temporary Amendment Eff. May 1, 2002.

10 NCAC 20C .0604 PROCEDURES

(a) Eligible individuals who are already receiving services under an Individualized Written Rehabilitation Program (IWRP) Individualized Plan for Employment (IPE) at the time the order of selection is implemented shall not be subject to the order of selection process. Their rehabilitation programs will continue until their records of service are closed.

~~(b) In establishing functional limitations as part of the priority category determination as set out in Rule .0603 of this Section, Division staff shall review all functional capacities that may pose problems in the rehabilitation program and employment outcomes with the eligible individual in order to identify functional limitations related to the person's disability(ies).~~

~~(b) In determining an eligible individual's priority category for order of selection as set out in Rule .0603 of this Section, Division staff shall review existing data regarding the seriousness of limitations in functional capacity areas as related to the individual's disability(ies) and the problems those limitations pose in terms of an employment outcome.~~

(c) The Division shall serve individuals in Priority Category One Priority Category 1A first and individuals in the other priority categories in descending order from Priority Category Two Priority Category 1-B down through Priority Category Four Priority Category Six according to the availability of resources.

~~(d) Individuals in applicant status prior to implementation of the order of selection and whose priority category classification is below the categories accepted for services when the individuals are determined eligible shall be placed in a "waiting" status until their priority category is opened for services.~~

~~(d)(e) Eligible individuals for whom rehabilitation services have not been planned under an Individualized Written Rehabilitation Program Individualized Plan for Employment prior to the implementation of the order of selection and whose classification is below the categories approved for service accepted for service shall be placed in a "waiting" status. They shall remain in the "waiting" status until their priority category is opened for services.~~

~~(e)(f) When the order of selection is implemented, all individuals whose classification priority category classification will mean they will be placed in a places those individuals in a "waiting" status shall be notified in writing of their status. When~~

services are made available to any category in which individuals have been in a "waiting" status, the Division shall notify all persons in that priority category that their rehabilitation program can be developed.

~~(f)(g) Individuals determined eligible after the order of selection for service is implemented shall receive services if they are classified in the categories being served accepted for services or shall be placed in a "waiting" status if their classification places them in a category not currently being served.~~

~~(h) Only those services specified in Rule .0606 of this Subchapter will be provided to eligible individuals in "waiting" status whose priority category is not accepted for services.~~

~~(i) When the Division Director determines that the availability of resources are adequate to serve all eligible individuals, the Division will provide services to all priority categories.~~

~~(j) All eligible individuals in a "waiting" status shall be notified in writing when the determination has been made to end order of selection implementation.~~

History Note: Authority G.S. 143-545A; 143-546A; P.L. 102-569, s. 101(a)(5)(A); 34 C.F.R. 361.36; Eff. October 1, 1994; Amended Eff. July 1, 1998; Temporary Amendment Eff. May 1, 2002.

10 NCAC 20C .0606 CASE FINDING AND INFORMATION AND REFERRAL PROGRAMS

(a) Case finding efforts shall not be modified because of an order of selection. The Division has a continuing responsibility to make the public and referral sources aware of the services it has to offer eligible individuals with disabilities, especially those with severe significant disabilities. Referral sources shall be informed of an existing order of selection or of the potential of an order of selection being implemented, but they shall be reassured that this should not discourage referrals or applications.

~~(b) The Division also may elect to establish an expanded information and referral program while operating under an order of selection for services. An expanded information and referral program The Division will implement an information and referral program adequate to ensure that individuals with disabilities, including eligible individuals with disabilities who do not meet the Division's order of selection criteria for acceptance of services, are provided accurate vocational rehabilitation information and guidance which may include counseling, guidance, and referral for job placement for those eligible individuals who are not in the priority categories to receive services under the State's order of selection, but the program shall meet the requirements of 34 C.F.R. 361.37(e).~~

History Note: Authority G.S. 143-545A; 143-546A; P.L. 102-569, s. 101(a)(5)(A); 34 C.F.R. 361.37; Eff. October 1, 1994; Amended Eff. July 1, 1998; Temporary Amendment Eff. May 1, 2002.

*This Section includes the Register Notice citation to Rules approved by the Rules Review Commission (RRC) at its meeting of February 21, 2002 pursuant to G.S. 150B-21.17(a)(1) and reported to the Joint Legislative Administrative Procedure Oversight Committee pursuant to G.S. 150B-21.16. The full text of rules is published below when the rules have been approved by RRC in a form different from that originally noticed in the Register or when no notice was required to be published in the Register. The rules published in full text are identified by an * in the listing of approved rules. Statutory Reference: G.S. 150B-21.17.*

These rules, unless otherwise noted, will become effective on the 31st legislative day of the 2001 Session of the General Assembly or a later date if specified by the agency unless a bill is introduced before the 31st legislative day that specifically disapproves the rule. If a bill to disapprove a rule is not ratified, the rule will become effective either on the day the bill receives an unfavorable final action or the day the General Assembly adjourns. Statutory reference: G.S. 150B-21.3.

APPROVED RULE CITATION**REGISTER CITATION TO THE
NOTICE OF TEXT**

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TITLE 4 - DEPARTMENT OF COMMERCE**04 NCAC 19L .0802 ELIGIBILITY REQUIREMENTS**

Urgent Needs grant applicants must meet all four of the following eligibility requirements:

- (1) the need addressed by the application must have arisen during the preceding 18-month period and represent an imminent threat to public health or safety;
- (2) the activity is designed to alleviate existing conditions which pose a serious and immediate

threat to the health or welfare of the community which are of recent origin or which recently became urgent;

(3) the applicant does not have sufficient local resources; and

(4) other financial resources are not available to alleviate the urgent need.

History Note: Authority G.S. 143B-10; 143B-431; 42 U.S.C.A. 5304(b)(3); 24 C.F.R. 570.483;
Eff. July 1, 1982;
Amended Eff. August 1, 1998; March 1, 1995; June 1, 1993;
March 1, 1986; March 1, 1984;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002.

04 NCAC 19L .0901 GRANT AGREEMENT

(a) Upon approval of the application by the Division, a written grant agreement shall be executed between the recipient and the Division. These Rules, the approved application, and any subsequent amendments to the approved application shall become a part of the grant agreement.

(b) The grant agreement in its original form and all modifications thereto shall be kept on file in the office of the recipient in accordance with Rule .0911 of this Section.

(c) The Division may condition the grant agreement until the recipient demonstrates compliance with all applicable laws and regulations. In the case of Housing Development and Revitalization Strategies projects the grant agreement may be conditioned until legally binding commitments have been obtained from all participating entities.

(d) Neither CDBG nor non-CDBG funds involved in a project may be obligated, nor may any conditioned project activities begin until the Division releases in writing any and all applicable conditions on the project. Recipients may incur costs prior to release of conditions with prior Division approval in accordance with Rule .0908 of this Section.

History Note: Authority G.S. 143B-10; 143B-431; 24 C.F.R. 570.483;
Eff. July 1, 1982;
Amended Eff. August 1, 1998; May 1, 1998; June 1, 1994; September 1, 1990; June 1, 1983;
Temporary Amendment Eff. January 1, 2001;
Amended Eff. August 1, 2002.

04 NCAC 19L .0912 AUDIT

(a) The recipient's financial management systems shall provide for audits to be made by the recipient or at the recipient's direction, in accordance with the following:

(1) The recipient shall provide for an audit of its CDBG program on an annual basis for any fiscal year in which twenty-five thousand (\$25,000) or more in CDBG funds are received in accordance with the annual independent audit procedures set forth in G.S. 159-34;

(2) The CDBG program audit shall be performed in conjunction with the regular annual independent audit of the recipient and shall contain an examination of all financial aspects

of the CDBG program as well as a review of the procedures and documentation supporting the recipient's compliance with applicable statutes and regulations;

(3) CDBG program funds may only be used to pay for the CDBG portion of the audit costs if more than three hundred thousand dollars (\$300,000) in all Federal Programs are used; The recipient shall submit the Annual Audit Report to the Division, including the information identified in Paragraph (b) of this Rule, along with an Annual Performance Report as required by Rule .1101 of this Subchapter; and

(4) The Division may require separate closeout audits to be prepared by the recipient in accordance with Paragraph .0913(e) of this Section.

(b) Audits shall comply with the requirements set forth in this Paragraph:

(1) Audits shall include, at a minimum, an examination of the systems of internal control, systems established to insure compliance with laws and regulations affecting the expenditure of grant funds, financial transactions and accounts, and financial statements and reports of recipient organizations;

(2) Financial statements shall include footnotes, comments which identify the statements examined, the period covered, identification of the various programs under which the recipient received CDBG funds, and the amount of the awards received;

(3) Audits shall be made in accordance with the GENERAL ACCOUNTING OFFICE STANDARDS FOR AUDIT OF GOVERNMENTAL ORGANIZATIONS, PROGRAMS, ACTIVITIES AND FUNCTIONS, THE GUIDELINES FOR FINANCIAL AND COMPLIANCE AUDITS OF FEDERALLY ASSISTED PROGRAMS, any compliance supplements approved by the Federal Office of Management and Budget (OMB), and generally accepted auditing standards established by the American Institute of Certified Public Accountants;

(4) The audit shall include the auditor's opinion as to whether the financial statements are fairly presented in accordance with generally accepted accounting principles. If an unqualified opinion cannot be expressed, the auditor shall state the nature of the qualification;

(5) The auditors' comments on compliance and internal control shall:

(A) Include comments on weaknesses in and noncompliance with the systems of internal control, separately identifying material weaknesses;

(B) Identify the nature and impact of any noted instances of noncompliance

APPROVED RULES

	with the terms of agreements and those provisions of State or Federal laws and regulations that could have a material effect on the financial statements and reports;	(4)	Encourage contracting with small or disadvantaged audit firms which have traditionally audited government programs, and in such cases where this is not possible, assure that these firms are given consideration for audit subcontracting opportunities;
(C)	Contain an expression of positive assurance with respect to compliance with requirements for tested items and negative assurance for untested items;	(5)	Encourage contracting with consortiums of small or disadvantaged audit firms when a contract is too large for an individual small or disadvantaged audit firm; and
(D)	Comment on the accuracy and completeness of financial reports and claims for advances or reimbursement to Federal agencies;	(6)	Use the services and assistance, as appropriate, of the Small Business Administration, and the Minority Business Development Agency of the U.S. Department of Commerce in the solicitation and utilization of small or disadvantaged audit firms.
(E)	Comment on corrective action taken or planned by the recipient;		
(6)	Work papers and reports shall be retained for a minimum of five years from the date of the audit report unless the auditor is notified in writing by the Division of the need to extend the retention period based on changes in Federal regulations. The audit work papers shall be made available upon request to the Division and the General Accounting Office or its designees;		(e) All records, data, audit reports and files shall be maintained in accordance with Rule .0909 of this Section, unless otherwise stated in this Rule.
(7)	If during the course of the audit, the auditor becomes aware of irregularities in the recipient organization the auditor shall promptly notify the Division and recipient management officials about the level of involvement. Irregularities include such matters as conflicts of interest, falsification of records or reports, and misappropriation of funds or other assets;		(f) The provisions of this Rule do not limit the authority of the Department to make audits of recipients' organizations.
(8)	Selection of an independent auditor shall be in accordance with Rule .0908 of this Section.		
(c)	A "single audit," in which the regular independent auditor will perform an audit of all compliance aspects for all federal grants along with the regular financial audit of the recipient, is permissible. Where feasible, the recipient shall use the same auditor so that the audit will include the financial and compliance work under a single plan in the most economical manner.		
(d)	Small audit firms and audit firms owned and controlled by socially and economically disadvantaged individuals shall have the maximum practicable opportunity to participate in the performance of contracts awarded with CDBG funds. Recipients shall take the following affirmative action to further this goal:		
(1)	Assure that small audit firms and audit firms owned and controlled by socially and economically disadvantaged individuals as defined in P.L. 95-507 are used to the fullest extent practicable;		
(2)	Make information on forthcoming opportunities available, and arrange time frames for the audit so as to encourage and facilitate participation by small or disadvantaged firms;		
(3)	Consider in the contract process whether firms competing for larger audits intend to subcontract with small or disadvantaged firms;		

History Note: Authority G.S. 143B-10; 143B-431; 159-34; 42 U.S.C.A. 5304(d)(2),(e); 24 C.F.R. 44.6; 24 C.F.R. 85.36(e); 24 C.F.R. 570.492; Eff. April 1, 19983; Amended Eff. June 1, 1994; June 1, 1993; September 1, 1990; May 1, 1988; Temporary Amendment Eff. January 1, 2001; Amended Eff. August 1, 2002.

04 NCAC 19L .2001 DESCRIPTION

The infrastructure category includes activities in which funds are directed toward improving existing infrastructure or providing new infrastructure to existing neighborhoods with environmental or health problems; and providing public infrastructure to low- and moderate-income persons.

History Note: Authority G.S. 143B-10; 143B-431; 24 C.F.R. 570.489; Temporary Adoption Eff. January 1, 2001; Amended Eff. August 1, 2002.

TITLE 10 – DEPARTMENT OF HEALTH AND HUMAN SERVICES

Note: Temporary Amendment Eff. January 1, 2002 amends and replaces this permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 03R .2113 DEFINITIONS

The following definitions shall apply to all rules in this Section:

- (1) "Ambulatory surgical case" means an individual who receives one or more ambulatory surgical procedures in an operating room during a single operative encounter.
- (2) "Ambulatory surgical service area" means a single or multi-county area as used in the development of the ambulatory surgical

facility need determination in the applicable State Medical Facilities Plan.

(3) "Ambulatory surgical services" means those surgical services provided to patients as part of an ambulatory surgical program within a licensed ambulatory surgical facility or a general acute care hospital licensed under G.S. 131E, Article 5, Part A.

(4) "Ambulatory surgical facility" means a facility as defined in G.S. 131E-176(1a).

(5) "Operating room" means an inpatient operating room, an outpatient or ambulatory surgical operating room, a shared operating room, or an endoscopy procedure room in a licensed health service facility.

(6) "Ambulatory surgical program" means a program as defined in G.S. 131E-176(1b).

(7) "Ambulatory surgical procedure" means a procedure performed in an operating room which requires local, regional or general anesthesia and a period of post-operative observation of less than 24 hours.

(8) "Existing operating rooms" means those operating rooms in ambulatory surgical facilities and hospitals which were reported in the License Application for Ambulatory Surgical Facilities and Programs and in Part III of Hospital Licensure Renewal Application Form submitted to the Licensure Section of the Division of Facility Services and which were licensed and certified prior to the beginning of the review period.

(9) "Approved operating rooms" means those operating rooms that were approved for a certificate of need by the Certificate of Need Section prior to the date on which the applicant's proposed project was submitted to the Agency but that have not been licensed and certified.

(10) "Approved ambulatory surgical program" means an ambulatory surgery program that was approved for a certificate of need by the Certificate of Need Section prior to the date on which the applicant's proposed project was submitted to the Agency but that has not been licensed and certified.

(11) "Dedicated ambulatory surgical operating room" means an operating room used solely for the performance of ambulatory surgical procedures.

(12) "Multispecialty ambulatory surgical program" means a program as defined in G.S. 131E-176(15a).

(13) "Shared operating room" means an operating room that is used for the performance of both ambulatory and inpatient surgical procedures.

(14) "Specialty area" means an area of medical practice in which there is an approved medical specialty certificate issued by a member board of the American Board of Medical Specialties and includes, but is not limited to the following: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, urology, orthopedics, and oral surgery.

(15) "Specialty ambulatory surgical program" means a program as defined in G.S. 131E-176(24c).

(16) "Practical utilization" is 4.3 surgical cases per day for a dedicated ambulatory surgical operating room and 3.5 surgical cases per day for a shared operating room.

History Note: Authority G.S. 131E-177(1); 131E-183(b);

Eff. November 1, 1990;

Temporary Amendment Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;

Amended Eff. January 4, 1994; March 1, 1993;

Temporary Amendment Eff. January 1, 1999;

Temporary Eff. January 1, 1999 Expired on October 12, 1999;

Temporary Amendment Eff. January 1, 2000;

Temporary Amendment effective January 1, 2000 amends and replaces a permanent rulemaking originally proposed to be effective August 2000;

Amended Eff. April 1, 2001;

Temporary Amendment Eff. July 1, 2001; made permanent Eff. August 1, 2002;

Temporary Amendment Eff. January 1, 2002;

Temporary Amendment effective January 1, 2002 amends and replaces a permanent rulemaking originally proposed to be effective August 1, 2002.

Note: Temporary Amendment Eff. January 1, 2002 amends and replaces this permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 03R .2114 INFORMATION REQUIRED OF APPLICANT

(a) An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms in an existing ambulatory surgical facility or hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify each of the following specialty areas that will be provided in the facility:

- (1) gynecology;
- (2) otolaryngology;
- (3) plastic surgery;
- (4) general surgery;
- (5) ophthalmology;
- (6) orthopedic;
- (7) oral surgery;
- (8) urology; and
- (9) other specialty area identified by the applicant.

(b) An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms in an existing ambulatory surgical facility or hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide the following

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information regarding the services to be offered in the facility following completion of the project:

- (1) the number and type of existing and proposed dedicated inpatient and dedicated ambulatory surgical operating rooms;
- (2) the number and type of existing and proposed shared operating rooms;
- (3) the number and type of shared operating rooms that are proposed to be converted to dedicated ambulatory surgical operating rooms;
- (4) the current and projected number of surgical procedures, identified by CPT code or ICD-9-CM procedure code, to be performed in the operating rooms;
- (5) the fixed and movable equipment to be located in each operating room;
- (6) the hours of operation of the proposed operating rooms;
- (7) if the applicant is an existing ambulatory surgical facility, the average charge for the 20 surgical procedures most commonly performed in the facility during the preceding twelve months and a list of all services and items included in each charge;
- (8) the projected average charge for the 20 surgical procedures which the applicant projects will be performed most often in the facility and a list of all services and items in each charge; and
- (9) identification of providers of pre-operative services and procedures which will not be included in the facility's charge.

History Note: Authority G.S. 131E-177; 131E-183(b); Eff. November 1, 1990;

Temporary Amendment Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;

Amended Eff. January 4, 1994;

Temporary Amendment Eff. July 1, 2001; made permanent Eff. August 1, 2002;

Temporary Amendment Eff. January 1, 2002;

Temporary Amendment effective January 1, 2002 amends and replaces a permanent rulemaking originally proposed to be effective August 1, 2002.

Note: Temporary Amendment Eff. January 1, 2002 amends and replaces this permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 03R .2115 NEED FOR SERVICES

- (a) In projecting utilization for existing, approved, proposed and expanded surgical programs, a program shall be considered to be open five days per week and 52 weeks a year.
- (b) A proposal to establish a new ambulatory surgical facility, to increase the number of operating rooms in an existing ambulatory surgical facility or hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall not be approved unless the applicant

documents that the average number of surgical cases per operating room to be performed in the applicant's facility is projected to be at least 2.7 surgical cases per day for each dedicated inpatient operating room, 4.3 surgical cases per day for each dedicated ambulatory surgical operating room and 3.5 surgical cases per day for each shared operating room during the fourth quarter of the third year of operation following completion of the project.

(c) An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing ambulatory surgery program in the ambulatory surgical service area that performs ambulatory surgery in the same specialty area as proposed in the application is currently operating at 4.3 surgical cases per day for each dedicated ambulatory surgical operating room and 3.5 surgical cases per day for each shared operating room.

(d) An applicant proposing to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall provide documentation to show that each existing and approved ambulatory surgery program in the ambulatory surgical service area that performs ambulatory surgery in the same specialty areas as proposed in the application is projected to be operating at 4.3 surgical cases per day for each dedicated ambulatory surgical operating room and 3.5 surgical cases per day for each shared surgical operating room prior to the completion of the proposed project. The applicant shall document the assumptions and provide data supporting the methodology used for the projections.

History Note: Authority G.S. 131E-177; 131E-183(b); Eff. November 1, 1990;

Temporary Amendment Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;

Amended Eff. January 4, 1994; March 1, 1993;

Temporary Amendment Eff. July 1, 2001; made permanent Eff. August 1, 2002;

Temporary Amendment Eff. January 1, 2002;

Temporary Amendment effective January 1, 2002 amends and replaces a permanent rulemaking originally proposed to be effective August 1, 2002.

Note: Temporary Amendment Eff. January 1, 2002 amends and replaces this permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 03R .2116 FACILITY

(a) An applicant proposing to establish an ambulatory surgical facility that will be licensed under G.S. 131E, Article 6, Part D shall demonstrate that reporting and accounting mechanisms exist and can be used to confirm that the licensed ambulatory surgery facility is a separately identifiable entity physically and administratively, and is financially independent and distinct from other operations in the building in which it is located.

(b) An applicant proposing a licensed ambulatory surgical facility shall receive accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care or a

comparable accreditation authority within two years of completion of the licensed facility.

(c) An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms in an existing ambulatory surgical facility or hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall document that the physical environment of the facility conforms to the requirements of federal, state, and local regulatory bodies.

(d) In competitive reviews, an applicant proposing to perform ambulatory surgical procedures in at least three specialty areas shall be considered more favorably than an applicant proposing to perform ambulatory surgical procedures in fewer than three specialty areas.

(e) The applicant shall provide a floor plan of the proposed facility clearly identifying the following areas:

- (1) receiving/registering area;
- (2) waiting area;
- (3) pre-operative area;
- (4) operating room by type;
- (5) recovery area; and
- (6) observation area.

(f) An applicant proposing to expand by converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or by adding a specialty to a specialty ambulatory surgical program that does not propose to add physical space to the existing ambulatory surgical facility shall demonstrate the capability of the existing ambulatory surgical program to provide the following for each additional specialty area:

- (1) physicians;
- (2) ancillary services;
- (3) support services;
- (4) medical equipment;
- (5) surgical equipment;
- (6) receiving/registering area;
- (7) clinical support areas;
- (8) medical records;
- (9) waiting area;
- (10) pre-operative area;
- (11) operating rooms by type;
- (12) recovery area; and
- (13) observation area.

History Note: Authority G.S. 131E-177; 131E-183(b); Eff. November 1, 1990;

Temporary Amendment Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;

Amended Eff. January 4, 1994;

Temporary Amendment Eff. July 1, 2001; made permanent Eff. August 1, 2002;

Temporary Amendment Eff. January 1, 2002;

Temporary Amendment effective January 1, 2002 amends and replaces a permanent rulemaking originally proposed to be effective August 1, 2002.

Note: Temporary Amendment Eff. January 1, 2002 amends and replaces this permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 03R .2118 STAFFING

(a) An applicant proposing to establish a new ambulatory surgical facility, to increase the number of operating rooms in an existing ambulatory surgical facility or hospital, to convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or to add a specialty to a specialty ambulatory surgical program shall identify, justify and document the availability of the number of current and proposed staff to be utilized in the following areas:

- (1) administration;
- (2) pre-operative;
- (3) post-operative;
- (4) operating room; and
- (5) other.

(b) The applicant shall identify the number of physicians who currently utilize the facility and estimate the number of physicians expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel.

(c) The applicant shall provide documentation that physicians with privileges to practice in the facility will be active members in good standing at a general acute care hospital within the ambulatory surgical service area in which the facility is, or will be, located or will have written referral procedures with a physician who is an active member in good standing at a general acute care hospital in the ambulatory surgical service area.

History Note: Authority G.S. 131E-177; 131E-183(b);

Eff. November 1, 1990;

Temporary Amendment Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;

Amended Eff. January 4, 1994;

Temporary Amendment Eff. July 1, 2001; made permanent Eff. August 1, 2002;

Temporary Amendment Eff. January 1, 2002;

Temporary Amendment effective January 1, 2002 amends and replaces a permanent rulemaking originally proposed to be effective August 1, 2002.

Note: Temporary Amendment Eff. January 1, 2002 amends and replaces this permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 03R .2119 RELATIONSHIP TO SUPPORT AND ANCILLARY SERVICES

(a) An applicant proposing to establish a new ambulatory surgical facility, increase the number of operating rooms in an existing ambulatory surgical facility or hospital, convert a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or add a specialty to a specialty ambulatory surgical program shall provide written policies and procedures demonstrating that the facility will have patient referral, transfer, and followup procedures.

(b) The applicant shall provide documentation showing the proximity of the proposed facility to the following services:

- (1) emergency services;
- (2) support services;
- (3) ancillary services; and
- (4) public transportation.

History Note: Authority G.S. 131E-177; 131E-183(b); Eff. November 1, 1990;
Temporary Amendment Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. January 4, 1994;
Temporary Amendment Eff. July 1, 2001; made permanent Eff. August 1, 2002;
Temporary Amendment Eff. January 1, 2002;
Temporary Amendment effective January 1, 2002 amends and replaces a permanent rulemaking originally proposed to be effective August 1, 2002.

10 NCAC 19C .0101 PURPOSE AND DEFINITIONS

(a) The Business Enterprises Program is a rehabilitative program which helps provide employment opportunities and economic security to blind individuals. The Rules in this Subchapter are promulgated pursuant to 34 CFR 395 for the purpose of governing the operation and administration of the Business Enterprises Program in this state.

(b) As used in this Subchapter:

- (1) "Blind licensee" means a blind person licensed by the Division to operate a Business Enterprises facility on federal or other property.
- (2) "Blind operator" means a blind licensee who is operating a Business Enterprises facility on federal or other property.
- (3) The "Business Enterprises Program" provides blind individuals with remunerative employment through the operation of vending facilities on federal, state, and other properties.
- (4) "Business Enterprises facility" means any vending facility operated by the North Carolina Business Enterprises Program as defined in 34 C.F.R. 395.1.

History Note: Authority G.S. 111-27; 143B-157; 34 C.F.R. 395; 20 U.S.C. Sec. 107;
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; February 1, 1986;
October 1, 1978.

10 NCAC 19C .0102 RESPONSIBILITY

(a) The Division shall not provide for services or costs which pertain to the ongoing operation of an individual facility after the initial establishment period.

(b) The Division shall assure that each operator is provided access to all program and financial data of the Division relevant to the operation of the state vending facility program, including quarterly and annual financial reports, to the extent that such disclosure does not violate applicable federal and state laws pertaining to the disclosure of confidential information; that insofar as practicable such data shall be made available on tape, disk, large print, and Braille; and that, at the request of an operator, the Division will arrange a convenient time to assist in the interpretation of such data.

(c) The Division shall furnish to each operator copies of documents relevant to the operation of the Business Enterprises

facility, including the rules and regulations, a written description of the arrangements for providing services, and the agreement and permit covering the operation of the Business Enterprises facility, and shall explain these documents to each operator in a timely manner.

History Note: Authority G.S. 111-27; 143B-157; 34 C.F.R. 395; 20 U.S.C. Sec. 107;
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; October 1, 1978.

10 NCAC 19E .0202 PAYMENT STANDARDS

(a) The following payment standards includes amounts to meet all the needs of consumers except for special medical care and personal needs:

- (1) allowance for one person who pays shelter and utilities: one hundred forty-six dollars (\$146.00);
- (2) allowance for one person who does not pay shelter and utilities: ninety-seven dollars (\$97.00);
- (3) allowance for couple - one-sighted, one blind, - who pay shelter and utilities: two hundred nineteen dollars (\$219.00);
- (4) allowance for couple - one sighted, one blind - who do not pay shelter and utilities: one hundred forty-six dollars (\$146.00);
- (5) allowance for couple - both blind - who pay shelter and utilities: two hundred forty-three dollars (\$243.00);
- (6) allowance for couple - both blind - who do not pay shelter and utilities: one hundred ninety-four dollars (\$194.00).

(b) Personal need allowance for every blind recipient shall be the amount set by the General Assembly. These funds are for the individual to spend at his discretion and include items of clothing, toiletries, etc.

(c) Payments shall be paid in advance on the first day of each month.

History Note: Authority G.S. 111-13; 111-14; 111-17; 143B-157;
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; February 1, 1986;
December 1, 1977.

10 NCAC 19E .0701 RESPONSIBILITIES OF AGENCY

The agency shall:

- (1) provide assistance and opportunities for consumers to express their rights;
- (2) keep recipients informed of changes in law or agency policy which may affect their payments;
- (3) explain fraud; and
- (4) employ methods that do not infringe upon the consumers' rights.

History Note: Authority G.S. 111-13; 143B-157;
Eff. February 1, 1976;

*Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002.*

Amended Eff. August 1, 2002; January 1, 1992; February 1, 1986; August 1, 1983; December 1, 1981.

10 NCAC 19E .0805 SUMMARY OF INFORMAL CONFERENCE

(a) If the petitioner is not satisfied with the results of the conference, he shall be informed of his right to a contested case hearing by the Agency's designated representative.

(b) All petitions for review of agency decisions (G.S. 150B) shall be heard by the Office of Administrative Hearings. The Division shall notify the applicant or recipient in writing that he has the right to petition the Office of Administrative Hearings and request a contested case hearing. The Division shall notify the applicant or recipient to contact OAH and request the specific forms which the applicant or recipient must complete.

(c) In this same written notice the applicant or recipient shall be instructed that he has 60 calendar days from the date he receives the agency notice to request a contested case hearing through OAH. Any petition for a contested case must be returned by the applicant or recipient directly to the Office of Administrative Hearings.

*History Note: Authority G.S. 111-16; 143B-157;
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; April 1, 1990; February 1, 1986.*

10 NCAC 19F .0104 BASIC ELIGIBILITY CRITERIA

(a) In addition to the requirements of 10 NCAC 35D .0300, where applicable, an individual must be determined eligible to receive services under the Social Services Block Grant (Title XX) on the basis of:

- (1) need, with regard to income for In-Home Aide Services;
- (2) need without regard to income for all other services.

(b) For purposes of determining and redetermining eligibility for services provided by the Division of Services for the Blind in this Subchapter, the rules in Subchapters 10 NCAC 35D and 35E shall apply.

(c) Individuals are eligible for these services at the following income levels:

- (1) Adjustment services are provided without regard to income-these are services provided in any combination as needed and appropriate to enable blind and visually impaired individuals to attain and maintain the highest level of functioning possible;
- (2) In-Home Aide Services: Chore Services for the Blind are provided to individuals whose monthly gross family income is less than 100 percent of the state's established income. State's established income is 150% of the federal poverty level.

*History Note: Authority G.S. 111-28; 143B-157;
42 U.S.C. 1397;
Eff. February 1, 1976;
Amended Eff. October 12, 1977; August 24, 1976;
Readopted Eff. November 16, 1977;*

10 NCAC 19F .0402 SERVICES

(a) The following services are provided by the Division of Services for the Blind under this Section:

- (1) In-Home Aide Services: Chore Services for the Blind. In-Home Aide Services are those services which assist the individual or family with essential home management tasks necessary to enable the individual and family to remain and function effectively at home for as long as possible.
- (2) Adjustment Services for the Blind and Visually Impaired. These are services provided in any combination as needed and appropriate to enable blind and visually impaired individuals to attain or maintain the highest level of functioning possible, to promote their well-being, and to prevent or reduce dependency. This is achieved through a focused regimen of counseling and casework assistance to individuals and their families to help individuals choose, obtain, and use needed resources, services, and mechanisms of support. Within this context one or more of the following service components or resource items may be provided as part of the Adjustment Services for the Blind and Visually Impaired category.
 - (A) Assistance with the demands of daily living may be provided through training in areas such as grooming skills; manipulative skills such as the use of household appliances; money identification and communication skills such as braille, typing, and use of the telephone;
 - (B) The teaching of orientation and mobility skills;
 - (C) Therapeutic experiences aimed at helping the individual to adjust to and accept his visual limitations through camping experiences, recreational programs, adjustment training at rehabilitation centers, and individual and group counseling sessions;
 - (D) The following services/items may be provided: reader services, interpreter services for the deaf/blind, braille, large print and taped material, low vision optical aids, travel aids and devices, community sponsored recreational activities, devices to support independence such as talking clocks, talking calculators, and braille watches.

Individual and Family Adjustment Services. These services are designed to assist the consumer and his or her family in adjusting to the consumer's vision loss, making necessary

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accommodations and modifications to the environment after vision loss, and identifying community supports. Activities may include counseling to assist the consumer to recognize, understand, and cope with problems in such areas as household management, consumer affairs, family life education, and other disabling conditions.

(4) Health Support Services. These services provide help to individuals and families to recognize health needs including those related to alcohol and drug abuse and to secure needed health services available under medicaid, medicare, or other agency health services programs and from other public or private agencies or providers of health services; counseling and planning with individuals, families, and health providers to help assure continuity of treatment and the carrying out of health recommendations; and helping individuals to secure admission to medical institutions and other health-related facilities as needed.

(5) Housing and Home Improvement Services. These services provide assistance to individuals and families in obtaining and retaining housing and basic furnishings. Services include helping to improve landlord-tenant relations, to identify housing, to secure correction of housing code violations, to obtain or retain ownership of own home, and to find and relocate to more suitable housing.

(6) Information and Referral. This means giving information about services provided under the state's social services program and other service programs, both public and private; brief assessment to determine the most appropriate resource to meet the stated needs of the person requesting services; and referral to and follow-up with those community resources which provide or make available such services.

(b) The following services are mandated in all parts of the state; the responsibility for the provision of these services rests with the Division of Services for the Blind.

(1) In-Home Aide Services;
(2) adjustment services for the blind and visually impaired.

*History Note: Authority G.S. 111-28; 143B-10;
Eff. February 1, 1976;
Amended Eff. October 12, 1977; August 24, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; January 1, 1992; April 1, 1990;
February 1, 1986; August 1, 1980.*

10 NCAC 19F .0602 APPEAL TO DESIGNATED AGENCY REPRESENTATIVE

(a) If a consumer is dissatisfied with an action taken by or service delivered by the independent living service program, that

consumer may request a conference with the designated agency representative.

(b) A conference shall be held within 30 calendar days from the receipt of the original request.

(c) If the conference solves the grievance or dissatisfaction, this shall be stated in writing and signed by the consumer.

(d) The agency representative shall prepare a written report of the conference within 15 calendar days of the conference.

*History Note: Authority G.S. 111-16; 143B-157;
Eff. February 1, 1976;
Amended Eff. October 12, 1977;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; December 1, 1990;
February 1, 1986.*

10 NCAC 19F .0603 REQUEST FOR CONTESTED CASE HEARING

(a) If the results of the conference are unsatisfactory, the consumer shall be informed by the designated agency representative of his or her right to a contested case hearing.

(b) All petitions for review of agency decisions (G.S. 150B) shall be heard by the Office of Administrative Hearings. The agency shall notify the consumer in writing that he has the right to petition the Office of Administrative Hearings and request a contested case hearing. The consumer shall be instructed to contact OAH and request the specific forms to be completed.

(c) In this same written notice the consumer shall be instructed that he or she has 60 calendar days from the date of receipt of the agency notice to request a contested case hearing through OAH. Any request for a contested case hearing must be returned by the consumer directly to the Office of Administrative Hearings.

(d) The Office of Administrative Hearings issues, as appropriate, either a final decision or a recommended decision which will be sent to the Director of the Division of Services for the Blind. The agency shall provide the consumer a written copy of the final decision. A copy shall also be placed in the consumer's file.

*History Note: Authority G.S. 143B-157; 150B-3;
Eff. December 1, 1990;
Amended Eff. August 1, 2002.*

10 NCAC 19G .0101 ELIGIBILITY FOR AND AUTHORIZATION OF SERVICES

(a) An Individualized Plan for Employment shall be developed to provide services to applicants to the vocational rehabilitation program who meet the following criteria:

(1) the applicant for services has a physical or mental impairment;

(2) that the physical or mental impairment constitutes or results in a substantial impediment to employment for the applicant; and

(3) that the applicant requires vocational rehabilitation services in order to prepare for, secure, retain, or regain employment.

(b) It is presumed that the applicant can benefit in terms of an employment outcome from the provision of vocational rehabilitation services unless it can be demonstrated through

clear and convincing evidence that the applicant is incapable of benefiting in terms of an employment outcome from vocational rehabilitation services due to the severity of the disability.

(c) Applicants who have been determined eligible for Social Security benefits under Title II or Title XVI of the Social Security Act are presumed eligible for vocational rehabilitation services; however, the applicant must intend to achieve an employment outcome.

(d) Authorization of Services:

- (1) The Division shall issue a written authorization for services prior to or simultaneously with the provision of the service. A copy of the authorization shall be retained in the case file.
- (2) The Division shall authorize services that are required for a consumer to participate in an assessment to determine eligibility for services. The Division shall also authorize services required for a consumer to complete the goals identified on his or her Individualized Plan for Employment (IPE).
- (3) Authorizations are issued based on availability of funds.

(c) Oral authorizations may be issued on occasions for services when it is a matter of urgency. Such authorizations may be made by a rehabilitation counselor or a rehabilitation supervisor. On such occasions, a record of such oral authorizations shall be made and retained in the consumer's case file. In all such cases confirming authorizations shall be written.

History Note: Authority G.S. 134B-157; 34 C.F.R. 361.1; 34 C.F.R. 361.3; 34 C.F.R. 361.42(a); 34 C.F.R. 361.45;

Eff. February 1, 1976;

Amended Eff. November 8, 1976; June 25, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. August 1, 2002.

10 NCAC 19G .0102 TRAINING AND TRAINING MATERIALS

(a) The Division shall furnish training to all eligible individuals to the extent necessary to achieve their vocational rehabilitation outcome and to the extent that entry level qualifications of the job, profession or employment are achieved.

(b) Training provided by the Division includes vocational, prevocational, personal adjustment training, and other rehabilitation training which contributes to the determination of the rehabilitation potential or to the individual's personal and vocational adjustment; it covers training provided directly by the Division or procured from other public or private training facilities, including community rehabilitation programs.

(c) The Division shall provide necessary books and other training materials to applicants accepted for evaluation of the rehabilitation potential and to financially eligible consumers.

(d) The Division shall provide financial support for postsecondary education under the following terms and conditions:

- (1) Financial support for consumers attending institutions of higher learning shall not exceed the maximum rate for tuition and fees, established at state supported colleges and universities in North Carolina

- (2) Requests for support will be considered only when the consumer has applied for grants and scholarships at the accepting institution. The Division shall deduct the grant amount from the consumer's training allotment.
- (3) Consumers who are sponsored for an undergraduate degree shall not receive more than 10 semesters or 15 quarters of sponsorship to complete their undergraduate degree or five semesters/eight quarters to complete a community college program. The Division may grant an exception to the semester/quarter requirements when necessary to accommodate the special training needs of consumers with severe disabilities;
- (4) Consumers who are sponsored for undergraduate programs must maintain a grade point ratio of 2.0. Agency sponsorship will be withdrawn from any consumer in an undergraduate program whose GPR falls below 2.0 for two consecutive semesters or quarters. If the consumer continues in the educational institution under his own sponsorship and brings his cumulative GPR to 2.0, the consumer may again be considered for sponsorship through the VR Program of this agency. Consumers under our Agency sponsorship for graduate or professional programs must maintain a grade point ratio commensurate with the standards established by the educational institution they are attending for degree requirements. Agency sponsorship shall be withdrawn from any consumer in graduate or professional programs whose GPR falls below the standards established by the educational institution for degree requirements for two consecutive semesters or quarters. If the consumer continues in the educational institution under his own sponsorship and brings his cumulative GPR to the standard established by the educational institution, the consumer may again be considered for sponsorship through the VR Program of this agency. Consumers may receive agency sponsorship for vocational training or on-the-job training outside of programs offered in undergraduate, graduate, and professional schools. A consumer who is participating in such a program must maintain grades or standards of performance commensurate with the standards established by the institution or trainer for satisfactory completion of the training program within an established time frame. The agency shall not sponsor a consumer in a vocational training or on-the-job training program for more than one additional unit of time as defined by the particular institution or trainer in order to complete the program. The Division may grant an exception to the length of training sponsorship when necessary to accommodate

the special training needs of consumers with severe disabilities;

(5) The Division may provide graduate training for consumers when said training is required to enter a position. The consumer's case file shall contain a letter from an official of the appropriate graduate school of higher learning designating the number of semesters or quarters required to achieve the graduate degree. The Division shall not sponsor consumers in excess of one quarter or one semester above that specified in the letter as a time required to receive the graduate degree. The Division may grant an exception to the length of training when necessary to accommodate the special training needs of consumers with severe disabilities.

(e) Other training services, including training at community rehabilitation programs, are purchased on the basis of agreements made between the trainer and staff members of the Division.

(f) Training at the Rehabilitation Center for the Blind and with the Business Enterprises program is purchased on the basis of rates established by the Division in consultation with the supervisors of the training units in this Rule. The rates are usually based on per diem costs.

*History Note: Authority G.S. 111-28; 34 C.F.R. 361.42; 34 C.F.R. 361.47; C.F.R. 361.48(f);
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. February 1, 1982;
Temporary Amendment Eff. August 1, 2001;
Amended Eff. August 1, 2002.*

10 NCAC 19G .0104 TRANSPORTATION

(a) The Division shall furnish transportation to eligible individuals and to members of their family, in connection with the provision of diagnostic and other services when such transportation is necessary to the individual's vocational rehabilitation.

(b) Such transportation includes:

(1) costs of travel and subsistence during travel (or per diem allowance in lieu of subsistence) for eligible consumers and their attendants or escorts, where such assistance is needed; and

(2) relocation and moving expenses necessary for the achievement of a job after it is determined that the eligible consumer has adjusted to the employment situation and the job is permanent.

(c) The Division shall pay an amount representing the down payment of the purchase price of an automobile for an eligible consumer who has been determined to be rehabilitated when the employment goal requires the individual to travel in the performance of his responsibilities and the employment goal is at or above the substantial gainful activity level as defined by the Social Security Administration. The Division shall not:

(1) make monthly automobile payments; or

(2) retain title to the automobile.

*History Note: Authority G.S. 111-28; 34 C.F.R. 361.48(h);
34 C.F.R. 361.5(b)35;
Eff. February 1, 1976;
Amended Eff. August 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002; February 1, 1982.*

10 NCAC 19G .0106 JOB PLACEMENT

(a) Successful employment in a competitive integrated setting is the ultimate goal of the vocational rehabilitation program and the goal toward which all services are directed. Division staff shall assist eligible consumers pursue employment in a job that is, to the greatest extent possible, consistent with that consumers skills, interests, needs, and informed choice. Job seeking skills training, job development, job placement, on-the-job training, supported employment, follow-up after placement, and employer education about vision loss and other employment-related incentives shall be used by staff in providing job placement service.

(b) The case file shall be closed for a consumer who has achieved a successful employment outcome when the following requirements have been met:

(1) The consumer has achieved the employment outcome as stated on his or her Individualized Plan for Employment consistent with that consumer's skills, abilities, interests, and informed choice, and the consumer is employed in the most integrated setting possible consistent with his or her informed choice;

(2) The consumer has maintained the job for period of time sufficient to demonstrate the stability of the employment outcome and that the consumer no longer needs vocational rehabilitation services. The job must be maintained for at least 90 days; and

(3) At the time of case closure the consumer and the Division's rehabilitation counselor must agree that the employment outcome is satisfactory and that the consumer is performing well in the job.

(c) The Division shall advise the consumer of the availability of post-employment services. These services shall be provided consistent with the following:

(1) The service is provided subsequent to the achievement of an employment outcome;

(2) The service is necessary in order for the consumer to maintain, regain, or advance in employment; and

(3) The services are designed to meet rehabilitation needs that do not require a complex or comprehensive program of services and are limited in scope and duration.

*History Note: Authority G.S. 111-28; 34 C.F.R. 361.47(a)(7),(8),(9),(10),(14),(15); 34 C.F.R. 361.48(l),(m)(o);
34 C.F.R. 361.5(b)(42); 34 C.F.R. 361.56;
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. August 1, 2002.*

10 NCAC 19G .0113 OTHER SERVICES: MEDICAL CARE

(a) The Division shall provide to eligible consumers other goods and services available as provided in 34 C.F.R. 361.48(t), when such services are necessary to determine the rehabilitation potential of the client or to render him fit for gainful employment.

(b) The Division shall furnish medical care for up to 30 days for acute conditions arising in the course of vocational rehabilitation, which, if not cared for, would constitute a hazard to the achievement of the vocational rehabilitation objective, or the completion of the extended evaluation to determine rehabilitation potential.

History Note: Authority G.S. 111-28; 34 C.F.R.

361.48(d)(t); 34 C.F.R. 361.5(b)(40);

Eff. February 1, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. August 1, 2002; April 1, 1990; February 1, 1986.

10 NCAC 19G .0402 TYPES OF FACILITIES

(a) The Division shall use whenever feasible facilities that are accredited by a public authority or professional organization to provide medical care, education, and other services. Facilities shall be selected for use in providing the eligible consumer's rehabilitation program based on the individualized rehabilitation needs of the consumer. Facilities may include hospitals, convalescent and nursing homes, rehabilitation centers, colleges, universities, community colleges and technical schools, community rehabilitation program or other facilities as needed by the eligible consumer.

(b) Students shall receive their training in schools and colleges accredited by the Southern Association of Secondary Schools and Colleges or state accrediting agencies.

(c) Any facility in which vocational rehabilitation services are provided and any provider of vocational rehabilitation services shall meet the program accessibility and special communication requirements specified in 34 C.F.R. 361.51.

History Note: Authority G.S. 111-6; 111-6.1; 111-28;

34 C.F.R. 361.51; 34 C.F.R. 361.52;

Eff. February 1, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. August 1, 2002; April 1, 1990.

10 NCAC 19G .0501 BENEFITS

(a) The Division of Services for the Blind shall give consideration to all other benefits available to the consumer with a visual disability by way of pension, compensation, or insurance to meet, in whole or in part, the cost of any vocational rehabilitation services provided to the consumer except the following:

- (1) assessment for determining eligibility and vocational rehabilitation needs;
- (2) counseling and guidance, including information and support services to assist the applicant or consumer in exercising informed choice;
- (3) referral and other services to secure needed services from other agencies if those services are not available;

- (4) job-related services, including job search and placement assistance, job retention services, and follow-up services;
- (5) rehabilitation technology, including telecommunications, sensory, and other technological aids; and
- (6) post-employment services listed in Subparagraphs (1) through (5) of this Paragraph.

(b) When and to the extent that a consumer is eligible for such benefits, such benefits shall be utilized unless such a determination would interrupt or delay:

- (1) the progress of the consumer toward achieving the employment outcome in the individualized plan for employment;
- (2) an immediate job placement; or
- (3) the provision of vocational rehabilitation services to any consumer who is determined to be at extreme medical risk, based on medical evidence provided by a medical professional.

(c) If benefits exist, but are not available at the time needed to achieve the consumer's rehabilitation outcome, the services shall be provided until those benefits become available. Such benefits include but need not be limited to:

- (1) medicare, medicaid hospital and physician's services plans in relation to physical restoration services; and
- (2) workmen's compensation, veterans' benefits, private insurance benefits, old age and survivors disability insurance benefits and unemployment compensation in relation to basic maintenance.

History Note: Authority G.S. 111-28; 34 C.F.R. 361.5;

34 C.F.R. 361.53;

Eff. February 1, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. January 1, 1996; April 1, 1990;

February 1, 1982;

Temporary Amendment Eff. August 1, 2001;

Amended Eff. August 1, 2002.

10 NCAC 19G .0502 ECONOMIC NEEDS POLICIES

(a) The Division of Services for the Blind shall establish economic need for each eligible consumer either simultaneously with or prior to the provision of those services for which the Division requires a needs test. The financial need of a consumer shall be determined by the financial needs test specified in Rule. 0503 of this Section. If the consumer has been determined eligible for Social Security benefits under Title II or XVI of the Social Security Act, the Division of Services for the Blind shall not apply a financial needs test or require the financial participation of the consumer. A financial needs test shall be applied for all consumers determined eligible to receive services through the Independent Living Rehabilitation Program regardless of SSA Title II or Title XVI eligibility.

(b) The Division of Services for the Blind shall furnish the following services not conditioned on economic need:

- (1) an assessment for determining eligibility and priority for services except those non-assessed services that are provided during an

exploration of the applicant's abilities, capabilities, and capacity to perform in work situations through the use of trial work experiences or an extended evaluation and an assessment by personnel skilled in rehabilitation technology;

(2) assessment for determining rehabilitation needs by a qualified vocational rehabilitation counselor;

(3) vocational rehabilitation counseling and guidance, including information and support services to assist an applicant or consumer in exercising informed choice;

(4) tuition and supplies for Community Rehabilitation Program training;

(5) tuition and fees for:

- (A) community college/college parallel and vocational programs up to the catalog rate; and
- (B) post-secondary education up to the maximum rate charged for the North Carolina public university system.

The Division shall require eligible consumers applying for training programs listed in Parts (b)(5)(A) and (B) of this Rule to first apply for all available grants and financial aid. The Division may grant an exception to the rate for tuition and required fees for post-secondary education specified in Part (b)(5)(B) of this Rule when necessary to accommodate the special training needs of severely disabled individuals who must be enrolled in special programs designed for severely physically disabled students;

(6) interpreter services including sign language and oral interpreter services for applicants or consumers who are deaf or hard of hearing and tactile interpreting services for applicants or consumers who are deaf-blind;

(7) reader services, rehabilitation teaching services, and orientation and mobility services;

(8) job-related services, including job search, job placement, employment assistance and job retention services;

(9) DSB Rehabilitation Center or fundamental independent living rehabilitation adjustment services including transportation and training supplies contingent on a consumer's participation in the program;

(10) diagnostic transportation;

(11) on-the-job training;

(12) training and associated maintenance and transportation costs for Business Enterprises Program trainees;

(13) upward mobility training and associated maintenance and transportation costs for Business Enterprises Program trainees;

(14) equipment and initial stocks and supplies for state-owned (Randolph-Sheppard) vending stands;

(15) Supported Employment Services;

(16) personal assistance services provided while a consumer with a disability is receiving vocational rehabilitation services;

(17) referral and other services designed to assist applicants or consumers with disabilities in securing needed services from other agencies through agreements developed under Section 101(a)(11) of the Act (P.L. 102-569), if such services are not available under this Act and to advise those individuals about client assistance programs established under the Act;

(18) transition services for students with disabilities that facilitate the achievement of the employment outcome identified in the student's individualized plan for employment except for those services based on economic need; and

(19) technical assistance and other consultation services to consumers who are pursuing self-employment or telecommuting or establishing a business operation as an employment outcome.

(c) The following services shall be provided by the Division of Services for the Blind and conditioned on economic need:

- (1) physical and mental restoration services (medical services other than diagnostic);
- (2) maintenance for additional costs incurred while participating in rehabilitation;
- (3) transportation in connection with the rendering of any vocational rehabilitation service except where necessary in connection with determination of eligibility or nature and scope of services;
- (4) services to members of a disabled consumer's family necessary to the adjustment or rehabilitation of the consumer with a disability;
- (5) rehabilitation technology including telecommunications, sensory, and other technological aids and devices;
- (6) post-employment services necessary to assist consumers with visual disabilities to maintain, regain or advance in employment except for those services not conditioned on economic need listed in Paragraph (b) of this Rule;
- (7) fees necessary to obtain occupational licenses;
- (8) tools, equipment, and initial stocks and supplies for items listed in Subparagraphs (1) through (7) of this Paragraph;
- (9) expenditures for short periods not to exceed 30 days of medical care for acute conditions arising during the course of vocational rehabilitation, which if not cared for, will constitute a hazard to the achievement of the vocational rehabilitation objective;
- (10) books and other training materials; and
- (11) other goods and services not prohibited by the Act (P.L. 102-569), which can reasonably be expected to benefit an individual with a disability in terms of his employability or independent living skill development.

(d) The Division of Services for the Blind shall publish the standard as determined by the Legislature for measuring the financial need of consumers with respect to normal living requirements and for determining their financial ability to meet the cost of necessary rehabilitation services, and for determining the amount of agency supplementation required to procure the necessary services.

History Note: Authority G.S. 111-28; 34 C.F.R. 361.48; 34 C.F.R. 361.5; 34 C.F.R. 361.52; 34 C.F.R. 361.54; P.L. 102-569, Section 103; Eff. February 1, 1976; Amended Eff. August 1, 1976; Readopted Eff. November 16, 1977; Amended Eff. January 1, 1996; June 1, 1993; October 1, 1990; April 1, 1990; Temporary Amendment Eff. August 1, 2001; Amended Eff. August 1, 2002.

10 NCAC 19G .0603 ORDER OF SELECTION FOR SERVICES

All vocational rehabilitation services shall be provided without delay to all individuals determined to be eligible for services; however, if a situation should develop under which vocational rehabilitation services cannot be extended without delay to all eligible individuals, because the Division does not have the financial or staff resources to serve all eligible individuals who apply for services, an order of selection for provision of services shall be implemented. Rules .0606, .0607, and .0608 in this Section set out the order of selection for services that shall be followed by the Division of Services for the Blind Rehabilitation Program. The Rules in this Section do not apply to the Independent Living Rehabilitation Program. As used in this order of selection, the following terms have the meaning specified:

- (1) "Division" means the Division of Services of the Blind of the Department of Health and Human Services.
- (2) "Division Director" or "Director" means the Director of the Division of Services for the Blind.
- (3) "Eligible individual" means an applicant whom the Division has determined meets the eligibility criteria as stated in Rule .0101 of this Subchapter.
- (4) "Individual with a significant disability" has the meaning specified in P.L. 105-220, Title IV, Section 7(21) which is incorporated by reference.
- (5) "Individual with the most significant disability" means an individual with a significant disability whose impairment seriously limits two or more functional capacities in terms of an employment outcome.
- (6) "Functional capacity" means the ability to perform in the following areas:
 - (a) mobility;
 - (b) communication;
 - (c) self-care;
 - (d) self-direction;

- (e) interpersonal skills;
- (f) work skills; and
- (g) work tolerance.

The Section of the Public Law incorporated by reference in this Rule shall automatically include any later amendments thereto as allowed by G.S. 150B-21.6. Copies of the Section of the Public Law so incorporated may be obtained at no cost from the Division.

History Note: Authority G.S. 111-28; 150B-21.6; 34 C.F.R. 361.36; P.L. 105-220, Title IV, Section 7(21); Section 101(a)(5)(A); Eff. February 1, 1976; Readopted Eff. November 16, 1977; Amended Eff. August 1, 2002; January 1, 1996.

10 NCAC 19G .0604 CASE RECORDS AND CONFIDENTIALITY OF INFORMATION

The Division shall carry out provisions relative to case records and confidentiality of information as indicated in 34 C.F.R. 361.38 and 361.47.

History Note: Authority G.S. 111-28; 34 C.F.R. 361.39; 34 C.F.R. 361.49; Eff. February 1, 1976; Amended Eff. November 8, 1976; Readopted Eff. November 16, 1977; Amended Eff. August 1, 2002; February 1, 1986; February 1, 1981.

10 NCAC 19G .0802 WRITTEN INFORMATION FOR APPLICANTS AND CONSUMERS

- (a) The Division shall inform all applicants for and consumers receiving vocational rehabilitation or independent living rehabilitation services of the opportunities for an administrative review, mediation, and impartial due process hearing available under 34 C.F.R. 361.57 and the Rules of this Section.
- (b) The Division shall provide written information to all applicants and consumers informing them:
 - (1) of their right to an impartial due process hearing when they are dissatisfied with any determinations made by the Division concerning the furnishing or denial of services;
 - (2) that they may seek resolution of the issue through an administrative review and mediation prior to an impartial due process hearing;
 - (3) that the rehabilitation counselor or other designated staff of the Division will inform them of the name and address of the area rehabilitation supervisor to whom the request shall be submitted and of the manner in which a mediator or impartial hearing officer is selected; and that they may receive assistance with the resolution of their problems through the Client Assistance Program.
- (c) The Division shall inform all applicants and consumers in writing of the rights established in Paragraph (b) of this Rule at the time of application for vocational rehabilitation services, at the time of assignment to a category in the State's order or selection, if established, at the time of development of the

Individualized Plan for Employment (IPE), and whenever vocational rehabilitation services are reduced, suspended, or terminated.

*Temporary Amendment Eff. August 1, 2001;
Amended Eff. August 1, 2002.*

*History Note: Authority G.S. 143B-157; 150B-2; 150B-23; 34 C.F.R. 361.57; 34 C.F.R. 364.30;
Eff. February 1, 1976;
Readopted Eff. November 16, 1977;
Amended Eff. December 1, 1990; June 1, 1983;
Temporary Amendment Eff. August 1, 2001;
Amended Eff. August 1, 2002.*

10 NCAC 19G .0803 REQUEST FOR ADMINISTRATIVE REVIEW, MEDIATION, AND IMPARTIAL DUE PROCESS HEARING

(a) When any applicant for or consumer receiving vocational rehabilitation or independent living rehabilitation services wishes to request an administrative review, mediation, or an impartial due process hearing, the individual shall submit a written request to the area rehabilitation supervisor of the Division designated pursuant to Rule .0802 of this Section.

(b) The request shall indicate if the individual is requesting:

- (1) An administrative review, mediation, and an impartial due process hearing to be scheduled concurrently; or
- (2) An administrative review and an impartial due process hearing to be scheduled concurrently; or
- (3) Mediation and impartial due process hearing to be scheduled concurrently; or
- (4) only an impartial due process hearing.

(c) The request shall contain the following information:

- (1) the name, address, and telephone number of the applicant or consumer and the individual's representative, if one has been designated; and
- (2) a concise statement of the determination made by the rehabilitation staff for which an administrative review, mediation, or impartial due process hearing is being requested and the manner in which the person's rights, duties or privileges have been affected by the determination(s).

(d) The Division shall not suspend, reduce, or terminate vocational rehabilitation or independent living rehabilitation services being provided an applicant or consumer for evaluation and assessment, for development of an Individualized Plan for Employment (IPE) or Independent Living Plan (ILP), and as provided for under an IPE or ILP pending final resolution of the issue through either an administrative review, mediation, or impartial due process hearing unless the individual or the individual's representative so requests, or the Division has evidence that the services have been obtained through misrepresentation, fraud, collusion, or criminal conduct on the part of the individual.

(e) Participation in the mediation is voluntary on the part of all parties.

*History Note: Authority G.S. 143B-157; 150B-2; 150B-23; 34 C.F.R. 361.57; P.L. 102-569, Section 102(d);
Eff. December 1, 1990;
Amended Eff. January 1, 1996;*

10 NCAC 19G .0807 SCHEDULING AND NOTICE OF IMPARTIAL DUE PROCESS HEARING

(a) The hearing officer shall schedule the impartial due process hearing to be held within 60 days of the original request by the applicant or consumer as described in Rule .0803 of this Section.

(b) The hearing officer shall provide the parties written notice of the date, time and place of the hearing and the issue to be considered at least 10 days prior to the hearing. A copy of the notice shall be sent to the Client Assistance Program.

(c) The notice shall inform the parties of the following:

- (1) the procedures to be followed in the hearing;
- (2) the particular sections of the statutes, federal regulations, state rules, and state plan involved;
- (3) the rights of the applicant or consumer as specified in 34 C.F.R. 361.57;
- (4) that the hearing officer shall extend the time for the hearing for up to 30 days if the parties jointly agree to a delay and submit a written statement to that effect to the hearing officer; and
- (5) that the hearing shall be cancelled if the matter is resolved in an administrative review or in mediation.

(d) Notice shall be given personally or by certified mail. If given by certified mail, it shall be deemed to have been given on the delivery date appearing on the return receipt.

*History Note: Authority G.S.; 143B-157; 150B-1(e)(5);
150B-2; 150B-23; 34 C.F.R. 361.57;
Eff. December 1, 1990;
Temporary Amendment Eff. August 1, 2001;
Amended Eff. August 1, 2002.*

10 NCAC 19G .0808 ADMINISTRATIVE REVIEW AND MEDIATION

(a) Administrative Review

(1) Within 15 days of the original request for an administrative review by the applicant or consumer, the area rehabilitation supervisor or his designee shall hold the administrative review with the applicant or consumer, the individual's parent or guardian if the individual is a minor, or representative if one has been designated, the CAP Director, if participating, and other individuals deemed necessary by the area rehabilitation supervisor or his designee.

(2) Within five working days of the administrative review, the area rehabilitation supervisor or his designee shall make a decision and notify the applicant or consumer and others using the following procedures:

(A) compile a written report of the administrative review outlining the purposes of the administrative review, the participants, the decision that was reached, and the rationale for the decision;

(B) send the written report containing the decision to the applicant or consumer by certified mail with return receipt requested, with a copy being placed in the individual's official case record, and copies being forwarded to the Division Director and the CAP Director; and

(C) provide instructions to the applicant or consumer of steps that may be taken in response to the decision and the deadline for the responses. A form indicating agreement with the decision and requesting that the hearing be cancelled shall be included for the applicant's or consumer's signature if the individual agrees with the decision.

(b) **Mediation**

(1) The qualified and impartial mediator shall conduct the mediation session with the parties and their representatives. All mediation discussions are confidential and the content may not be used as evidence in subsequent impartial due process hearings or civil proceedings.

(2) The Division shall bear the costs of mediation. At any point in the mediation process, either party or the mediator may elect to terminate the mediation process. Should this occur, resolution through an impartial due process hearing shall continue unless cancelled by the applicant or consumer.

(3) If an agreement is reached during the mediation session, a written mediation agreement must be developed by the parties with the assistance of the mediator. Both parties must sign it. It must include a clear statement from the consumer that he or she is satisfied with the agreement and that they request cancellation of the impartial due process hearing.

History Note: Authority G.S. 143B-157; 150B-1(e)(5); 150B-2; 150B-23; 34 C.F.R. 361.57; Eff. December 1, 1990; Temporary Amendment Eff. August 1, 2001; Amended Eff. August 1, 2002.

10 NCAC 19G .0823 SECRETARY'S REVIEW AND FINAL DECISION

(a) Either party may request a review of the hearing officer's decision by the Secretary of the Department of Health and Human Services within 20 days of the receipt of the decision.

(b) The Secretary may delegate the responsibility for reviewing the hearing officer's decision and making the final decision to another employee of the Department but shall not delegate the responsibility to any officer or employee of the Division.

(c) In conducting the review, the reviewing official shall send the written notification to both parties and allow the submission of additional evidence as required by Sec. 102(c) of the Rehabilitation Act of 1973 (as amended by the Rehabilitation Act Amendments of 1998, P.L. 105-220). The written notification shall be given personally or by certified mail. If given by certified mail, it shall be deemed to have been given on the delivery date appearing on the return receipt.

(d) The reviewing official's review shall be based on the following standards of review:

(1) The hearing officer's decision shall not be arbitrary, capricious, abuse of discretion, or otherwise unreasonable.

(2) The hearing officer's decision shall be supported by substantial evidence, i.e. consistent with facts and applicable federal and state policy.

(3) In reaching the decision, the hearing officer shall consider such factors as:

(A) the federal statute and regulations as they apply to a specific issue in question;

(B) the State Plans as they apply to a specific issue in question;

(C) Commission rules as they apply to a specific issue in question;

(D) key portions of conflicting testimony;

(E) Division options in the delivery of services where such options are permissible under federal statute; and

(F) restrictions in the federal statute with regard to supportive services as maintenance and transportation.

(e) The reviewing official shall make the final decision and provide such decision in writing to both parties within 30 days from receipt of the request to review the hearing officer's decision. The decision shall include a full report of the findings and the grounds for the decision. The reviewing official shall not overturn or modify a decision, or part of a decision, of an impartial hearing officer that supports the position of the individual except as allowed under Sec. 102(c) of the Rehabilitation Act of 1973 (as amended by the Rehabilitation Act Amendments of 1998, P.L. 105-220). The final decision shall be given to both parties personally or by certified mail. If

10 NCAC 19G .0821 FAILURE TO APPEAR

(a) If the applicant or consumer fails to appear at the hearing and does not have a representative present, the hearing officer shall cancel the hearing.

(b) The applicant or consumer may submit a written request for rescheduling of the hearing to the Director. The request shall provide an explanation of the individual's failure to appear at the hearing or to have a representative present. The Director may instruct the hearing officer to reschedule the hearing upon a showing of good cause by the applicant or consumer. Good cause includes Acts of God, illness, death in the family, or other reasons not in the control of the applicant or consumer.

given by certified mail, it shall be deemed to have been given on the delivery date appearing on the return receipt.

(f) If the applicant or consumer does not request the Secretary's review, the hearing officer's decision shall be the final decision under the conditions specified in Sec. 102(c) of the Rehabilitation Act of 1973 (as amended by the Rehabilitation Act Amendments of 1998, P.L. 105-220).

(g) The Division Director shall forward a copy of the final decision, whether issued under Paragraph (e) or (f) of this Rule, to the CAP Director, the area rehabilitation supervisor, and the applicant's or consumer's representative, if one is designated. A copy shall also be included in the individual's official case record.

History Note: Authority G.S. 143B-157; 143-545.1; 150B-2; 150B-23; 34 C.F.R. 361.57; P.L. 105-220;

Eff. December 1, 1990;

Amended Eff. January 1, 1996;

Temporary Amendment Eff. March 15, 1999;

Amended Eff. August 1, 2000;

Temporary Amendment Eff. August 1, 2001;

Amended Eff. August 1, 2002.

10 NCAC 19G .0826 TRANSCRIPTS

Any person desiring a transcript of all or part of an impartial due process hearing shall contact the office of the Director. A fee to cover the cost of preparing the transcript shall be charged, and the party may be required to pay the fee in advance of receipt of the transcript. The transcript may be edited to remove confidential material.

History Note: Authority G.S. 143B-157; 150B-1(e)(5);

150B-2; 150B-23; 34 C.F.R. 361.57;

Eff. December 1, 1990;

Temporary Amendment Eff. August 1, 2001;

Amended Eff. August 1, 2002.

10 NCAC 19H .0101 COVERED SERVICES

(a) Services provided to any eligible North Carolina resident, pursuant to G.S. 111-8, include:

- (1) eye examinations. Refractions are restricted to one every two years for persons 25 years of age or older and one refraction per year for persons under 25 years of age, without prior approval by division staff;
- (2) treatment to the eye including medication;
- (3) eyeglasses and ocular prostheses. Eyeglasses are restricted to one pair every two years for persons 25 years of age or older and one pair per year for persons under 25 years of age, without prior approval by Division staff. Contact lenses are restricted to therapeutic types;
- (4) hospitalization for eye-related disorders; and
- (5) surgery to the eye and supporting structures except that there shall be no cosmetic surgery for adults and no payment shall be made for unnecessary surgery as determined by the State Supervising Ophthalmologist. The State Supervising Ophthalmologist is a medical doctor with a specialty in ophthalmology duly

licensed to practice by the State of North Carolina. Services are obtained by contract between the Agency and practitioner.

(b) **Prior Approval:**

- (1) A second refraction request within the time limitation period must be submitted on the general Request for Prior Approval form documenting the medical necessity for a second refraction (loss of vision, significant decrease in acuity, eye injury, retinal or muscle surgery, etc.).
- (2) Prior approval is required for all visual aids. The Area Nursing Eye Care Consultant reviews each request for prior services, medical justification, necessity, age, and other criteria before approving or denying the request.
- (3) Prior approval is required for all treatment, surgery, and prescription drugs. The Area Nursing Eye Care Consultant reviews each request for prior services, medical justification, necessity, age, and other criteria before approving or denying the request.

History Note: Authority G.S. 111-8; 143B-157;

Eff. February 1, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. August 1, 2002; September 1, 1984; February 1, 1983; July 1, 1981.

10 NCAC 19H .0202 CLAIMS

(a) Claims for services or supplies must be submitted no later than twelve months from the date of service. The division shall not pay claims received more than 12 months from the date of service.

(b) The amount reimbursed is payment in full. The consumer shall not be billed for any unrealized balance except a co-payment. A co-payment not to exceed five dollars (\$5.00) may be charged the consumer by both the practitioner who provides the eye exam and follow-up and by the optical supplier. This will reduce the division's liability by the amount of the co-payment.

History Note: Authority G.S. 111-8; 143B-157;

Eff. February 1, 1976;

Amended Eff. November 8, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. August 1, 2002; February 1, 1986; June 1, 1983; June 1, 1978.

10 NCAC 19H .0203 FRAUD: PAYMENT OF CLAIM

(a) All services billed by licensed eye practitioners and optical providers, institutions and suppliers must be consistent with the services actually performed.

(b) The Division shall use the Medicaid schedule of benefit payments for services charged the Division. This schedule is maintained by the Department of Health and Human Services, Division of Medical Assistance, 1985 Umstead Drive, Raleigh, NC 27603-2001. The schedule is incorporated by reference including subsequent amendments and additions.

(c) Licensed eye practitioners, licensed optical providers, institutions, and suppliers must keep records disclosing the services charged the division for five years. The division may have access to these records on written request by the division director.

History Note: Authority G.S. 108-48; 111-8; 111-23; 143B-157; Eff. February 1, 1976; Amended Eff. July 1, 1976; February 19, 1976; Readopted Eff. November 16, 1977; Amended Eff. August 1, 2002; April 1, 1990; February 1, 1986.

10 NCAC 19H .0206 EXAMINATION REPORTS

(a) An eye examination report shall be completed by ophthalmologists and optometrists on all persons having:

- (1) a chronic, degenerative eye disorder; or
- (2) no vision or vision with glasses so defective as to prevent the performance of ordinary activities requiring sight.

(b) The Division may request specific reports on persons not meeting the criteria in Paragraph (a) of this Rule, with the person's consent.

(c) Licensed eye practitioners shall not be paid for services until the requested information is supplied.

History Note: Authority G.S. 111-4; 111-8; 143B-157;

Eff. February 1, 1976;

Amended Eff. February 19, 1976;

Readopted Eff. November 16, 1977;

Amended Eff. August 1, 2002; April 1, 1990; June 1, 1978.

TITLE 11 – DEPARTMENT OF INSURANCE**11 NCAC 20 .0404 APPLICATION**

For all providers who submit applications to be added to a carrier's network on or after October 1, 2001:

- (1) Each carrier shall obtain and retain on file a complete signed and dated application on the form approved by the Commissioner under G.S. 58-3-230. All required information shall be current upon final approval by the carrier. The application shall include, when applicable:
 - (a) The provider's name, address, and telephone number.
 - (b) Practice information, including call coverage.
 - (c) Education, training and work history.
 - (d) The current provider license, registration, or certification, and the names of other states where the applicant is or has been licensed, registered, or certified.
 - (e) Drug Enforcement Agency (DEA) registration number and prescribing restrictions.
 - (f) Specialty board or other certification.
 - (g) Professional and hospital affiliation.
 - (h) The amount of professional liability coverage and any malpractice history.

- (i) Any disciplinary actions by medical organizations and regulatory agencies.
- (j) Any felony or misdemeanor convictions.
- (k) The type of affiliation requested (for example, primary care, consulting specialists, ambulatory care, etc.).
- (l) A statement of completeness, veracity, and release of information, signed and dated by the applicant.
- (m) Letters of reference or recommendation or letters of oversight from supervisors, or both.

(2) The carrier shall obtain and retain on file the following information regarding facility provider credentials, when applicable:

- (a) Joint Commission on Accreditation of Healthcare Organization's certification or certification from other accrediting agencies.
- (b) State licensure.
- (c) Medicare and Medicaid certification.
- (d) Evidence of current malpractice insurance.

(3) No credential item listed in Items (1) or (2) of this Rule shall be construed as a substantive threshold or criterion or as a standard for credentials that must be held by any provider in order to be a network provider.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;

Eff. October 1, 1996;

Temporary Amendment Eff. October 1, 2001;

Amended Eff. August 1, 2002.

11 NCAC 20 .0405 VERIFICATION OF CREDENTIALS

- (a) Each carrier's process for verifying credentials shall take into account and make allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials, and shall make allowance for the scheduling of a final decision by a credentialing committee, if the carrier's credentialing program requires such review.
- (b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60th day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and

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phone number of a credentialing staff person who will serve as a contact person for the applicant.

(c) Within 15 days after receipt of an incomplete application, the carrier shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures:

- (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant.
- (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule.
- (3) If the missing information or documents have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

(d) If a carrier elects not to include an applicant in its network, for reasons that do not require review of the application, the carrier shall provide written notice to the applicant of that determination within 30 days after receipt of the application.

(e) Nothing in this rule shall require a carrier to include a health care provider in its network or prevent a carrier from conducting a complete review and verification of an applicant's credentials, including an assessment of the applicant's office, before agreeing to include the applicant in its network.

History Note: Authority G.S. 58-2-40(1); 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996; Temporary Amendment Eff. October 1, 2001; Eff. July 1, 2002.

TITLE 12 – DEPARTMENT OF JUSTICE

12 NCAC 10B .0304 MEDICAL EXAMINATION

(a) Each applicant for certification or enrollee in a Commission-accredited basic training course shall complete, sign and date the Commission's Medical History Statement Form (F-1) and shall be examined by a physician, surgeon, physician=s assistant or nurse practitioner licensed in North Carolina to help determine

his/her fitness in carrying out the physical requirements of the position of justice officer.

(b) Prior to conducting the examination, the physician shall:

- (1) read the "Medical Screening Guidelines Implementation Manual for Certification of Justice Officers" in the State of North Carolina as published by the North Carolina Department of Justice. Copies of this publication may be obtained at no cost at the time of the adoption of this Rule by contacting the North Carolina Department of Justice, Sheriffs= Standards Division, PO Box 629, Raleigh, North Carolina 27602; and
- (2) read, sign, and date the Medical History Statement Form (F-1); and
- (3) read the F2A Form attached to the Medical Examination Report Form (F-2).

(c) The examining physician, surgeon, physician=s assistant or nurse practitioner shall record the results of the examination on the Medical Examination Report Form (F-2) and sign and date the form.

(d) The Medical Examination Report Form (F-2) and the Medical History Statement Form (F-1) shall be valid one year from the date the examination was conducted and shall be completed prior to:

- (1) the applicant's beginning the Detention Officer Certification Course, the Basic Law Enforcement Training Course, or the Telecommunicator Certification Course; and
- (2) the applicant's applying to the Commission for Certification.

Note: Although not presently required by these Rules, it is recommended by the Commission that each candidate for the position of justice officer be examined by a licensed psychiatrist or clinical psychologist, or be administered a psychological evaluation test battery, to determine his/her suitability to perform the essential job functions of a justice officer.

History Note: Authority G.S. 17E-7;

Eff. January 1, 1989;

Amended Eff. January 1, 1996; January 1, 1993; January 1, 1991; January 1, 1990;

Temporary Amendment Eff. March 1, 1998;

Amended Eff. August 1, 2002; April 1, 2001; August 1, 1998.

12 NCAC 10B .0408 VERIFICATION OF RECORDS TO DIVISION

(a) Prior to issuing certification of each justice officer, for the purpose of verifying compliance with these Rules, the employing agency shall submit to the Division, along with the Report of Appointment (F-4), the following documents:

- (1) verification of the applicant's compliance with the educational requirement pursuant to 12 NCAC 10B .0302(a);
- (2) certified copy of the applicant's Oath of Office, if applying for certification as a deputy sheriff;
- (3) the applicant's Medical History Statement (F-1);
- (4) the applicant's Medical Examination Report (F-2 and F-2A);

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(5) the applicant's notarized Personal History Statement (F-3);
(6) the Commission-mandated Background Investigation Form (F-8) with all accompanying documentation set out in 12 NCAC 10B .0305;
(7) documentation of negative results on a drug screen pursuant to 12 NCAC 10B .0301(6); and
(8) verification of the applicant's compliance with the probationary certification requirements pursuant to 12 NCAC 10B .0403(b), if the applicant is a deputy sheriff or a detention officer.

(b) Compliance with this Rule is waived, with the exception of the requirements of 12 NCAC 10B .0408(a)(8), for officers applying for dual certification as defined in 12 NCAC 10B .0103(12) provided that:

- (1) the officer holds a valid certification as either a deputy sheriff, detention officer, or telecommunicator with the employing agency requesting dual certification; and
- (2) the officer has not had a break in service since initial certification with the employing agency requesting dual certification.

(c) Where the Division has previously received a complete Background Investigation Form (F-8) with all accompanying documentation set out in 12 NCAC 10B .0305 in connection with another application for certification to this Commission, the Background Investigation need only be updated from the date of the last background investigation on file in the Division with documentation of compliance with 12 NCAC .0305(e)(1), (2), (3), and a county-wide and certified records check for each name used by the applicant for each jurisdiction where the applicant has resided in North Carolina since the initial Background Investigation (Form F-8) was completed. In addition:

- (1) If the applicant has been issued an out-of-state driver=s license by a state other than North Carolina since obtaining certification, then compliance with 12 NCAC 10B .0305(e)(4), is required; and
- (2) If the applicant has resided in a state other than North Carolina since obtaining certification, a certified and county-wide record check from each jurisdiction (if available) shall be provided.

(d) All information maintained pursuant to the requirements of this Rule shall be subject to all state and federal laws governing confidentiality.

*History Note: Authority G.S. 17E-4; 17E-7;
Eff. January 1, 1989;
Recodified from 12 NCAC 10B .0407 Eff. January 1, 1991;
Amended Eff. January 1, 1996; January 1, 1994; January 1, 1993; January 1, 1992;
Temporary Amendment Eff. March 1, 1998;
Amended Eff. August 1, 2002; August 1, 1998.*

12 NCAC 10B .0409 EMPLOYING AGENCY RETENTION OF CERTIFICATION RECORDS

(a) Each employing agency shall place in the appropriate justice officer's personnel file the official notification of either probationary or general certification. Such files shall be available for examination at any reasonable time by representatives of the Commission for the purpose of verifying compliance with these Rules. Each personnel file shall also contain copies of the original documentation submitted to the Division in accordance with 12 NCAC 10B .0408(a)(8), for officers applying for dual certification as defined in 12 NCAC 10B .0103(12) provided that:

- (1) the officer holds a valid certification as a deputy sheriff, detention officer, or telecommunicator with the employing agency requesting dual certification; and
- (2) the officer has not had a break in service since initial certification with the employing agency requesting dual certification.

(c) Where the Division has previously received a complete Background Investigation Form (F-8) with all accompanying documentation set out in 12 NCAC 10B .0305 in connection with another application for certification to this Commission, and a subsequent hiring agency requests a copy of such documentation, the Division shall comply with that request upon submission of a commission-approved Release Authorization Form for Law Enforcement Agencies.

(d) All information maintained pursuant to the requirements of this Rule shall be subject to all state and federal laws governing confidentiality.

History Note: Authority G.S. 17E-4;

Eff. January 1, 1989;

*Recodified from 12 NCAC 10B .0408 Eff. January 1, 1991;
Amended Eff. January 1, 1996; January 1, 1994; January 1, 1993; January 1, 1991;*

Temporary Amendment Eff. March 1, 1998;

Amended Eff. August 1, 2002; August 1, 1998.

12 NCAC 10B .0505 EVALUATION FOR TRAINING WAIVER

The Division staff shall evaluate each deputy's training and experience to determine if equivalent training has been satisfactorily completed as specified in 12 NCAC 10B .0504(a). The following rules shall be used by Division staff in evaluating an applicant's training and experience to determine eligibility for a waiver of training.

- (1) Persons who separated from a sworn law enforcement position during their probationary period after having completed a commission-accredited Basic Law Enforcement Training Course and who have been separated from a sworn law enforcement position for one year or less shall serve the remainder of the initial probationary period in accordance with G.S. 17E-7(b), but need not complete an additional training program.
- (2) Persons who separated from a sworn law enforcement position during their probationary period without having completed Basic Law Enforcement Training, or whose certification

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was suspended pursuant to 12 NCAC 10B .0204(b)(1), and who have remained separated or suspended for over one year shall complete a commission-accredited Basic Law Enforcement Training Course in its entirety and pass the State Comprehensive Examination, and shall be allowed a 12 month probationary period as prescribed in 12 NCAC 10B .0503(a).

(3) Persons transferring to a Sheriff's Office from another law enforcement agency who held certification and who have previously completed a commission-accredited Basic Law Enforcement Training Course beginning on or after October 1, 1984, and continuing to July 1, 2000 and who have been separated from a sworn law enforcement position for no more than one year or who have had no break in service shall be required to complete the following enumerated topics of a commission-accredited Basic Law Enforcement Training Course and pass that portion of the State Comprehensive Examination which deals with those subjects within 12 months of the date of appointment as defined in 12 NCAC 10B .0103(1).

(a)	Civil Process	24 hours
(b)	Sheriffs' Responsibilities: Detention Duties	4 hours
(c)	Sheriffs' Responsibilities: Court Duties	6 hours
	UNIT TOTAL	34 hours

(4) Persons who have training and experience as a military law enforcement officer and are appointed as a deputy sheriff in North Carolina shall be required to complete a commission-accredited Basic Law Enforcement Training Course in its entirety regardless of previous military training and experience and pass the State Comprehensive Examination within the 12 month probationary period as prescribed in 12 NCAC 10B .0503(a).

(5) Persons transferring to a sheriff's office from another law enforcement agency who have previously completed a commission accredited Basic Law Enforcement Training Course beginning on or after January 1, 1996 and continuing to July 1, 1997, and who did not complete the Commission's Driver Training curriculum, and who have been separated from a sworn law enforcement position for no more than one year or who have had no break in service shall be required to complete the following enumerated topics of a commission - accredited Basic Law Enforcement Training Course within 12 months of the date of appointment as defined in 12 NCAC 10B .0103(1): Law Enforcement Driver Training - 40 hours

(6) North Carolina applicants shall:

(a) have a minimum of two years full-time sworn law enforcement experience which occurred prior to their application;

(b) have had a break in service exceeding one year;

(c) have previously received General or Grandfather certification as a sworn law enforcement officer by either the Commission or the North Carolina Criminal Justice Education and Training Standards Commission, and such certification has not been denied, revoked or suspended by either Commission; and

(d) have held general powers of arrest.

(7) Out-of-state transferees shall:

(a) have a minimum of two years full-time sworn law enforcement experience which occurred prior to their application;

(b) have held certification in good standing as a sworn law enforcement officer from the appropriate Peace Officer's Standards and Training entity in the transferee's respective state;

(c) have had general powers of arrest; and

(d) submit documentation verifying their qualified status.

(8) Federal Transferees shall:

(a) have a minimum of two years full-time sworn law enforcement experience which occurred prior to their application;

(b) have held certification or commissioning as a sworn law enforcement officer from the appropriate federal entity authorized to issue such sworn law enforcement officers certification or commission;

(c) have held general powers of arrest; and

(d) submit documentation verifying their qualified status.

(9) North Carolina applicants; qualified out-of-state transferees; and qualified federal transferees shall be allowed to select one of the following two options for gaining North Carolina certification as a deputy sheriff:

(a) Undertake and successfully complete Basic Law Enforcement Training in its entirety during a one year probationary period and successfully pass the State Comprehensive Examination;

(b) Pass the following entry criteria:

(i) Challenge the Basic Law Enforcement Training Comprehensive State

*History Note: Authority G.S. 17E-4; 17E-7;**Eff. January 1, 1989;**Amended Eff. August 1, 2002; August 1, 2000; August 1, 1998; February 1, 1998; January 1, 1996; January 1, 1994; January 1, 1993; January 1, 1992.*

12 NCAC 10B .0601 DETENTION OFFICER CERTIFICATION COURSE

(a) This Section establishes the current standard by which Sheriffs' Office and district confinement personnel shall receive detention officer training. These Rules will serve to raise the level of detention officer training heretofore available to law enforcement officers across the state. The Detention Officer Certification Course shall consist of a minimum of 162 hours of instruction designed to provide the trainee with the skills and knowledge necessary to perform those tasks considered essential to the administration and operation of a confinement facility.

(b) Each Detention Officer Certification Course shall include the following identified topic areas and approximate minimum instructional hours for each area:

(1)	Orientation Criminal Justice System Legal Aspects of Management & Supervision	2 hours 3 hours 19 hours
(2)	Contraband/Searches Processing Inmates	6 hours 5 hours
(3)	First Aid & CPR Medical Care in the Jail	10 hours 5 hours
(4)	Patrol/Security Funct. of the Jail Key and Tool Control	5 hours 2 hours
(5)	Supervision/Mgmt. of Inmates Suicides & Crisis Management	5 hours 5 hours
(6)	Introduction to Rules & Regulations Governing Jails	24 hours 2 hours
(7)	Stress Investigative Process in the Jail	2 hours 9 hours
(8)	Subject Control Techniques Aspects of Mental Illness	24 hours 4 hours
(9)	Transportation of Inmates Fire Emergencies	6 hours 4 hours
(10)	Fingerprinting and Photographing Arrestees	6 hours
(11)	Physical Fitness for Detention Officers	20 hours
(12)	Communication Skills	5 hours
(13)	Ethics	3 hours
(14)	Review/Testing	7 hours
(15)	State Comprehensive Examination	3 hours
(16)	TOTAL HOURS	162 hours

(c) Consistent with the curriculum development policy of the Commission as published in the "Detention Officer Certification Course Management Guide", the Commission shall designate the developer of the Detention Officer Certification Course curricula and such designation shall be deemed by the Commission as approval for the developer to conduct pilot Detention Officer Certification Courses. Individuals who complete such a pilot Detention Officer Certification Course offering shall be deemed to have complied with and satisfied the minimum training requirement.

(d) The "Detention Officer Certification Training Manual" as published by the North Carolina Justice Academy shall be used as the basic curriculum for the Detention Officer Certification Course. Copies of this manual may be obtained by contacting the North Carolina Justice Academy, Post Office Box 99, Salemburg, North Carolina 28385-0099. The cost of this manual is forty dollars (\$40.00) at the time of adoption of this Rule.

(e) The "Detention Officer Certification Course Management Guide" as published by the North Carolina Justice Academy is hereby incorporated by reference and shall automatically include any later amendments, editions of the incorporated matter to be used by school directors in planning, implementing and delivering basic detention officer training. The standards and requirements established by the "Detention Officer Certification Course Management Guide" must be adhered to by the school director. Each certified school director shall be issued a copy of the guide at the time of certification at no cost to the accredited school.

History Note: Authority G.S. 17E-4(a);

Eff. January 1, 1989;

Amended Eff. August 2, 2002; August 1, 2000; August 1, 1998; February 1, 1998; January 1, 1996; June 1, 1992; January 1, 1992; January 1, 1991.

12 NCAC 10B .0603 EVALUATION FOR TRAINING WAIVER

Applicants for certification with prior detention or correctional officer experience shall have been employed and certified as a detention or correctional officer in order to be considered for a training evaluation under this Rule. The following rules shall be used by division staff in evaluating a detention officer's training and experience to determine eligibility for a waiver of training:

(1) Persons who have separated from a detention officer position during the probationary period after having completed a commission-accredited detention officer training course and who have been separated from a detention officer position for more than one year shall complete a subsequent commission-accredited detention officer training course in its entirety and pass the State Comprehensive Examination within the 12 month probationary period as described in 12 NCAC 10B .0602(a).

(2) Persons who separated from a detention officer position during their probationary period after having completed a commission-accredited detention officer training course and who have been separated from a detention officer position for one year or less shall serve the

remainder of the initial probationary period in accordance with G.S. 17E-7(b), but need not complete an additional training program.

(3) Persons who separated from a detention officer position during the probationary period without having completed a detention officer training course or whose certification was suspended pursuant to 12 NCAC 10B .0204(b)(1) and who have remained separated or suspended for over one year shall complete a commission-accredited detention officer training course in its entirety and pass the State Comprehensive Examination, and shall be allowed a 12 month probationary period as prescribed in 12 NCAC 10B .0602(a).

(4) Persons holding General Detention Officer Certification who have completed a commission-accredited detention officer training course and who have separated from a detention officer position for more than one year shall complete a subsequent commission-accredited detention officer training course in its entirety and pass the State Comprehensive Examination within the 12 month probationary period as prescribed in 12 NCAC 10B .0602(a).

(5) Persons holding Grandfather Detention Officer Certification who separate from a detention officer position and remain separated from a detention officer position for more than one year shall complete a commission-accredited detention officer training program in its entirety and pass the State Comprehensive Examination within the 12 month probationary period as prescribed in 12 NCAC 10B .0602(a).

(6) Persons transferring to a sheriff's office from another law enforcement agency who hold a detention officer certification issued by the North Carolina Criminal Justice Education and Training Standards Commission shall be subject to evaluation of their prior training and experience on an individual basis. The Division staff shall determine the amount of training, which is comparable to that received by detention officers pursuant to 12 NCAC 10B .0601(b), required of these applicants.

(7) Persons holding general certification as a correctional officer issued by the North Carolina Criminal Justice Education and Training Standards Commission and who:

- (a) completed training as a correctional officer between January 1, 1981 and August 1, 2002; and
- (b) transfer to a sheriff's office or a district confinement facility in a detention officer position; and
- (c) have had less than a one year break in service, or no break in service, shall serve a 12-month probationary period as prescribed in 12 NCAC 10B .0602(a).

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.0602(a) and shall complete the following topic areas in a commission-accredited detention officer certification course and take the state examination in its entirety during that probationary period:

(i)	Orientation	2 hours
(ii)	Legal Aspects of Management & Supervision	19 hours
(iii)	Medical Care in the Jail	5 hours
(iv)	Investigative Process in the Jail	9 hours
(v)	Suicides and Crisis Management	5 hours
(vi)	Introduction to Rules and Regulations Governing Jails	2 hours
(vii)	Fire Emergencies	4 hours
	TOTAL HOURS	46 hours

(8) Persons holding general certification as a correctional officer issued by the North Carolina Criminal Justice Education and Training Standards Commission and who:

- (a) completed training as a correctional officer after August 1, 2002; and
- (b) transfer to a sheriff's office or a district confinement facility in a detention officer position; and
- (c) have had less than a one year break in service, or no break in service, shall serve a 12-month probationary period as prescribed in 12 NCAC 10B .0602(a); may apply for a waiver to the Division by submitting documentation of the training completed as a correctional officer.

Division staff shall compare the completed correctional officer training to the existing Detention Officer Certification Course and determine whether any of the Detention Officer Certification Course blocks of instruction can be waived. The Division shall notify the employing agency of the resulting training requirements. The detention officer and shall complete the required training in a commission-accredited Detention Officer Certification Course and take the state examination in its entirety during the probationary period.

(a) At the conclusion of a school's offering of the "Detention Officer Certification Course", an authorized representative of the Commission shall administer a comprehensive written examination to each trainee who has satisfactorily completed all of the course work. A trainee shall not be administered the comprehensive written examination until such time as all course work is successfully completed.

(b) The examination shall be an objective test covering the topic areas as described in 12 NCAC 10B .0601(b).

(c) The Commission's representative shall submit to the school director within 10 days of the administration of the examination a report of the results of the test for each trainee examined.

(d) A trainee shall successfully complete the comprehensive written examination if he/she achieves a minimum of 70 percent correct answers.

(e) A trainee who has fully participated in a scheduled delivery of an accredited training course and has demonstrated satisfactory competence in each motor-skill or performance area of the course curriculum but has failed to achieve the minimum score of 70 percent on the Commission's comprehensive written examination may request the Director to authorize a re-examination of the trainee.

- (1) A trainee's Request for Re-examination shall be made in writing on the Commission's form within 30 days after the original examination and shall be received by the Division before the expiration of the trainee's probationary certification as a detention officer.
- (2) The trainee's request for re-examination shall include the favorable recommendation of the school director who administered the trainee's "Detention Officer Certification Course".
- (3) A trainee shall have only one opportunity for re-examination and shall satisfactorily complete the subsequent examination in its entirety within 90 days after the original examination.
- (4) A trainee shall be assigned in writing by the Division a place, time, and date for re-examination.
- (5) Should the trainee on re-examination not achieve the prescribed minimum score of 70 on the examination, the trainee may not be recommended for certification and must enroll and complete a subsequent course in its entirety before further examination may be permitted.

History Note: Authority G.S. 17E-4; 17E-7;

Eff. January 1, 1989;

Amended Eff. August 1, 2002; August 1, 1998; February 1, 1998; January 1, 1996; January 1, 1993; January 1, 1992; January 1, 1991.

History Note: Authority G.S. 17E-4; 17E-7;

Eff. January 1, 1989;

Amended Eff. August 1, 2002; August 1, 1998;

February 1, 1998; January 1, 1996; January 1, 1993;

January 1, 1992; January 1, 1991.

12 NCAC 10B .0606 COMP WRITTEN EXAM – DETENTION OFFICER CERTIFICATION COURSE

12 NCAC 10B .0905 TERMS AND CONDITIONS OF DETENTION OFFICER INSTRUCTOR CERTIFICATION

(a) An applicant meeting the requirements for certification as a Detention Officer Instructor shall serve a probationary period. The probationary period will be set to expire concurrently with the expiration of the instructors = General Instructor Certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. As of August 1, 2002, the

expiration dates of any existing commission-issued Probationary General Detention Officer Instructor Certifications will be amended to expire concurrently with the expiration of the instructors = General Instructor Certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. If the time-period before the expiration date is less than one year, then the eight hours of instruction shall be waived for this shortened term and Full General Detention Officer Instructor Certification will be issued provided all other conditions for Full status as set out in Paragraph (b) of his Section are met.

(b) The probationary instructor shall be awarded full Detention Officer Instructor Certification at the end of the probationary period if the instructor, through application, submits to the Division documentation that certification required in 12 NCAC 10B .0904(a)(2) remains valid, and either:

- (1) a favorable recommendation from a school director accompanied by certification on a commission Instructor Evaluation Form that the instructor satisfactorily taught a minimum of eight hours as specified in Paragraph (e) of this Rule in a commission-accredited Detention Officer Certification Course during his/her probationary year; or
- (2) an acceptable written evaluation as specified in Paragraph (e) of this Rule by a commission member or staff member based on an on-site classroom evaluation of the probationary instructor in a commission-accredited Detention Officer Certification Course. Such evaluation shall be certified on a commission Instructor Evaluation Form. In addition, instructors evaluated by a commission or staff member must also teach a minimum of eight hours in a commission-accredited Detention Officer Certification Course during his/her probationary year.

(c) As of August 1, 2002, the expiration dates of any existing commission-issued Full General Detention Officer Instructor Certifications will be amended to expire concurrently with the expiration of the instructors = General Instructor Certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. If the time-period before the expiration date is less than two years, then the eight hours of instruction shall be waived for this shortened term and Full General Detention Officer Instructor Certification will be renewed. Full Detention Officer Instructor Certification is continuous so long as the instructor submits to the Division every two years a renewal application to include documentation that certification required in 12 NCAC 10B .0904(a)(2) remains valid, and either:

- (1) a favorable recommendation from a school director accompanied by certification on a commission Instructor Evaluation Form that the instructor satisfactorily taught a minimum of eight hours as specified in Paragraph (e) of this Rule in a commission-accredited Detention Officer Certification Course during the previous two year period. The date full Instructor Certification is originally issued is

the anniversary date from which each two year period is figured; or
(2) an acceptable written evaluation as specified in Paragraph (e) of this Rule by a commission member or staff member based on a minimum eight hours, on-site classroom observation of the instructor in a commission-accredited Detention Officer Certification Course.

(d) In the event a General Detention Officer Instructor Certification (either Probationary or Full) is terminated for failure to have been satisfactorily evaluated for eight hours of instruction in a Detention Officer Certification Course, the individual may re-apply for certification meeting the initial conditions for such certification, but must also provide documentation that he/she has audited eight hours of instruction in a delivery of an accredited Detention Officer Certification Course.

(e) An Instructor Evaluation Form records a rating of the instructor=s qualities, organization and presentation of materials consistent with the requirements for successfully completing the Criminal Justice Instructor Training as set out in 12 NCAC 09B .0209. Instructor qualities, organization and presentation are rated on a scale of 1 (poor), 2 (fair), 3 (good), 4 (excellent) and 5 (superior). Instructor qualities include, but may not be limited to appearance, gestures, verbal pauses, grammar, pronunciation, enunciation, voice, rate (too slow or too fast), eye contact, and enthusiasm. Organization and presentation include, but may not be limited to:

- (1) Major objectives of the course made clear;
- (2) Class Presentation planned and organized;
- (3) Important ideas clearly explained;
- (4) Instructor=s mastery of the course content;
- (5) Class time well used;
- (6) Encouragement of critical thinking and analysis;
- (7) Encouragement of student involvement;
- (8) Reaction to student viewpoints different from instructors;
- (9) Students = attitude toward instructor; and
- (10) Instructor=s use of training aids.

A rating of 1 or 2 is unacceptable or unsatisfactory; and a rating of 3, 4, or 5 is acceptable or satisfactory.

History Note: Authority G.S. 17E-4;

Eff. January 1, 1989;

Amended Eff. August 1, 2002; January 1, 1996;

January 1, 1992.

12 NCAC 10B .0907 TERMS AND CONDITIONS OF PROFESSIONAL LECTURER CERT

As of August 1, 2002, the expiration dates of any existing commission-issued Professional Lecturer Certifications, where the individual also holds another instructor certification(s) issued through this Commission, the expiration date will be amended to expire concurrently with the other instructor certification(s) issued by this Commission. In the event such instructor does not hold another instructor certification under this Commission, but holds an instructor certification under the North Carolina Criminal Justice Education and Training Standards Commission, the expiration date will be amended to expire concurrently with the other instructor certification(s) issued by the North Carolina

Criminal Justice Education and Training Standards Commission. Where the instructor holds no certification through either Commission, certification as a professional lecturer shall remain effective for 24 months from the date of issuance. The lecturer shall apply for recertification at or before the expiration date.

*History Note: Authority G.S. 17E-4;
Eff. January 1, 1989;
Amended Eff. August 1, 2002.*

12 NCAC 10B .0908 LIMITED LECTURER CERTIFICATION

(a) The Commission may issue a Limited Lecturer Certification to an applicant who has developed specific or special skills by virtue of specific or special training. Limited Lecturer Certification may be issued in the following topical areas:

- (1) First Aid and CPR;
- (2) Subject Control Techniques;
- (3) Fire Emergencies in the Jail;
- (4) Medical Care in the Jail;
- (5) Physical Fitness for Detention Officers; and
- (6) Fingerprinting and Photographing Arrestees.

(b) To be eligible for a Limited Lecturer Certificate for topic areas set forth in Rule .0908(a), the applicant must meet the qualifications as follows:

- (1) First Aid and CPR: Certified Standard First Aid Instructor with the American Red Cross or a licensed physician, Family Nurse Practitioner, Licensed Practical Nurse (LPN), Registered Nurse (RN), Physician's Assistant, or EMT;
- (2) Subject Control Techniques: certified by N.C. Criminal Justice Education and Training Standards Commission as Defensive Tactics Instructor and compliance with Rule .0903(c) of this Section;
- (3) Fire Emergencies in the Jail: Certified Fire Instructor through the North Carolina Department of Insurance Office of State Fire Marshal;
- (4) Medical Care in a Jail: A Licensed Physician, Family Nurse Practitioner, LPN, RN, or EMT, or Physician's Assistant;
- (5) Physical Fitness for Detention Officer: certified as a Physical Fitness Instructor by the North Carolina Criminal Justice Education and Training Standards Commission; and
- (6) Fingerprinting and Photographing Arrestees: certified as a General Instructor by the North Carolina Criminal Justice Education and Training Standards Commission.

(c) In addition to the requirements set out in Paragraph (b) of this Rule, applicants for Limited Lecturer Certification, with the exception of Fingerprinting and Photographing Arrestees, must possess current certification to perform CPR and which was obtained through the applicant having shown proficiency both cognitively and through skills testing.

*History Note: Authority G.S. 17E-4;
Eff. January 1, 1989;
Amended Eff. August 1, 2002; August 1, 2000; August 1, 1998;*

*January 1, 1996; January 1, 1992; January 1, 1991;
January 1, 1990.*

12 NCAC 10B .0909 TERMS AND CONDITIONS OF A LIMITED LECTURER CERTIFICATION

(a) An applicant meeting the requirements for certification as a Limited Lecturer shall serve a probationary period. As of August 1, 2002, the expiration dates of any existing commission-issued Limited Lecturer Certifications, where the individual holds instructor certification under the North Carolina Criminal Justice Education and Training Standards Commission, will be amended to expire concurrently with the other instructor certification(s) issued by the North Carolina Criminal Justice Education and Training Standards Commission. In the event such instructor does not hold instructor certification under the North Carolina Criminal Justice Education and Training Standards Commission, but holds another instructor certification(s) issued through this Commission, the expiration date will be amended to expire concurrently with the other instructor certification(s) issued by this Commission. Where the instructor holds no certification through either Commission, certification as a Limited Lecturer shall remain effective for 12 months from the date of issuance. The lecturer shall apply for Full Limited Lecturer Certification at or before the expiration date. If the time-period before the expiration date is less than one year, then the four hours of instruction shall be waived for this shortened term and Full Limited Lecturer Certification will be issued provided all other conditions for Full status as set out in this Section are met.

(b) The probationary instructor shall be eligible for full Limited Lecturer status at the end of the probationary period if the instructor, through application, submits to the Commission:

- (1) documentation on a commission-approved Form LL1 of at least four hours of instruction occurring within the probationary period in an area of the instructor=s expertise related to each topic for which Limited Lecturer Certification was granted; and
- (2) documentation that all other certifications required in 12 NCAC 10B .0908 remain valid.

(c) As of August 1, 2002, the expiration dates of any existing commission-issued Full Limited Lecturer Certifications will be amended to expire concurrently with the expiration of the corresponding instructors= certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. In the event such instructor does not hold instructor certification under the North Carolina Criminal Justice Education and Training Standards Commission, but holds another instructor certification(s) issued through this Commission, the expiration date will be amended to expire concurrently with the other instructor certification(s) issued by this Commission. The lecturer shall apply for recertification at or before the expiration date. If the time period before the expiration date is less than two years, then the 4 hours of instruction shall be waived for this shortened term and Full Limited Lecturer Instructor Certification will be renewed provided all other conditions for Full status as set out in Subparagraph (2) of this Paragraph are met. Full Limited Lecturer Certification shall be continuous so long as the lecturer submits to the Division every two years:

- (1) documentation on a commission-approved Form LL1 of at least four hours of instruction

occurring within the two-year certification period in an area of the instructor=s expertise related to each topic for which Limited Lecturer Certification was granted; and

(2) a renewal application to include documentation that all other certifications required in 12 NCAC 10B .0908 remain valid.

(d) In the event a Limited Lecturer Instructor Certification (either Probationary or Full) is terminated for failure to have provided documentation of at least four hours of instruction occurring within the respective certification periods in an area of the instructor=s expertise related to each topic for which Limited Lecturer Certification was granted, the individual may re-apply for certification meeting the initial conditions for such certification, but must also provide documentation on a commission-approved Form LL2 that he/she has audited four hours of instruction in the topic area for which Limited Lecturer Certification was granted in a delivery of an accredited Detention Officer Certification Course.

*History Note: Authority G.S. 17E-4;
Eff. January 1, 1989;
Amended Eff. August 1, 2002; August 1, 2000; August 1, 1998;
January 1, 1996; January 1, 1994; January 1, 1992;
January 1, 1991.*

12 NCAC 10B .0915 TERMS AND CONDITIONS OF TELECOMMUNICATOR INSTRUCTOR CERTIFICATION

(a) An applicant meeting the requirements for certification as a Telecommunicator Instructor shall serve a probationary period. The Telecommunicator Instructor Certification probationary period shall be set to automatically expire concurrently with the expiration of the instructor=s General Instructor Certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. As of August 1, 2002, the expiration dates of any existing commission-issued Probationary General Telecommunicator Instructor Certifications will be amended to expire concurrently with the expiration of the instructors = General Instructor Certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. If the time-period before the expiration date is less than one year, then the eight hours of instruction shall be waived for this shortened term and Full General Telecommunicator Instructor Certification will be issued provided all other conditions for Full status as set out in Paragraph (b) of this Rule are met.

(b) The probationary instructor shall be awarded full Telecommunicator Instructor Certification at the end of the probationary period if the instructor, through application, submits to the Division: Division documentation that certification required in 12 NCAC 10B .0914(a)(2) remains valid, and either:

(1) a favorable recommendation from a school director accompanied by certification on a commission Instructor Evaluation Form that the instructor satisfactorily taught a minimum of eight hours as specified in Paragraph (e) of this Rule in a commission-accredited Telecommunicator Certification Course during his/her probationary year; or

(2) an acceptable written evaluation as specified in Paragraph (e) of this Rule by a commission member or staff member based on an on-site classroom evaluation of the probationary instructor in a commission-accredited Telecommunicator Certification Course. Such evaluation shall be certified on a commission Instructor Evaluation Form. In addition, instructors evaluated by a commission or staff member must also teach a minimum of eight hours in a commission-accredited Telecommunicator Certification Course during his/her probationary year.

(c) As of August 1, 2002, the expiration dates of any existing commission-issued Full General Telecommunicator Instructor Certifications will be amended to expire concurrently with the expiration of the instructors = General Instructor Certification issued by the North Carolina Criminal Justice Education and Training Standards Commission. If the time-period before the expiration date is less than two years, then the eight hours of instruction shall be waived for this shortened term and Full General Telecommunicator Instructor Certification will be renewed. Full Telecommunicator Instructor Certification is continuous so long as the instructor submits to the Division every two years a renewal application to include documentation that certification required in 12 NCAC 10B .0914(a)(2) remains valid, and either:

(1) a favorable recommendation from a school director accompanied by certification on a commission Instructor Evaluation Form that the instructor satisfactorily taught a minimum of eight hours as specified in Paragraph (e) of this Rule in a commission-accredited Telecommunicator Certification Course during the previous two year period. The date full Instructor Certification is originally issued is the anniversary date from which each two year period is figured; or

(2) an acceptable written evaluation as specified in Paragraph (e) of this Rule by a commission member or staff member based on a minimum eight hours, on-site classroom observation of the instructor in a commission-accredited Telecommunicator Certification Course.

(d) In the event a General Telecommunicator Instructor Certification (either Probationary or Full) is terminated for failure to have been evaluated for eight hours of instruction in a Telecommunicator Certification Course, the individual may re-apply for certification meeting the initial conditions for such certification, but must also provide documentation that he/she has audited 8-hours of instruction in a delivery of an accredited Telecommunicator Certification Course.

(e) An Instructor Evaluation Form records a rating of the instructor=s qualities, organization and presentation of materials consistent with the requirements for successfully completing the Criminal Justice Instructor Training as set out in 12 NCAC 09B .0209. Instructor qualities, organization and presentation are rated on a scale of 1(poor), 2 (fair), 3 (good), 4 (excellent) and 5 (superior). Instructor qualities include, but may not be limited to appearance, gestures, verbal pauses, grammar, pronunciation, enunciation, voice, rate (too slow or too fast), eye contact, and

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enthusiasm. Organization and presentation include, but may not be limited to:

- (1) Major objectives of the course made clear;
- (2) Class presentation planned and organized;
- (3) Important ideas clearly explained;
- (4) Instructor=s mastery of the course content;
- (6) Encouragement of critical thinking and analysis;
- (7) Encouragement of student involvement;
- (8) Reaction to student viewpoints different from instructors;
- (9) Students attitude toward instructor; and
- (10) Instructor=s use of training aids.

A rating of 1 or 2 is unacceptable or unsatisfactory; and a rating of 3, 4, or 5 are acceptable or satisfactory.

History Note: Authority G.S. 17E-4;

Eff. April 1, 2001;

Amended Eff. August 1, 2002.

12 NCAC 10B .0917 TERMS AND CONDITIONS OF PROFESSIONAL LECTURER CERTIFICATION:

12 NCAC 10B .1004 INTERMEDIATE LAW ENFORCEMENT CERTIFICATE

(a) In addition to the qualifications set forth in Rule .1002, applicants for the Intermediate Law Enforcement Certificate shall possess or be eligible to possess the Basic Law Enforcement Certificate and shall have acquired the following combination of educational points or degrees, law enforcement training and years of law enforcement training experience:

Educational Degrees	None	None	None	Associate	Bachelor
Years of Law Enforcement Experience	8	6	4	4	2
Minimum Law Enforcement Training Points	20	35	50	24	23
Minimum Total Education and Training Points	39	69	99	24	23

(b) Educational points claimed shall have been earned at a technical institute, technical college, community college, junior college, college or university accredited as such by the Department of Education of the state in which the institution is located, a national or regional accrediting body, or the state university of the state in which the institution is located. No credit shall be given for any correspondence or vocational courses unless credited towards a degree by an accredited institution.

(c) No more than 160 hours of training obtained by completing the commission-mandated basic law enforcement training course shall be credited toward training points.

History Note: Authority G.S. 17E-4;

Eff. January 1, 1989;

Amended Eff. August 1, 2002; August 1, 1998; January 1, 1996; January 1, 1992.

12 NCAC 10B .1005 ADVANCED LAW ENFORCEMENT CERTIFICATE

(a) In addition to the qualifications set forth in Rule .1002, applicants for the Advanced Law Enforcement Certificate shall possess or be eligible to possess the Intermediate Law Enforcement Certificate and shall have acquired the following combination of educational points or degrees, law enforcement training points and years of law enforcement experience:

Educational Degrees	None	None	Associate	Bachelor	Doctoral, Professional or Master
Years of Law					

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Enforcement Experience	12	9	9	6	4
Minimum Law Enforcement Training Points	35	50	33	27	23
Minimum Total Education and Training Points	69	99	33	27	23

(b) Educational points claimed shall have been earned at a technical institute, technical college, community college, junior college, college or university accredited as such by the Department of Education of the state in which the institution is located, a national or regional accrediting body, or the state university of the state in which the institution is located. No credit shall be given for any correspondence or vocational courses unless credited towards a degree by an accredited institution.

(c) No more than 160 hours of training obtained by completing the commission-mandated basic law enforcement training course shall be credited toward training points.

*History Note: Authority G.S. 17E-4;
Eff. January 1, 1989;
Amended Eff. August 1, 2002; August 1, 1998; January 1, 1996; January 1, 1994; January 1, 1992.*

12 NCAC 10B .1204 INTERMEDIATE DETENTION OFFICER PROFESSIONAL CERTIFICATE

(a) In addition to the qualifications set forth in Rule .1202 of this Section, applicants for the Intermediate Detention Officer Professional Certificate shall possess or be eligible to possess the Basic Detention Officer Professional Certificate and shall have acquired the following combination of educational points or degrees, detention officer or corrections training points and years of detention officer experience:

Educational Degrees	None	None	None	Associate	Bachelor
Years of Detention Officer Experience	8	6	4	4	2
Minimum Detention Officer Training Points	6	12	16	24	23
Minimum Total Education and Training Points	13	23	33	24	23

(b) Educational points claimed shall have been earned at a technical institute, technical college, community college, junior college, college or university accredited as such by the Department of Education of the state in which the institution is located, a national or regional accrediting body, or the state university of the state in which the institution is located. No credit shall be given for any correspondence or vocational courses unless credited towards a degree by an accredited institution.

(c) No more than 80 hours of training obtained by completing the commission-mandated detention certification course shall be credited toward training points.

*History Note: Authority G.S. 17E-4;
Eff. January 1, 1990;
Amended Eff. August 1, 2002; August 1, 1998; January 1, 1996; January 1, 1992.*

12 NCAC 10B .1205 ADVANCED DETENTION OFFICER PROFESSIONAL CERTIFICATE

(a) In addition to the qualifications set forth in Rule .1202 of this Section, applicants for the Advanced Detention Officer Professional Certificate shall possess or be eligible to possess the Intermediate Detention Officer Professional Certificate and shall have acquired the following combination of educational points or degrees, detention officer or corrections training points and years of detention officer experience:

Educational Degrees	None	None	Associate	Bachelor	Doctoral, Professional or Master
Years of Detention Officer					

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Experience	12	9	9	6	4
Minimum Detention Officer Training Points	12	16	27	26	26
Minimum Total Education and Training Points	23	33	27	26	26

(b) Educational points claimed shall have been earned at a technical institute, technical college, community college, junior college, college or university accredited as such by the Department of Education of the state in which the institution is located, a national or regional accrediting body, or the state university of the state in which the institution is located. No credit shall be given for any correspondence or vocational courses unless credited towards a degree by an accredited institution.

(c) No more than 80 hours of training obtained by completing the commission-mandated detention certification course shall be credited toward training points.

History Note: Authority G.S. 17E-4;

Eff. January 1, 1990;

Amended Eff. August 1, 2002; August 1, 1998; January 1, 1996; January 1, 1994; January 1, 1992.

12 NCAC 10B .1307 COMPREHENSIVE WRITTEN EXAM - TELECOMMUNICATOR CERTIFICATION COURSE

(a) At the conclusion of a school's offering of the "Telecommunicator Certification Course", an authorized representative of the Commission shall administer a comprehensive written examination to each trainee who has satisfactorily completed all of the course work. A trainee shall not be administered the comprehensive written examination until such time as all course work is successfully completed.

(b) The examination shall be an objective test covering the topic areas as described in 12 NCAC 10B .1302(b).

(c) The Commission's representative shall submit to the school director within 10 days of the administration of the examination a report of the results of the test for each trainee examined.

(d) A trainee shall successfully complete the comprehensive written examination if he/she achieves a minimum of 70 percent correct answers.

(e) A trainee who has fully participated in a scheduled delivery of a commission-approved training course and has demonstrated satisfactory competence in each motor-skill or performance area of the course curriculum but has failed to achieve the minimum score of 70 percent on the Commission's comprehensive written examination may request the Director to authorize a re-examination of the trainee.

(1) A trainee's Request for Re-examination shall be made in writing on the Commission's form

within 30 days after the original examination and shall be received by the Division before the expiration of the trainee's probationary certification as a telecommunicator.

(2) The trainee's request for re-examination shall include the favorable recommendation of the school director who administered the trainee's "Telecommunicator Certification Course".

(3) A trainee shall have only one opportunity for re-examination and shall satisfactorily complete the subsequent examination in its entirety within 90 days after the original examination.

(4) A trainee shall be assigned in writing by the Division a place, time, and date for re-examination.

(5) Should the trainee on re-examination not achieve the prescribed minimum score of 70 on the examination, the trainee may not be recommended for certification and must enroll and complete a subsequent course in its entirety before further examination may be permitted.

History Note: Authority G.S. 17E-4; 17E-7;

Eff. April 1, 2001;

Amended Eff. August 1, 2002.

12 NCAC 10B .1604 INTERMEDIATE TELECOMMUNICATOR CERTIFICATE

(a) In addition to the qualifications set forth in Rule .1602 of this Section, applicants for the Intermediate Telecommunicator Certificate shall possess or be eligible to possess the Basic Telecommunicator Certificate and shall have acquired the following combination of educational points or degrees, telecommunicator training points and years of telecommunicator training experience:

Educational Degrees	None	None	None	Associate	Bachelor
Years of Telecommunicator Experience	8	6	4	4	2
Minimum Telecommunicator Training Points	5	10	14	12	10
Minimum Total Education and	12	20	28	12	10

Training Points					
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(b) Educational points claimed shall have been earned at a technical institute, technical college, community college, junior college, college or university accredited as such by the Department of Education of the state in which the institution is located, a national or regional accrediting body, or the state university of the state in which the institution is located. No credit shall be given for any correspondence or vocational courses unless credited towards a degree by an accredited institution.

(c) No more than 40 hours of training obtained by completing the commission-mandated telecommunicator certification course shall be credited toward training points.

History Note: Authority G.S. 17E-4;

Eff. April 1, 2001;

Amended Eff. August 1, 2002.

12 NCAC 10B .1605 ADVANCED TELECOMMUNICATOR CERTIFICATE

(a) In addition to the qualifications set forth in Rule .1602, applicants for the Advanced Telecommunicator Certificate shall possess or be eligible to possess the Intermediate Telecommunicator Certificate and shall have acquired the following combination of educational points or degrees, telecommunicator training points and years of telecommunicator experience:

Educational Degrees	None	None	Associate	Bachelor	Doctoral, Professional or Master
Years of Telecommunicator Experience	12	9	9	6	4
Minimum Telecommunicator Training Points	10	12	17	14	12
Minimum Total Education and Training Points	20	23	17	14	12

(b) Educational points claimed shall have been earned at a technical institute, technical college, community college, junior college, college or university accredited as such by the Department of Education of the state in which the institution is located, a national or regional accrediting body, or the state university of the state in which the institution is located. No credit shall be given for any correspondence or vocational courses unless credited towards a degree by an accredited institution.

(c) No more than 40 hours of training obtained by completing the commission-mandated telecommunicator certification course shall be credited toward training points.

History Note: Authority G.S. 17E-4;

Eff. April 1, 2001;

Amended Eff. August 1, 2002.

(b) A listing of certifiable inorganic parameters follows:

TITLE 15A – DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

15A NCAC 02H .0804 PARAMETERS FOR WHICH CERTIFICATION MAY BE REQUESTED

(a) Commercial laboratories are required to obtain certification for parameters which will be reported by the client to comply with State surface water monitoring, groundwater, and pretreatment Rules. Municipal and Industrial Laboratories are required to obtain certification for parameters which will be reported to the State to comply with State surface water monitoring, groundwater, and pretreatment Rules. Commercial, Municipal, Industrial and Other facilities are required to obtain certification for field parameters which will be reported by the client to comply with State surface water, groundwater, and pretreatment Rules.

- (1) Alkalinity
- (2) Aquatic Humic Substances
- (3) BOD
- (4) COD
- (5) Chloride
- (6) Chlorine, Total Residual
- (7) Chlorophyll
- (8) Coliform, Fecal
- (9) Coliform, Total
- (10) Color
- (11) Conductivity
- (12) Cyanide
- (13) Dissolved Oxygen
- (14) Fluoride
- (15) Hardness, Total
- (16) MBAS

(17)	Ammonia Nitrogen	(8)	Organochlorine Pesticides
(18)	Total Kjeldahl Nitrogen (TKN)	(9)	Polychlorinated Biphenyls
(19)	Nitrate plus Nitrite Nitrogen	(10)	Nitroaromatics and Isophorone
(20)	Nitrate Nitrogen	(11)	Polynuclear Aromatic Hydrocarbons
(21)	Nitrite Nitrogen	(12)	Haloethers
(22)	Total Phosphorus	(13)	Chlorinated Hydrocarbons
(23)	Orthophosphate	(14)	Purgeable Organics
(24)	Oil and Grease	(15)	Base/Neutral and Acid Organics
(25)	pH	(16)	Chlorinated Acid Herbicides
(26)	Phenols	(17)	Organophosphorus Pesticides
(27)	Residue, Settleable	(18)	Total Petroleum Hydrocarbons - (TPH)
(28)	Residue, Total		California GC Method - Diesel Range Organics
(29)	Residue, Total Dissolved 180°C	(19)	Total Petroleum Hydrocarbons - (TPH)
(30)	Residue, Total Suspended		California GC Method - Gasoline Range Organics
(31)	Salmonella	(20)	Nonhalogenated Volatile Organics
(32)	Sulfate	(21)	N-Methylcarbamates
(33)	Sulfide	(22)	1,2, Dibromoethane (EDB)
(34)	Sulfite	(23)	Extractable Petroleum Hydrocarbons
(35)	Temperature	(24)	Volatile Petroleum Hydrocarbons
(36)	Total Organic Carbon (TOC)	(25)	Chlorinated Phenolics
(37)	Turbidity	(26)	Adsorbable Organic Halides
(38)	Leachate Procedures		
(39)	Vector Attraction Reduction - All Options		

(c) Metals: Each of the following will be considered a certifiable Metals analyte:

- (1) Aluminum
- (2) Antimony
- (3) Arsenic
- (4) Barium
- (5) Beryllium
- (6) Cadmium
- (7) Calcium
- (8) Chromium, Total
- (9) Chromium, Hexavalent
- (10) Cobalt
- (11) Copper
- (12) Iron
- (13) Lead
- (14) Magnesium
- (15) Manganese
- (16) Mercury
- (17) Molybdenum
- (18) Nickel
- (19) Selenium
- (20) Silver
- (21) Thallium
- (22) Tin
- (23) Vanadium
- (24) Zinc

(d) Each of the analytical categories listed in this Paragraph shall be considered a certifiable parameter. Analytical methods shall be determined from the sources listed in Rule .0805(a)(1) of this Section. A listing of certifiable organic parameters follows:

- (1) Purgeable Halocarbons
- (2) Purgeable Aromatics
- (3) Acrolein, Acrylonitrile, Acetonitrile
- (4) Phenols
- (5) Benzidines
- (6) Phthalate Esters
- (7) Nitrosamines

History Note: Authority G.S. 143-215.3(a)(1);

143-215.3(a)(10);

Eff. February 1, 1976;

Amended Eff. November 2, 1992; December 1, 1984;

Temporary Amendment Eff. October 1, 2001;

Amended Eff. August 1, 2002.

15A NCAC 02H .0806 FEES ASSOCIATED WITH CERTIFICATION PROGRAM

- (a) An applicant for laboratory certification, excluding those laboratories seeking Field Parameter Certification only, must submit to the Department of Environment and Natural Resources, Laboratory Section, a non-refundable fee of three hundred dollars (\$300.00) for the evaluation and processing of each application.
- (b) Municipal, Industrial and Other laboratories must pay an annual fee of fifty dollars (\$50.00) for each inorganic parameter plus one hundred dollars (\$100.00) for each organic parameter and metals analyte; however, the minimum fee will be one thousand three hundred fifty dollars (\$1,350.00) per year.
- (c) Commercial laboratories must pay an annual fee of fifty dollars (\$50.00) for each inorganic parameter plus one hundred dollars (\$100.00) for each organic parameter and metals analyte; however, the minimum fee will be two thousand seven hundred dollars (\$2,700.00) per year.
- (d) Prior to receiving initial certification, a laboratory must pay the required fee as specified in Paragraph (b) or (c) of this Rule. Initial certification fee will be prorated on a semi-annual basis to make all certification renewals due on the first day of January.
- (e) Once certified, a laboratory must pay the full annual parameter fee for each parameter added to their certificate.
- (f) A laboratory decertified for all parameters must pay initial certification fees prior to recertification.
- (g) A laboratory decertified for one or more parameters must pay a fee of two hundred dollars (\$200.00) for each parameter for which it was decertified prior to recertification.

(h) Out-of-state laboratories shall reimburse the state for actual travel and subsistence costs incurred in certification and maintenance of certification.

(i) Annual certification fees are due 60 days after receipt of invoice.

(j) A two hundred fifty dollar (\$250.00) late payment fee must be paid when annual certification fees are not paid by the date due.

(k) Commercial facilities analyzing samples for field parameters only must pay an annual fee of two hundred dollars (\$200.00) per year.

(l) Municipal and Industrial facilities analyzing samples for field parameters only must pay an annual fee of one hundred dollars (\$100.00) per year.

History Note: Authority G.S. 143-215.3(a)(1);

143-215.3(a)(10);

Eff. February 1, 1976;

Amended Eff. November 2, 1992; December 1, 1984;

Temporary Amendment Eff. October 1, 2001;

Amended Eff. August 1, 2002.

15A NCAC 02H .0807 DECERTIFICATION AND CIVIL PENALTIES

(a) **Laboratory Decertification.** A laboratory may be decertified, for any or all parameters, for up to one year for any of the following infractions:

- (1) Failing to maintain the facilities, or records, or personnel, or equipment, or quality control program as set forth in the application, and these Rules; or
- (2) Submitting inaccurate data or other information; or
- (3) Failing to pay required fees by the date due; or
- (4) Failing to discontinue supplying data for clients or programs described in Rule .0802 of this Section during periods when a decertification is in effect; or
- (5) Failing to submit a split sample to the State Laboratory as requested; or
- (6) Failing to use approved methods of analysis; or
- (7) Failing to report laboratory supervisor or equipment changes within 30 days of such changes; or
- (8) Failing to report analysis of required annual performance evaluation samples submitted by an EPA approved vendor within the specified time limit; or
- (9) Failing to allow an inspection by an authorized representative of the State Laboratory; or
- (10) Failing to supply analytical data requested by the State Laboratory; or
- (11) Failing to submit a written amendment to the certification application within 30 days of applicable changes; or
- (12) Failing to meet required sample holding times; or
- (13) Failing to respond to requests for information by the date due; or

- (14) Failing to comply with any other terms, conditions, or requirements of this Section or of a laboratory certification.

(b) **Parameter Decertification.** A laboratory may receive a parameter decertification for failing to:

- (1) Obtain acceptable results on two consecutive blind or announced performance evaluation samples submitted by an EPA accredited vendor or the State Laboratory; or
- (2) Obtain acceptable results on two consecutive blind or announced split samples that have also been analyzed by the State Laboratory.

(c) **Falsified Data.** A laboratory that submits falsified data or other information may be decertified for all parameters for up to two years.

(d) **Decertification Factors.** In determining a period of decertification, the Director shall recognize that any harm to the natural resources of the State arising from violations of these Rules in this Section may not be immediately observed and may be incremental or cumulative with no damage that can be immediately observed or documented. Decertification for periods up to the maximum may be based on any and or a combination of the following factors to be considered:

- (1) The degree and extent of harm, or potential harm, to the natural resources of the State or to the public health, or to private property resulting from the violation;
- (2) The duration, and gravity of the violation;
- (3) The effect, or potential effect, on ground or surface water quantity or quality or on air quality;
- (4) Cost of rectifying any damage;
- (5) The amount of money saved by noncompliance;
- (6) As to violations other than submission of falsified data or other information, whether the violation was committed willfully or intentionally;
- (7) The prior record of the laboratory in complying or failing to comply with any State and Federal laboratory Rules and regulations;
- (8) The cost to the State of investigation and enforcement procedures;
- (9) Cooperation of the laboratory in discovering, identifying, or reporting the violation;
- (10) Measures the laboratory implemented to correct the violation or abate the effect of the violation, including notifying any affected clients;
- (11) Measures the laboratory implemented to correct the cause of the violation;
- (12) Any other relevant facts.

(e) **Decertification Requirements.**

- (1) A decertified laboratory is not to analyze samples for the decertified parameters for programs described in Rule .0802 of this Section or clients reporting to these programs.
- (2) A decertified commercial laboratory must supply written notification of the decertification to clients with Division of Water Quality reporting requirements. Within

30 days, the decertified laboratory must supply the State Laboratory with a list of clients involved and copies of the notices sent to each.

(3) A commercial laboratory that has received a parameter decertification may make arrangements to supply analysis through another certified laboratory during any decertification periods. The decertified laboratory must supply the State Laboratory, by written notice, the name of the laboratory to be used.

(4) A commercial laboratory decertified for all parameters cannot subcontract samples for analyses to other certified laboratories during the decertification period.

(5) A decertified municipal or industrial laboratory must have its samples analyzed by another certified laboratory during any decertification period and supply the State Laboratory, by written notice, the name of the certified laboratory to be used.

(f) Civil Penalties. Civil penalties may be assessed against a laboratory which violates or fails to act in accordance with any of the terms, conditions, or requirements of the Rules in this Section or of a laboratory certification. A laboratory is subject to both civil penalties and decertification.

History Note: Authority G.S. 143-215.3(a)(1); 143-215.3(a)(10); 143-215.6A;

Eff. February 1, 1976;

Amended Eff. November 2, 1992; December 1, 1984;

Temporary Amendment Eff. October 1, 2001;

Amended Eff. August 1, 2002.

15A NCAC 02H .0808 RECERTIFICATION

(a) A laboratory decertified in accordance with Paragraph (a) of Rule .0807 of this Section may be recertified at the end of the decertification period by showing to the satisfaction of the State Laboratory that it has corrected the deficiency(ies).

(b) A laboratory decertified for a parameter due to unacceptable results on two consecutive performance evaluation samples submitted by an EPA accredited vendor, or on two consecutive split samples may be recertified after 60 days by reporting acceptable results on two consecutive performance evaluation samples submitted by an EPA accredited vendor. Recertification samples may be requested from an EPA accredited vendor at any time, however, recertification must be requested in writing at the end of the 60 day period immediately following the date of decertification.

(c) A laboratory decertified for submitting falsified data or other information may be recertified at the end of the decertification period by demonstrating compliance with all requirements of this Section.

History Note: Authority G.S. 143-215.3(a)(1); 143-215.3(a)(10);

Eff. February 1, 1976;

Amended Eff. November 2, 1992; December 1, 1984;

Temporary Amendment Eff. October 1, 2001;

Amended Eff. August 1, 2002.

15A NCAC 02H .0810 ADMINISTRATION

(a) The Director of the Division of Water Quality, Department of Environment and Natural Resources, or his delegate, is authorized to issue certification, to reject applications for certification, to renew certification, to issue recertification, to issue decertification, and to issue reciprocity certification.

(b) Appeals. In any case where the Director of the Division of Water Quality, Department of Environment and Natural Resources or his delegate denies certification, or decertifies a laboratory, the laboratory may appeal to the N.C. Office of Administrative Hearings in accordance with Chapter 150B of the General Statutes.

(c) The State Laboratory will maintain a current list of certified commercial laboratories.

(d) Implementation of the October 1, 2001 changes to this Section.

(1) All requirements of the Rules in this Section are effective on the effective date of the amendments.

(2) Requests for the new parameters may be made by submitting a properly completed amendment form.

(3) Laboratories subject to the amended requirements of these Rules must submit a completed application, or amendment form, within three months of the effective date of the amendments. Laboratories submitting an application or amendment form for any of the newly certifiable parameters may analyze samples for these new parameters until the State Laboratory has issued or denied certification. Fees for parameter additions requested during the initial three month period will be calculated as initial certification fees.

(4) Laboratory facilities, not currently certified, that are performing analyses for Field Parameters only must submit an application within three months of the effective date of the amendments. After submitting an application, these laboratories may continue to analyze samples until the State Laboratory has issued or denied certification.

History Note: Authority G.S. 143-215.3(a)(1);

143-215.3(a)(10); 150B-23;

Eff. February 1, 1976;

Amended Eff. November 2, 1992; July 1, 1988; December 1,

1984; November 1, 1978;

Temporary Amendment Eff. October 1, 2001;

Amended Eff. August 1, 2002.

15A NCAC 07B .0701 PLANNING OPTIONS

(a) Each county within the coastal area may prepare and adopt a CAMA Land Use Plan that meets the planning requirements adopted by the Coastal Resources Commission (CRC). The CRC shall prepare and adopt a CAMA Land Use Plan for each county that chooses not to prepare and adopt a CAMA Land Use Plan. Municipalities may develop individual CAMA Land Use Plans if:

(1) the County delegates this authority to the municipality; or

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(2) the CRC grants this authority upon application from a municipality that is currently enforcing its zoning ordinance, its subdivision regulations and the State Building Code within its jurisdiction.

(b) The minimum types of plans presumed for municipalities, based on population, growth rates and the presence of Areas of

Environmental Concern (AECs) are illustrated in Figure 1. In addition, community characteristics other than those listed in Figure 1, such as extent of growth and resource protection issues (e.g., water quality concerns), shall be considered when determining the type of plan to be prepared.

Figure 1: TYPES OF CAMA PLANS PRESUMED FOR MUNICIPALITIES

		AREAS OF ENVIRONMENTAL CONCERN (AECs)		
POPULATION	GROWTH RATE*	OCEAN HAZARD AREAS	NON-OCEAN HAZARD AREAS**	DO NOT MEET STATUTORY THRESHOLD IN G.S. 113A-110 (c) ***
= 5,000	N/A			
= 2,500	HIGH			
>1,000 and < 2,500	HIGH			
<1,000	HIGH			
= 2,500	MODERATE			
< 2,500	MODERATE			
= 2,500	LOW			
< 2,500	LOW			

 **Minimum Core Plan Presumed**

 **Core or Workbook plan**

 **Fold into County CAMA Land Use Plan**

* GROWTH RATE (Source: Office of State Planning)

High = 18.4%
Moderate > 9.2% and < 18.4%
Low = 9.2%

** Estuarine Waters, Coastal Shorelines, Public Trust Areas, and Coastal Wetlands

*** 113A-110 (c) provides that municipalities may develop individual plans if (1) the County delegates this authority to the municipality or (2) the CRC grants this authority upon application from a municipality that is currently enforcing its zoning ordinance, its subdivision regulations and the State Building Code within its jurisdiction.

(c) Types of Plans

(1) Workbook plan: This is a simplified CAMA Land Use Plan that addresses the following elements:

- (A) statement of community concerns, aspirations and vision;
- (B) existing land use map;
- (C) land suitability analysis;
- (D) local growth and development policies addressing each Management Topic and applicable Areas of Environmental Concern; and

(E) future land use map.

The Division of Coastal Management (DCM) shall provide a workbook plan template to municipalities preparing this type of plan containing all required data and examples of policy alternatives.

(2) Core plan: This plan addresses all of the plan elements in Rule .0702 of this Section (Elements of CAMA Core and Advanced Core Land Use Plans) in a complete and thorough manner. This type of plan is the standard

CAMA Land Use Plan required for all 20 coastal counties.

(3) Advanced core plan: The plan prepared by local governments that, due to consideration of specific local conditions, elect to exceed the core plan requirements in two or more areas. This plan also may be used to help meet the requirements of other planning programs, such as the Environmental Protection Agency's (EPA) Phase II Stormwater requirements or hazard mitigation plans, that address the CAMA goals, or to address issues of local concern, (i.e. location of a new industry or redevelopment after storm events.)

(d) Counties preparing a CAMA Land Use Plan shall prepare a core plan at a minimum.

(e) Municipalities that contain AECs may prepare a Workbook Plan, Core Plan, or Advanced Core Plan, depending on the presumptive type of plan shown in Figure 1. However, the type of plan to be prepared may change depending on needs that are identified in the scoping process described in 15A NCAC 07L. Municipalities with Ocean Hazard AECs that choose to plan shall prepare a minimum of a Core Plan. Municipalities with only Non-Ocean Hazard AECs that choose to plan shall prepare a Core Plan if they meet the population and growth rate thresholds as shown in Figure 1. Municipalities with only Non-Ocean Hazard AECs that choose to plan and are at or below the population and growth rate thresholds shown in Figure 1 may prepare a Core Plan or a Workbook Plan.

(f) A County shall accept a municipality's locally adopted policies for inclusion in the County CAMA Land Use Plan for the municipality's jurisdiction if requested to do so by any municipality not preparing an individual CAMA Land Use Plan. Inclusion of a municipality's adopted policies shall occur either at the time of County CAMA Land Use Plan preparation or a subsequent County CAMA Land Use Plan amendment. The municipality's policies are limited to its jurisdiction and may differ from the County's policies.

(g) Municipalities may seek CRC certification for these plans if all requirements found in 15A NCAC 07B and G.S. 113A-110 are met.

History Note: Authority G.S. 113A-107(a); 113A-110, 113A-124; Eff. August 1, 2002.

15A NCAC 07B .0801 PUBLIC HEARING AND LOCAL ADOPTION REQUIREMENTS

(a) Public Hearing Requirements: The local government shall provide written proof to DCM that it has followed the process required in G.S. 113A-110

(b) Final Plan Content. The final decision on local policies and all contents of the CAMA Land Use Plan consistent with the CAMA land use planning rules shall be made by the elected body of each participating local government.

(c) Transmittal to the CRC. The local government shall provide the Executive Secretary of the CRC with copies of the locally adopted land use plan and a certified statement of the local government adoption action no earlier than 45 days and no later than 30 days prior to the next regularly scheduled CRC meeting.

History Note: Authority G.S. 113A-107(a); 113A-110, 113A-124; Eff. August 1, 2002.

15A NCAC 07L .0510 PUBLIC HEARING AND LOCAL ADOPTION REQUIREMENTS

(a) Public Hearing Requirements For Local Governments Receiving Funding From DENR For Land Use Planning. Local adoption of the CAMA land use plan requires a public hearing. Notice of the hearing shall state the date, time, place, proposed action, and that copies of the document may be reviewed at a particular office in the county courthouse, county office building, or town hall during designated hours. Any other public facility where the document can be reviewed such as a library or community center shall be designated in the notice. The notice must appear at least twice in a newspaper of general circulation in the planning jurisdiction. The first notice must appear not less than 30 days prior to the hearing. The second notice must appear not less than 10 days prior to the hearing. Written notice of the public hearing shall be posted on the local government's principal bulletin board 30 days prior to the hearing or, if there is no such bulletin board, at the door of the governing body's usual meeting room. If possible, an electronic hearing notice shall be provided on the World Wide Web at the time of the original notice.

(b) 30-Day Local Review Period. Copies of the proposed CAMA land use plan or update (final draft) shall be available for public review at the time the first notice is provided and in the place(s) listed in the notice. At least one copy of the draft plan shall be available for checkout for a 24-hour period by residents and property owners of the planning jurisdiction.

(c) Minor editorial changes after the public hearing are acceptable without re-advertising the notice. Substantive changes such as re-wordings that alter the basic intent of policy statements or changes in timelines for actions in the original notice shall require a new public hearing. This notice shall be advertised in the same manner as the original.

History Note: Authority G.S. 113A-112; 113A-124; Eff. August 1, 2002.

15A NCAC 18A .0618 HEAT SHOCK METHOD OF PREPARATION OF SHELLFISH

(a) Facilities. If a shucking and packing plant uses the heat shock process, it shall be done in a separate room adjacent to the shellstock storage room and the shucking room.

(b) Tank construction. The heat shock tank shall be constructed of smooth, non-corrosive metal, designed to drain quickly and completely and to be easily and thoroughly cleaned.

(c) Booster heaters. All heat shock tanks shall be equipped with booster heaters that are thermostatically controlled.

(d) Shellstock washing. All shellstock subjected to the heat shock process shall be thoroughly washed with flowing potable water immediately prior to the heat shock operation.

(e) Water temperature. During the heat shock process the water shall be maintained at not less than 140°F (60°C) or more than 150°F (65°C). An accurate thermometer shall be available and used to determine the temperature during the heat shock process. The heat shock tanks shall be drained and cleaned at the end of each day's operation.

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(f) Alternatives to heat shock method. Nothing in these Rules shall be construed to prohibit any other process which has been found equally effective.

(g) Water requirements. At least eight gallons of heat shock water shall be maintained in the tank for each one half bushel of shellstock being treated. All water used in the heat shock process shall be from a source approved by the Division under Rule .0413 of this Subchapter.

(h) Cooling. Immediately after the heat shock process, all treated shellstock shall be subjected to a cool-down with potable tap water. All heat shocked shellstock shall be handled in a manner to prevent adulteration of the product. Shellfish which have been subjected to the heat shock process shall be cooled to an internal temperature of 45°F (7°C) or below within two hours after this process and shall be placed in storage at 40°F (4°C) or below.

(i) Cleaning. At the close of each day's operation, the heat shock tank shall be completely emptied of all water, mud, detritus, and thoroughly cleaned and then rinsed with flowing potable water.

(j) Sanitizing. All heat shock tanks shall be sanitized immediately before starting each day's operation.

History Note: Authority G.S. 130A-230;

Eff. February 1, 1987;

Amended Eff. August 1, 2002; August 1, 1998; February 1, 1997; September 1, 1990.

(f)	vehicle or combination over 65'
	Special Permit @ \$1.00 Per Foot
(3)	Commuter Passes are valid for one year from date of purchases. Passes are available to anyone.
Type	System-Wide Pass
Vehicles up to 20'	\$150.00
Vehicles over 20'-40'	\$200.00
Vehicles over 40' to 65'	\$250.00
	Site Specific Pass
	\$100.00
	\$125.00
	\$150.00

History Note: Authority G.S. 136-82; 143B-10(j);

Eff. July 1, 1978;

Amended Eff. August 1, 2002; November 1, 1991; May 1, 1983.

TITLE 21 – OCCUPATIONAL LICENSING BOARDS

CHAPTER 19 - BOARD OF ELECTROLYSIS EXAMINERS

21 NCAC 19 .0622 CERTIFICATION OF SCHOOLS IN OTHER STATES OR JURISDICTIONS

(a) The Board will certify a school in another state or jurisdiction for purposes of G.S. 88A-10 provided that:

- (1) The school applies for certification, submits the information required by G.S. 88A-19(a)(1)-(6), and meets the requirements of 21 NCAC 19 .0602, .0606, .0607, .0608, and .0609;
- (2) If the school is in a state or jurisdiction that approves electrolysis schools, the school is approved by the proper agency for that state or jurisdiction; and
- (3) The school has a curriculum of at least 600 hours.

(b) A school located in another state or jurisdiction shall pay an application fee of seventy five dollars (\$75.00) and a yearly certification fee of fifty dollars (\$50.00).

(c) The Board shall revoke the certification of a school in another state or jurisdiction upon a proof that the school in a jurisdiction that licenses electrologists has lost its approval in that state.

(d) The school must agree to teach North Carolina's sanitation standards to any student who states to the school an intention of taking North Carolina's licensing examination.

History Note: Authority G.S. 88A-6; 88A-9; 88A-19;

88A-21;

Eff. February 1, 1994;

Temporary Amendment Eff. September 17, 2001;

Amended Eff. August 1, 2002.

CHAPTER 46 - BOARD OF PHARMACY

21 NCAC 46 .2502 RESPONSIBILITIES OF PHARMACIST-MANAGER

(a) The pharmacist-manager shall assure that prescription legend drugs and controlled substances are safe and secure within the pharmacy.

(b) The pharmacist-manager employed or otherwise engaged to supply pharmaceutical services may have a flexible schedule of

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attendance but shall be present for at least one-half the hours the pharmacy is open or 32 hours a week, whichever is less.

(c) Whenever a change of ownership or change of pharmacist-manager occurs, the successor pharmacist-manager shall complete an inventory of all controlled substances in the pharmacy within 10 days. A written record of such inventory, signed and dated by the successor pharmacist-manager, shall be maintained in the pharmacy with other controlled substances records for a period of three years.

(d) The pharmacist-manager shall develop and implement a system of inventory record-keeping and control which will enable that pharmacist-manager to detect any shortage or discrepancy in the inventories of controlled substances at that pharmacy at the earliest practicable time.

(e) The pharmacist-manager shall maintain complete authority and control over any and all keys to the pharmacy and shall be responsible for the ultimate security of the pharmacy. A pharmacy shall be secured to prohibit unauthorized entry if no pharmacist will be present in the pharmacy for a period of 90 minutes or more.

(f) These duties are in addition to the specific duties of pharmacist-managers at institutional pharmacies and pharmacies in health departments as set forth in the Rules in this Chapter.

(g) A person shall not serve as pharmacist-manager at more than one pharmacy at any one time except for limited service pharmacies.

(h) When a pharmacy is to be closed permanently, the pharmacist-manager shall inform the Board and the United States Drug Enforcement Administration of the closing, arrange for the proper disposition of the pharmaceuticals and return the pharmacy permit to the Board's offices within 10 days of the closing date. Notice of the closing shall be given to the public by posted notice at the pharmacy at least 30 days prior to the closing date and, if possible, 15 days after the closing date. Such notice shall notify the public that prescription files may be transferred to a pharmacy of the patient's or customer's choice during the 30 day period prior to the closing date. During the 30 day period prior to the closing date, the pharmacist-manager, and the pharmacy's owner (if the owner is other than the pharmacist-manager), shall transfer prescription files to another pharmacy chosen by the patient or customer, upon request. Absent specific instructions from the patient or customer, the pharmacist-manager, and the pharmacy's owner (if the owner is other than the pharmacist-manager), shall transfer prescription files to another pharmacy for maintenance of patient therapy and shall inform the public of such transfer by posted notice at the pharmacy for 15 days after the closing date, if possible. Controlled substance records shall be retained for the period of time required by law.

(i) The pharmacist-manager shall ensure that notice of the temporary closing of any pharmacy for more than 14 consecutive days is given to the public by posted notice at the pharmacy at least 30 days prior to the closing date, and, if possible, 15 days after the closing date. Such notice shall notify the public that prescription files may be transferred to a pharmacy of the patient's or customer's choice during the 30 day period prior to the closing date. During the 30 day period prior to the closing date, the pharmacist-manager, and the pharmacy's owner (if the owner is other than the pharmacist-manager), shall transfer prescription files to another pharmacy chosen by the patient or customer, upon request.

(j) The pharmacist-manager shall prepare a plan to safeguard prescription records and pharmaceuticals in the event of a natural disaster such as hurricane or flood.

(k) The pharmacist-manager shall separate from the dispensing stock all drug products more than six months out of date.

(l) The pharmacist-manager shall report to the Board of Pharmacy information that reasonably suggests that there is a probability that a prescription drug or device dispensed from a location holding a permit has caused or contributed to the death of a patient or customer. This report shall be filed in writing on a form provided by the Board within 14 days of the owner representative or pharmacist-manager's becoming aware of the event. The pharmacist-manager shall retain all documents, labels, vials, supplies, substances and internal investigative reports relating to the event. All such items shall be made available to the Board upon request.

(m) The Board shall not disclose the identity of a pharmacist-manager who makes a report under Paragraph (l) of this Rule, except as required by law. All reports made under Paragraph (l) of this Rule shall not be released except as required by law.

(n) Dispensing errors which are not detected and corrected prior to the patient receiving the medication shall be documented and reported to the pharmacist-manager. Documentation shall include pertinent chronological information and appropriate forms including the identity of individual(s) responsible. These documents, including action taken as part of a quality assurance plan, shall be archived in a readily retrievable manner and open for review, copying or seizure by the Board or its designated employees within 48 hours of a request for inspection for a period of three years. These documents shall be released only to the Board or its designated employees pursuant to an investigation and shall not otherwise be released except as required by law. Upon request by the Board or its designated employees, these documents shall be transmitted by the pharmacist-manager to an office of the Board.

(o) In any Board proceeding, the Board shall consider compliance with Paragraphs (l) and (n) of this Rule as a mitigating factor and noncompliance with Paragraphs (l) and (n) of this Rule as an aggravating factor.

History Note: Authority G.S. 90-85.6; 90-85.21; 90-85.25; 90-85.26; 90-85.32;

Eff. May 1, 1989;

Amended Eff. August 1, 2002; December 1, 2001; April 1, 2001; April 1, 1999; July 1, 1996; March 1, 1992; October 1, 1990.

CHAPTER 57 - REAL ESTATE APPRAISAL BOARD

21 NCAC 57A .0201 QUALIFICATIONS FOR TRAINEE REGISTRATION, APPRAISER LICENSURE AND CERTIFICATION

(a) Applicants for trainee registration, licensure as a state-licensed residential real estate appraiser and for certification as a state-certified real estate appraiser must satisfy the qualification requirements stated in G.S. 93E-1-6 as further set forth in Subparagraphs (a)(1), (a)(2), (a)(3), and (a)(4) of this Rule, provided however that registration as a trainee or licensure as a state-licensed residential real estate appraiser is not prerequisite

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for certification as a state-certified residential or general real estate appraiser:

- (1) Applicants for trainee registration shall have completed, within the five-year period immediately preceding the date application is made, 90 hours of education in the areas of Introduction to Real Estate Appraisal, Valuation Principles and Practices, Applied Residential Property Valuation, and, effective January 1, 2003, the Uniform Standards of Professional Appraisal Practice (USPAP) or appraisal education found by the Board to be equivalent to such courses.
- (2) Applicants for licensure as a state-licensed residential real estate appraiser shall have completed, within the five-year period immediately preceding the date application is made, 90 hours of education as set forth in Subparagraph (a)(1) of this Rule, and have at least 2,000 hours of appraisal experience.
- (3) Applicants for certification as a state-certified residential real estate appraiser shall have completed those courses required for registration as a trainee or licensure as a state-licensed residential real estate appraiser or equivalent education and, in addition, within the five-year period immediately preceding the date application is made, a course in Introduction to Income Property Appraisal consisting of at least 30 classroom hours of instruction or equivalent education; and shall have obtained at least 2,500 hours of appraisal experience acquired over a minimum period of two calendar years.
- (4) Applicants for certification as a state-certified general real estate appraiser shall have completed those courses required for certification as a state-certified residential real estate appraiser or equivalent education and, in addition, within the five-year period immediately preceding the date application is made, courses in Advanced Income Capitalization Procedures and Applied Income Property Valuation each consisting of at least 30 classroom hours of instruction or equivalent education; and shall have obtained at least 3,000 hours of appraisal experience acquired over a minimum period of two and a half calendar years of which at least 50 percent must have been in appraising non-residential real estate.

(b) Applicants for licensure or certification may be required to provide to the Board copies of appraisal reports in support of experience credit. All appraisals submitted in support of experience credit must comply with the Uniform Standards of Professional Appraisal Practice (USPAP) and with any applicable state statutes or rules.

(c) When a trainee becomes a state-licensed or state-certified real estate appraiser or when a state-licensed real estate appraiser becomes certified as a state-certified real estate appraiser, his registration or licensure shall be immediately canceled by the

Board. When a state-certified residential real estate appraiser becomes certified as a state-certified general real estate appraiser, his previous certification as a state-certified residential real estate appraiser shall be immediately canceled by the Board.

History Note: Authority G.S. 93E-1-6(a); 93E-1-10;

Eff. July 1, 1994;

Amended Eff. August 1, 2002; April 1, 1999.

21 NCAC 57A .0203 REGISTRATION, LICENSE AND CERTIFICATE RENEWAL

- (a) All registrations, licenses and certificates expire on June 30 of each year unless renewed before that time.
- (b) A holder of a trainee registration, an appraiser license or certificate desiring the renewal of such registration, license or certificate shall apply for same in writing and shall forward the required fee of two-hundred dollars (\$200.00). Forms are available upon request to the Board.
- (c) All trainees, licensees and certificate holders, either active or inactive, resident or non-resident, who are required by G.S. 93E-1-93E-7 to complete continuing education as a condition of renewal, shall be required to satisfy the continuing education requirements set forth in Rule .0204 of this Section.
- (d) An applicant applying for renewal of a registration, license or certificate obtained by reciprocity must submit with the renewal application a current license history from the appraiser regulatory authority of the state upon whose qualification requirements the reciprocal registration, license or certificate was granted showing that the applicant is currently registered, licensed or certified in good standing. Submission of false or misleading information to the Board in connection with registration, license or certificate renewal shall constitute grounds for disciplinary action.
- (e) Any person who acts or holds himself out as a registered trainee, state-licensed or state-certified real estate appraiser while his trainee registration, appraiser license or certificate is expired will be subject to disciplinary action and penalties as prescribed in G.S. 93E.

History Note: Authority G.S. 93E-1-7(a),(b); 93E-1-10;

Eff. July 1, 1994;

Amended Eff. August 1, 2002; April 1, 1999.

21 NCAC 57A .0407 SUPERVISION OF TRAINEES

(a) A state-licensed or state-certified real estate appraiser may engage a registered trainee to assist in the performance of real estate appraisals, provided that the state-licensed or state-certified real estate appraiser:

- (1) has been licensed or certified for at least two years;
- (2) has no more than two trainees working under his or her supervision at any one time, either as employees or as a subcontractors. Prior to the date any trainee begins performing appraisals under his or her supervision, the supervisor must inform the Board of the name of the trainee;
- (3) actively and personally supervises the trainee. The supervisor must accompany the trainee on the inspections of the subject property on the first 50 appraisal assignments performed after

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the effective date of this Rule for which the trainee will perform more than 75% of the work. After that point, the trainee may perform the inspections without the presence of the supervisor provided that the trainee is competent to perform those inspections, and provided that the subject property is less than 50 miles from the supervisor's primary business address. If the subject property is more than 50 miles from the supervisor's business address, the supervisor must accompany the trainee on all inspections;

(4) reviews all appraisal reports and supporting data used in connection with appraisals in which the services of a trainee is utilized;

(5) complies with all provisions of Rule .0405 of this Section regarding appraisal reports;

(6) prepares and furnishes to each trainee, whose services were utilized in connection with the appraisal, a report describing the nature and extent of assistance rendered by the trainee in connection with the appraisal, and places a copy of such report in the supporting file for the appraisal. In addition, the supervisor must make available to the trainee a copy of every appraisal report to the trainee where the trainee performs more than 75% of the work on the appraisal; and

(7) has not received any disciplinary action regarding his or her appraisal license or certificate from the State of North Carolina or any other state within the previous two years. For the purposes of this Section, disciplinary action means only an active suspension or a revocation.

(b) The trainee must maintain a log on a form prescribed by the Board that includes, but is not limited to, each appraisal performed by the trainee, the name of the supervisor for that appraisal, the supervisor's license or certificate number and whether the supervisor accompanied the trainee on the inspection of the subject property.

(c) The Appraisal Board may require a license or certificate holder who wishes to supervise a trainee to attend an education program regarding the role of a supervisor before such supervision may begin.

History Note: Authority G.S. 93E-1-3(b); 93E-1-10; Eff. July 1, 1994; Amended Eff. August 1, 2002; April 1, 1999.

21 NCAC 57A .0409 REPORTING REQUIRED ACTIONS

Whenever any of the actions outlined in G.S. 93E-1-12(b)(1),(2),(4),(5),(6) are taken against a trainee, licensee or certificate holder, the registration/license/certificate holder must report those actions to the Board within 60 days of the final judgment or final order on a form prescribed by the Board.

History Note: Authority G.S. 93E-10; 93E-1-12(b)(7); Eff. August 1, 2002.

21 NCAC 57B .0211 PROGRAM CHANGES

Approved schools and course sponsors must notify the Board of any changes to be made with respect to course content, course completion standards, instructors, school director or textbooks as prescribed in Section .0300 of this Subchapter. Requests for approval of such changes must be in writing.

History Note: Authority G.S. 93E-1-8(a); 93E-1-10; Eff. July 1, 1994; Amended Eff. August 1, 2002.

21 NCAC 57B .0303 COURSE COMPLETION STANDARDS

(a) Academic standards for course completion must reasonably assure that students receiving a passing grade possess adequate knowledge and understanding of the subject areas prescribed for the course. A student's grade must be based solely on his or her performance on examinations and on graded homework and class work assignments.

(b) Course completion requirements must include a comprehensive final course examination which covers all prescribed subject areas and which accounts for at least 50 percent of a student's grade for the course. Take-home or open-book final course examinations are prohibited. Schools and course sponsors may, within 90 days of the course ending date, allow a student one opportunity to make up any missed course examination or to retake any failed course examination without repeating the course however any make up examination must be comparable to the initial examination with regard to the number of questions and overall difficulty, and at least 75 percent of the questions in the makeup examination must be different from those used in the initial examination.

(c) The minimum attendance required for satisfactory course completion is 90 percent of all scheduled classroom hours for the course.

(d) The instructor may, in his or her discretion, offer additional hours of instruction so that students can make up lost hours of instruction.

History Note: Authority G.S. 93E-1-8(a); 93E-1-10; Eff. July 1, 1994; Amended Eff. August 1, 2002.

21 NCAC 57B .0306 INSTRUCTOR REQUIREMENTS

(a) Except as indicated in Paragraph (b) of this Rule, all appraisal prelicensing and precertification courses or courses deemed equivalent by the Board shall be taught by instructors who possess the fitness for licensure required of applicants for trainee registration or real estate appraiser licensure or certification and either the minimum appraisal education and experience qualifications listed in this Rule or other qualifications that are found by the Board to be equivalent to those listed. These qualification requirements shall be met on a continuing basis. The minimum qualifications are as follows:

(1) Residential appraiser courses: 120 classroom hours of real estate appraisal education equivalent to the residential appraiser education courses prescribed in Rules .0101 and .0102 of this Subchapter and either two years' full-time experience as a residential real

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estate appraiser within the previous five years or three years full time experience as a general real estate appraiser within the previous five years, with at least one-half of such experience being in residential property appraising. Instructors must also be either state-certified residential or state-certified general real estate appraisers.

(2) General appraiser courses: 180 classroom hours of real estate appraisal education equivalent to the general appraiser education courses prescribed in Rules .0101, .0102 and .0103 of this Subchapter and three years' full-time experience as a general real estate appraiser within the previous five years, with at least one-third of such experience being in income property appraising. Instructors must also be state-certified general real estate appraisers.

(3) USPAP: certification by the Appraiser Qualifications Board of the Appraisal Foundation as an instructor for the National USPAP Course.

(b) Guest lecturers who do not possess the qualifications stated in Paragraph (a) of this Rule may be utilized to teach collectively up to one-fourth of any course, provided that each guest lecturer possesses education and experience directly related to the particular subject area he is teaching.

(c) Instructors shall conduct themselves in a professional and courteous manner when performing their instructional duties and shall conduct their classes in a manner that demonstrates a thorough knowledge of the subject matter being taught and mastery of the following basic teaching skills:

(1) The ability to communicate effectively through speech, including the ability to speak clearly at an appropriate rate of speed and with appropriate grammar and vocabulary.

(2) The ability to present instruction in a thorough, accurate, logical, orderly, and understandable manner, to utilize illustrative examples as appropriate and to respond appropriately to questions from students;

(3) The ability to effectively utilize varied instructive techniques other than straight lecture, such as class discussion or other techniques;

(4) The ability to effectively utilize instructional aids to enhance learning;

(5) The ability to effectively maintain an effective learning environment and effective control of a class; and

(6) The ability to interact with adult students in a manner that encourages students to learn, that demonstrates an understanding of students backgrounds, that avoids offending the sensibilities of students, and that avoids personal criticism of any other person, agency or organization.

(d) Upon request of the Board, an instructor or proposed instructor must submit to the Board a videotape in a manner and format which depicts the instructor teaching portions of a prelicensing course specified by the Board and which demonstrates that the instructor possesses the basic teaching skills described in Paragraph (c) of this Rule.

(e) The inquiry into fitness will include consideration of whether the instructor has ever had any disciplinary action taken on his or her appraisal license or certificate or any other professional license or certificate in North Carolina or any other state, or whether the instructor has ever been convicted of or pleaded guilty to any criminal act.

(f) Instructors shall not have received any disciplinary action regarding his or her appraisal license or certificate from the State of North Carolina or any other state within the previous two years. For the purposes of this section, disciplinary action means a reprimand, suspension (whether active or inactive) or a revocation.

History Note: Authority G.S. 93E-1-8(a); 93E-1-10; Eff. July 1, 1994; Amended Eff. August 1, 2002.

21 NCAC 57B .0602 APPLICATION AND FEE

(a) Course sponsors seeking approval of their courses as appraisal continuing education courses must make written application to the Board. A course sponsor must be the owner of the proprietary rights to the course for which approval is sought or must have the permission of the course owner to seek course approval. If the course for which approval is sought is one that may be offered outside North Carolina, and the course owner wants the Board to approve such course when it is conducted outside North Carolina, application must be made by the course owner. After receipt of a properly completed application the Board will review the application pursuant to the criteria set forth in 21 NCAC 57B .0603 and shall notify the sponsor of its decision. Decisions to approve or withhold approval lie within the sole discretion of the Board.

(b) The original application fee shall be one hundred dollars (\$100.00) for each course for which approval is sought, provided that no fee is required if the course sponsor is an accredited North Carolina college, university, junior college, or community or technical college, or if the course sponsor is an agency of the federal, state or local government. The fee is non-refundable. A course sponsor may offer approved courses as frequently as is desired during the period for which approval is granted without paying additional fees.

History Note: Authority G.S. 93E-1-8(c),(d); Eff. July 1, 1994; Amended Eff. August 1, 2002.

CHAPTER 58 - REAL ESTATE COMMISSION

21 NCAC 58C .0304 COURSE COMPLETION STANDARDS

(a) Academic standards for course completion shall reasonably assure that students receiving a passing grade possess adequate knowledge and understanding of the subject areas prescribed for the course. A student's grade shall be based solely on his or her performance on examinations and on graded homework and classwork assignments.

(b) Course completion requirements shall include, at a minimum, obtaining a grade of at least 75 percent on a

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comprehensive final course examination which covers all prescribed subject areas and satisfactorily completing any mandatory graded homework or classwork assignments. Schools and instructors may utilize other course tests in addition to the final course examination provided that a student=s grade on the final course examination accounts for at least 75 percent of the student=s grade for the course. The development or acquisition of appropriate salesperson course examinations shall be the responsibility of approved instructors and schools. The broker course final examinations provided by the Commission shall be utilized by schools and instructors unless the school or instructor has obtained written approval from the Commission to use another final examination which is substantially equivalent to the Commission-provided examinations. All course examinations shall be subject to review and approval by the Commission as provided in G.S. 93A-4(a) and (d) and Rule .0304(a) of this Section. Take-home or open-book final course examinations are prohibited. Schools may, within 90 days of the course ending date, allow a student one opportunity to make up any missed course examination or to retake any failed course examination without repeating the course; however, any makeup examination must be comparable to the initial examination with regard to the number of questions and overall difficulty, and at least 75 percent of the questions in the makeup examination shall be different from those used on the initial examination.

(c) Schools and instructors shall take appropriate steps to protect the security and integrity of course examinations at all times. These steps shall include, but not be limited to:

- (1) Maintaining examinations and answer keys in a secure place accessible only to the instructor or appropriate school officials;
- (2) Prohibiting students from retaining copies of examinations, answer sheets, and closing statement forms or scratch paper containing notes or calculations that jeopardize examination security; and
- (3) Monitoring students at all times when examinations are being administered.

(d) Any student who is found by an instructor or other school official to have cheated in any manner on any course examination shall be dismissed from the course in which enrolled and shall not be awarded a passing grade for the course or any credit for partial completion of the course. The cheating incident shall be reported in writing to the Commission within 10 days of the incident.

(e) The minimum attendance required for satisfactory course completion shall be 80 percent of all scheduled classroom hours for the course.

History Note: Authority G.S. 93A-4(a),(d);

Eff. September 1, 1979;

Amended Eff. April 1, 1987; September 1, 1984;

Recodified Paragraphs (d) and (e) to Rule 58A .1113 (a) and (b) Eff. January 6, 1989;

Amended Eff. February 1, 1989;

Transferred and Recodified from 21 NCAC 58A .1105 Eff. November 27, 1989;

Amended Eff. September 1, 2002; July 1, 2000.

(a) An individual seeking original approval as a pre-licensing course instructor shall make application on a form prescribed by the Commission. An applicant who is not a resident of North Carolina shall also file with the application a consent to service of process and pleadings. No application fee shall be required. All required information regarding the applicant's qualifications shall be submitted.

(b) An instructor applicant shall demonstrate that he or she possesses good moral character and the following qualifications or other qualifications found by the Commission to be equivalent to the following qualifications: A current North Carolina real estate broker license; a current continuing education record; three years active full-time experience in general real estate brokerage, including substantial experience in real estate sales, within the previous seven years; 120 classroom hours of real estate education excluding company or franchise in-service sales training; and 60 semester hours of college-level education at an institution accredited by a nationally recognized college accrediting body.

(c) In addition to the qualification requirements stated in Paragraph (b) of this Rule, an applicant shall also demonstrate completion of an instructor seminar prescribed by the Commission and shall submit a one -hour videotape which depicts the applicant teaching a real estate pre-licensing course topic and which demonstrates that the applicant possesses the basic teaching skills described in Rule .0604 of this Section. The videotape shall comply with the requirements specified in Rule .0605(c) of this Section. An applicant who is a Commission-approved continuing education update course instructor under Subchapter E, Section .0200 of this Chapter or who holds the Distinguished Real Estate Instructor (DREI) designation granted by the Real Estate Educators Association or an equivalent real estate instructor certification shall be exempt from the requirement to demonstrate satisfactory teaching skills by submission of a videotape. An applicant who is qualified under Paragraph (b) of this Rule but who has not satisfied these additional requirements at the time of application shall be approved and granted a six-month grace period to complete these requirements. The approval of any instructor who is granted such six-month period to complete the requirements shall automatically expire on the last day of the period if the instructor has failed to fully satisfy his or her qualification deficiencies and the period has not been extended by the Commission. The Commission may in its discretion extend the six-month period for up to three additional months when the Commission requires more than 30 days to review and act on a submitted videotape, when the expiration date of the period occurs during a course being taught by the instructor, or when the Commission determines that such extension is otherwise warranted by exceptional circumstances which are outside the instructor=s control or when failure to extend the grace period could result in harm or substantial inconvenience to students, licensees, or other innocent persons. An individual applying for instructor approval shall be allowed the authorized six-month period to satisfy the requirements stated in this Paragraph only once.

History Note: Authority G.S. 93A-4(a),(d); 93A-33; 93A-34;

Eff. October 1, 2000;

Amended Eff. September 1, 2002.

21 NCAC 58C .0603 APPLICATION AND CRITERIA FOR ORIGINAL APPROVAL

**CHAPTER 61 - THE NORTH CAROLINA
RESPIRATORY CARE BOARD****21 NCAC 61 .0204 FEES**

(a) Fees are as follows:

- (1) For an initial application, a fee of twenty-five dollars (\$25.00);
- (2) For issuance of an active license, a fee of one hundred dollars (\$100.00);
- (3) For the renewal of an active license, a fee of fifty dollars (\$50.00);
- (4) For the late renewal of any license, an additional late fee of fifty dollars (\$50.00);
- (5) For a license with a provisional or temporary endorsement, a fee of thirty-five dollars (\$35.00);
- (6) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

(b) Fees shall be nonrefundable and shall be paid in the form of a cashier's check, certified check or money order made payable to the North Carolina Respiratory Care Board. However, personal checks may be accepted for payment of renewal fees.

History Note: Authority G.S. 90-652(2);(9); G.S. 90-660; Temporary Adoption Eff. October 15, 2001; Eff. August 1, 2002.

21 NCAC 61 .0302 LICENSE RENEWAL

- (a) Any licensee desiring the renewal of a license shall apply for renewal and shall submit the required fee.
- (b) Any person whose license is lapsed or expired and who engages in the practice of respiratory care as defined in G.S. 90-648(10) will be subject to the penalties prescribed in G.S. 90-659.
- (c) Licenses lapsed in excess of 24 months shall not be renewable. Persons whose licenses have been lapsed in excess of 24 months and who desire to be licensed shall apply for a new license and shall meet all the requirements then existing.

History Note: Authority G.S. 90-652(1),(2),(4); Temporary Adoption Eff. October 15, 2001; Eff. August 1, 2002.

**21 NCAC 61 .0601 PETITIONS FOR ADOPTION,
AMENDMENT, OR REPEAL OF RULES**

- (a) General. The procedure for petitioning the Board to adopt, amend, or repeal a rule is governed by G.S. 150B-20.
- (b) Submission. Rule-making petitions shall be sent to the Board. No special form is required, but the petitioner shall state his name and address. There are no minimum mandatory contents of a petition, but the Board considers the following information to be pertinent:

- (1) a draft of any proposed rule or amendment to a rule;
- (2) the reason for the proposal;
- (3) the effect of the proposal on existing rules or decisions;
- (4) data supporting the proposed rule change;

- (5) practices likely to be affected by the proposed rule change;
- (6) persons likely to be affected by the proposed rule change.

(c) Disposition. The Board shall render its decision to either deny the petition or initiate rulemaking, and shall notify the petitioner of its decision in writing, within the 120-day period set by G.S. 150B-20.

History Note: Authority G.S. 90-652(2); Temporary Adoption Eff. October 15, 2001; Eff. August 1, 2002.

**21 NCAC 61 .0602 PROCEDURE FOR ADOPTION
OF RULES**

- (a) General. The procedure for the adoption, amendment or repeal of a rule is governed by G.S. 150B, Article 2A.
- (b) Notice of Rule-Making. In addition to the mandatory publication of notice in the North Carolina Register, the Board, in its discretion, may also publish notice to licensees through its newsletter or by separate mailing. Any person who wishes to receive individual notice shall file a written request with the Board and shall be responsible for the cost of mailing said notice.
- (c) Public Hearing. Any public rule-making hearing required by G.S. 150B, Article 2A shall be conducted by the Chairman of the Board or by any person he may designate. The presiding officer shall have complete control of the hearing and shall conduct the hearing so as to provide a reasonable opportunity for any interested person to present views, data and comments.

- (1) Oral presentations shall not exceed 15 minutes unless the presiding officer, in his discretion, prescribes a greater time limit.
- (2) Written presentations shall be acknowledged by the presiding officer and shall be given the same consideration as oral presentations.

History Note: Authority G.S. 90-652(2); Temporary Adoption Eff. October 15, 2001; Eff. August 1, 2002.

21 NCAC 61 .0603 TEMPORARY RULES

The power of the Board to adopt temporary rules and the procedure by which such rules are put into effect are governed by G.S. 150B-21.1.

History Note: Authority G.S. 90-652(2); Temporary Adoption Eff. October 15, 2001; Eff. August 1, 2002.

21 NCAC 61 .0604 DECLARATORY RULINGS

- (a) General. The issuance of declaratory rulings by the Board is governed by G.S. 150B-4.
- (b) Contents of Request. A request for a declaratory ruling shall be in writing and addressed to the Board. The request shall contain the following information:
 - (1) The name and address of the person making the request;
 - (2) The statute or rule to which the request relates;

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(3) A concise statement of the manner in which the person has been aggrieved by the statute or rule; and

(4) A statement as to whether a hearing is desired, and if desired, the reason therefor.

(c) Refusal to Issue Ruling. The Board shall ordinarily refuse to issue a declaratory ruling under the following circumstances:

(1) When the Board has already made a controlling decision on substantially similar facts in a contested case or when the matter at issue is properly the subject of a contested case;

(2) When the facts underlying the request for a ruling on a rule were specifically considered at the time of the adoption of the rule in question; and

(3) When the subject matter of the request is involved in pending litigation in North Carolina.

*History Note: Authority G.S. 90-652(1),(2);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0702 RIGHT TO HEARING

When the Board acts or proposes to act, other than in rule-making or declaratory ruling proceedings, in a manner which will affect the rights, duties, or privileges of a specific, identifiable licensee or applicant for a license, such person has the right to an administrative hearing. When the Board proposes to act in such a manner, it shall give any such affected person notice of the right to a hearing by mailing to the person, by certified mail at the person's last known address, a notice of the proposed action and a notice of a right to a hearing.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0703 REQUEST FOR HEARING

(a) An individual who believes that individual's rights, duties, or privileges have been affected by the Board's administrative action, and who has not received notice of a right to an administrative hearing, may file a formal request for a hearing.

(b) Before an individual may file a request, that individual is encouraged to exhaust all reasonable efforts to resolve the issue informally with the Board. Upon the request of an individual, the Board may designate one or more of its members, but in all cases less than a majority of the currently serving members of the Board, to meet informally with the individual, and attempt to reach an informal resolution of all matters at issue. Each Board member who is designated to serve in this capacity with regard to an individual's matter, whether the Board member actually meets with the individual or not, shall be disqualified from hearing any contested case when the matter designated for informal resolution is any part of the subject matter of the contested case.

(c) Subsequent to such informal action, if still dissatisfied, the individual may submit a request to the Board's office, with the request bearing the notation: "REQUEST FOR

"ADMINISTRATIVE HEARING". The request shall contain the following information:

(1) name and address of the petitioner;

(2) a concise statement of the action taken by the Board which is challenged;

(3) a concise statement of the way in which the petitioner has been aggrieved; and

(4) clear and specific statement of request for a hearing.

(d) The request shall be acknowledged promptly and, if deemed appropriate by the Board in accordance with 21 NCAC 61 .0704, a hearing will be scheduled.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0704 GRANTING OR DENYING HEARING REQUEST

(a) The Board shall grant a request for a hearing if it determines that the party requesting the hearing is a "person aggrieved" within the meaning of G.S. 150B-2(6). Whenever the Board proposes to deny, suspend, or revoke a license, or issue a letter of reprimand to a licensee, the licensee shall be deemed to be a person aggrieved.

(b) The denial of a request for a hearing shall be issued immediately upon decision, and in no case later than 60 days after the submission of the reasons leading the Board to deny the request.

(c) Approval of a request for a hearing shall be signified by issuing a notice as required by G.S. 150B-38(b) and explained in Rule .0705 of this Section.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0705 NOTICE OF HEARING

(a) The Board shall give the party or parties in a contested case a notice of hearing not less than 15 days before the hearing. Said notice shall contain the following information, in addition to the items specified in G.S. 150B-38(b):

(1) the name, position, address, and telephone number of a person at the offices of the Board to contact for further information or discussion;

(2) the date, time and place for a pre-hearing conference, if any; and

(3) any other information deemed relevant to informing the parties as to the procedure of the hearing.

(b) If the Board determines that the public health, safety or welfare requires such action, it may issue an order summarily suspending a license pursuant to G.S. 150B-3. Upon service of the order, the licensee to whom the order is directed shall immediately cease the practice of respiratory care in North Carolina.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0706 CONTESTED CASES

(a) All administrative hearings shall be conducted by the Board, a panel consisting of a majority of the members of the Board then serving, or an administrative law judge designated to hear the case pursuant to G.S. 150B-40(e).

(b) The hearing of a contested case shall commence no later than 90 days from the date the Board grants a request for a hearing, unless the licensee and the Board together shall jointly agree to extend this deadline.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0708 PETITION FOR INTERVENTION

(a) A person desiring to intervene in a contested case must file a written petition with the Board's office. The request shall bear the notation: "PETITION TO INTERVENE IN THE CASE OF (name of case)".

(b) The petition must include the following information:

- (1) the name and address of petitioner;
- (2) the business or occupation of petitioner, where relevant;
- (3) a full identification of the hearing in which petitioner is seeking to intervene;
- (4) the statutory or non-statutory grounds for intervention;
- (5) any claim or defense in respect of which intervention is sought; and
- (6) a summary of the arguments or evidence petitioner seeks to present.

(c) If the Board determines to allow intervention, notice of that decision will be issued promptly to all parties, and to the petitioner. In cases of discretionary intervention, such notification will include a statement of any limitations of time, subject matter, evidence or whatever else is deemed necessary which are imposed on the intervenor.

(d) If the Board's decision is to deny intervention, the petitioner will be notified promptly. Such notice will be in writing, identifying the reasons for the denial, and will be issued to the petitioner and all parties.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0710 DISQUALIFICATION OF BOARD MEMBERS

(a) Self-disqualification. If for any reason a Board member determines that personal bias or other factors render that member unable to hear a contested case and perform all duties in an impartial manner, that Board member shall voluntarily decline to participate in the hearing or decision.

(b) Petition for Disqualification. If for any reason any party in a contested case believes that a Board member is personally biased or otherwise unable to hear a contested case and perform all duties in an impartial manner, the party may file a sworn, notarized affidavit with the Board. The title of such affidavit shall bear the notation: "AFFIDAVIT OF

DISQUALIFICATION OF BOARD MEMBER IN THE CASE OF (name of case)".

(c) Contents of Affidavit. The affidavit must state all facts the party deems to be relevant to the disqualification of the Board member.

(d) Timeliness and Effect of Affidavit. An affidavit of disqualification shall be considered timely if filed 10 days before commencement of the hearing. Any other affidavit shall be considered timely provided it is filed at the first opportunity after the party becomes aware of facts which give rise to a reasonable belief that a Board member may be disqualified under this Rule. Where a petition for disqualification is filed less than 10 days before a hearing or during the course of a hearing, the Board may continue the hearing with the challenged Board member sitting. Petitioner shall have the opportunity to present evidence supporting his petition, and the petition and any evidence relative thereto presented at the hearing shall be made a part of the record. The Board, before rendering its decision, shall decide whether the evidence justifies disqualification. In the event of disqualification, the disqualified member shall not participate in further deliberation or decision of the case.

(e) Procedure for Determining Disqualification when a timely Affidavit of Disqualification is filed:

- (1) The Board will appoint a Board member to investigate the allegations of the affidavit.
- (2) The investigator will report to the Board the findings of the investigation.
- (3) The Board shall decide whether to disqualify the challenged individual.
- (4) The person whose disqualification is to be determined shall not participate in the decision but may be called upon to furnish information to the other members of the Board.
- (5) When a Board member is disqualified prior to the commencement of the hearing or after the hearing has begun, such hearing shall continue with the remaining members sitting provided that the remaining members still constitute a majority of the Board.
- (6) If four or more members of the Board are disqualified pursuant to this Rule, the Board shall petition the Office of Administrative Hearings to appoint an administrative law judge to hear the contested case pursuant to G.S. 150B-40(e).

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0711 SUBPOENAS

(a) Requests for subpoenas for the attendance and testimony of witnesses or for the production of documents, either at a hearing or for the purposes of discovery, shall be made in writing and delivered to the Board at least 10 days before the date of a contested case hearing and at least twenty days before a date given to provide discovery, shall identify any document sought with specificity, and shall include the full name and home or business address of all persons to be subpoenaed and, if known, the date, time, and place for responding to the subpoena. The

APPROVED RULES

Board shall issue the requested subpoenas within three days of receipt of the request.

(b) Subpoenas shall contain: the caption of the case; the name and address of the person subpoenaed; the date, hour and location of the hearing in which the witness is commanded to appear; a particularized description of the books, papers, records or objects the witness is directed to bring with him to the hearing, if any; the identity of the party on whose application the subpoena was issued; the date of issue; the signature of the presiding officer or his designee; and a "return of service". The "return of service" form, as filled out, shows the name and capacity of the person serving the subpoena, the date on which the subpoena was delivered to the person directed to make service, the date on which service was made, the person on whom service was made, the manner in which service was made, and the signature of the person making service.

(c) Subpoenas shall be served by the sheriff of the county in which the person subpoenaed resides, when the party requesting such subpoena prepays the sheriff's service fee. The subpoena shall be issued in duplicate, with a "return of service" form attached to each copy. A person serving the subpoena shall fill out the "return of service" form for each copy and properly return one copy of the subpoena, with the attached "return of service" form completed, to the Board.

(d) Any person receiving a subpoena from the Board may object thereto by filing a written objection to the subpoena with the Board's office. Such objection shall include a concise, but complete, statement of reasons why the subpoena should be revoked or modified. These reasons may include lack of relevancy of the evidence sought, or any other reason sufficient in law for holding the subpoena invalid, such as that the evidence is privileged, that appearance or production would be so disruptive as to be unreasonable in light of the significance of the evidence sought, or other undue hardship.

(e) Any objection to a subpoena must be served on the party who requested the subpoena simultaneously with the filing of the objection with the Board.

(f) The party who requested the subpoena, in such time as may be granted by the Board, may file a written response to the objection. The written response shall be served by the requesting party on the objecting witness simultaneously with filing the response with the Board.

(g) After receipt of the objection and response thereto, if any, the Board shall issue a notice to the party who requested the subpoena and the party challenging the subpoena, and may notify any other party or parties of an open hearing, to be scheduled as soon as practicable, at which evidence and testimony may be presented, limited to the narrow questions raised by the objection and response.

(h) Promptly after the close of such hearing, the majority of the Board members hearing the contested case shall rule on the challenge and issue a written decision. A copy of the decision shall be issued to all parties and made a part of the record.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;*

Eff. August 1, 2002.

21 NCAC 61 .0713 FINAL DECISION

In all cases heard by the Board, the Board shall issue its decision within 120 days after its next regularly scheduled meeting following the close of the hearing. The decision will be the "final agency decision" for the right to judicial review. To obtain judicial review, the person seeking review must file a petition with the court in accordance with the provisions of G.S. 150B-45.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

21 NCAC 61 .0714 PROPOSALS FOR DECISION

(a) When an administrative law judge conducts a hearing pursuant to G.S. 150B-40(e), a "proposal for decision" shall be rendered pursuant to the Rules of the Office of Administrative Hearings, 26 NCAC 03 .0126. The parties may file written exceptions to this "proposal for decision" and submit their own proposed findings of fact and conclusions of law. The exceptions and alternative proposals must be filed within 10 days after the party has received the "proposal for decision" as drafted by the administrative law judge.

(b) Any exceptions to the procedure during the hearing, the handling of the hearing by the administrative law judge, rulings on evidence, or any other matter must be written and refer specifically to pages of the record or otherwise precisely identify the occurrence to which exception is taken. The exceptions must be filed with the Board within 10 days of the receipt of the proposal for decision. The written exceptions shall bear the notation: "EXCEPTIONS TO THE PROCEEDINGS IN THE CASE OF (name of case)".

(c) Any party may present oral argument to the Board upon request. The request must be included with the written exceptions.

(d) Upon receipt of request for further oral argument, notice shall be issued promptly to all parties designating the time and place for such oral argument.

(e) Giving due consideration to the proposal for decision and the exceptions and arguments of the parties, the Board may adopt the proposal for decision or may modify it as the Board deems necessary. The decision rendered shall be a part of the record and a copy thereof given to all parties. The decision as adopted or modified becomes the "final agency decision" for the right to judicial review. Said decision shall be rendered by the Board within 60 days of the next regularly scheduled meeting following the oral arguments, if any. If there are no oral arguments presented, the decision shall be rendered within 60 days of the next regularly scheduled Board meeting following receipt of the written exceptions.

*History Note: Authority G.S. 90-652(2),(5),(8);
Temporary Adoption Eff. October 15, 2001;
Eff. August 1, 2002.*

This Section contains the agenda for the next meeting of the Rules Review Commission on Thursday, April 18, 2002, 10:00 a.m. at 1307 Glenwood Avenue, Assembly Room, Raleigh, NC. Anyone wishing to submit written comment on any rule before the Commission should submit those comments to the RRC staff, the agency, and the individual Commissioners by Friday, April 12, 2002 at 5:00 p.m. Specific instructions and addresses may be obtained from the Rules Review Commission at 919-733-2721. Anyone wishing to address the Commission should notify the RRC staff and the agency at least 24 hours prior to the meeting.

RULES REVIEW COMMISSION MEMBERS

Appointed by Senate

Thomas Hilliard, III
Robert Saunders
Laura Devan
Jim Funderburke
David Twiddy

Appointed by House

Paul Powell - Chairman
Jennie J. Hayman Vice - Chairman
Dr. Walter Futch
Jeffrey P. Gray
Dr. John Tart

RULES REVIEW COMMISSION MEETING DATES

July 18, 2002

RULES REVIEW COMMISSION
March 21, 2002
MINUTES

The Rules Review Commission met on Thursday morning, March 21, 2002, in the Assembly Room of the Methodist Building, 1307 Glenwood Avenue, Raleigh, North Carolina. Commissioners present: Vice Chairman Jennie Hayman, Laura Devan, Jeffrey Gray, Thomas Hilliard, John Tart, Robert Saunders, and Walter Futch.

Staff members present were: Bobby Bryan, Rules Review Specialist; and Lisa Johnson.

The following people attended:

Walter Wise	Iron Workers Union
Charles Koontz	Iron Workers Greensboro
Jean Stanley	NC Board of Nursing
Charles Willis	NC Water Treatment Facilities
David Williams	DENR
David Cobbs	Wildlife Resources Commission
Bob Curry	Wildlife Resources Commission
Bob Andrews	Department of Transportation
Barbara Jackson	NC Department of Labor
John Hoomani	NC Department of Labor
Cynthia Temoshenko	GACPD
Lynette Johnson	NC Department of Labor
Ron Hancock	Department of Transportation
Richard Holshouster	Sanford Contractors
Jayne Simpkins	NC Propane Gas Association
Ellen Sprenkel	Department of Insurance
Charles Swindell	Department of Insurance
Susan Collins	DMH/DD/SAS
Cindy Kornegay	DMH/DD/SAS
Diane Pomper	Attorney General's Office
Satana Deberry	DHHS
Christine Trottier	Carolina Legal Assistance
Sarah Meacham	Attorney General's Office
Patty Holloway	Secretary of State
Carol Bauman	Secretary of State
Thomas Allen	DENR/DAQ
Carl Eifalco	Department of Agriculture

Billy Tesh	NCPCA
John Dunbar	NCPCA
Bub McCarry	DENR
Fonda Raynor	DENR
Michael Thompson	DENR
Kris Horton	Department Social Services
Dedra Alston	DENR
Ann Christian	NC Substance Abuse Professional Certification Board
Chip Murray	Carolina AGC
Mike Link	Crowder Construction Company
Mary Shuping	General Assembly
Bill Hale	Department of Insurance
Dee Williams	NC Board of Cosmetic Art Examiners
Emily Lee	Department of Transportation
Howard Kramer	NC Board of Nursing
Nellie Riley	Office of State Personnel

APPROVAL OF MINUTES

The meeting was called to order at 10:05 a.m. with Vice Chairman Hayman residing. Vice Chairman Hayman asked for any discussion, comments, or corrections concerning the minutes of the March 21, 2002, meeting. The minutes were approved as written.

FOLLOW-UP MATTERS

2 NCAC 38.0701: Department of Agriculture – The Commission approved the rewritten rule submitted by the agency.

10 NCAC 14J .0201: DHHS/Commission for MH/DD/SAS – The Commission approved the rewritten rule submitted by the agency.

10 NCAC 14P .0102: DHHS/Commission for MH/DD/SAS – The Commission approved the rewritten rule submitted by the agency.

10 NCAC 14R .0101; .0105: DHHS/Commission for MH/DD/SAS – The Commission approved the rewritten rules submitted by the agency.

10 NCAC 14V .6002: DHHS/Commission for MH/DD/SAS – The Commission approved the rewritten rule submitted by the agency.

10 NCAC 41F .0601; .0705: DHHS/Social Services Commission – The Commission approved the rewritten rules submitted by the agency.

11 NCAC 8 .1418: NC Manufactured Home Board – The Commission approved the rewritten rule submitted by the agency.

11 NCAC 12 .01006; .1028: Department of Insurance – The Commission approved the rewritten rules submitted by the agency.

15A NCAC 6E .0103: DENR/Soil & Water Conservation Commission – The Commission approved the rewritten rule submitted by the agency.

15A NCAC 9C .0507; .0510; .0516; .0604; .0605; .0607; .0902; .0903 – DENR/Division of Forest Resources – The Commission approved the rewritten rules submitted by the agency.

15A NCAC 11 .0104; .0320; .1403; .1408; .1417; .1418; .1610; .1613: DENR/Radiation Protection Commission – The Commission approved the rewritten rules submitted by the agency.

18 NCAC 5B .0103; .0105; .0106; .0107; .0108; .0310; .0410: Secretary of State – The Commission approved the rewritten rules submitted by the agency.

21 NCAC 12 .0210: NC Licensing Board for General Contractors – The agency requested that the rule be returned. It will be. No action was necessary.

21 NCAC 16B .0315: NC Board of Dental Examiners – The Commission approved the rewritten rule submitted by the agency.

21 NCAC 16C .0310: NC Board of Dental Examiners – The Commission approved the rewritten rule submitted by the agency.

21 NCAC 16D .0102: NC Board of Dental Examiners – The Commission approved the rewritten rule submitted by the agency.

21 NCAC 16Q .0202; .0302: NC board of Dental Examiners – The Commission approved the rewritten rules submitted by the agency.

21 NCAC 16Y .0101; .0102; .0103; .0104: NC Board of Dental Examiners – The Commission approved the rewritten rules submitted by the agency.

21 NCAC 36 .0227; .0301; .0302; .0321: NC Board of Nursing – The Commission approved the rewritten rules submitted by the agency.

21 NCAC 50 .0104; .0404: NC Board of Examiners of Plumbing, Heating & Fire Sprinkler Contractors – The Commission approved the rewritten rules submitted by the agency.

21 NCAC 68 .0202; .0203; .0205; .0215: NC Substance Abuse Professional Certification Board – The Commission approved the rewritten rules submitted by the agency.

LOG OF FILINGS

Chairman Hayman presided over the review of the log and all rules were approved unanimously with the following exceptions:

2 NCAC 34 .0102; .0501; .0503; .0505; .0506; .0601; .0604; .0605; .0703; .0803; .0805; .0806; .0904: Department of Agriculture – The Commission extended the period of review to give the agency an opportunity to work with the Commission staff to resolve problems raised by the staff and Commission members. It is understood that some of the rules will be rewritten.

10 NCAC 14G .0101: DHHS/Commission for MH/DD/SAS – The Commission voted to return the rule to the agency for failure to comply with the notice and hearing provisions of the Administrative Procedure Act. Because no notice of text was ever published on

this rule as required by G.S. 150B-21.2(a)(3), the rule was not adopted in accordance with Part 2 of Article 2A of Chapter 150B of the General Statutes.

10 NCAC 14J .0206: DHHS/Commission for MH/DD/SAS – The Commission objected to the rule due to ambiguity. In (c)(1), it is not clear who must approve the techniques. If the Commission or Division, it is not clear what the approval standards are. The objection applies to existing language in the rule.

10 NCAC 14J .0210: DHHS/Commission for MH/DD/SAS – The Commission voted to return the rule to the agency for failure to comply with the notice and hearing provisions of the Administrative Procedure Act. Because no notice of text was ever published on this rule as required by G.S. 150B-21.2(a)(3), the rule was not adopted in accordance with Part 2 of Article 2A of Chapter 150B of the General Statutes.

10 NCAC 20A .0102: DHHS/Division of Vocational Rehabilitation Services – This rule was inadvertently on the log so no action was necessary.

10 NCAC 20C .0304; .0314: DHHS/Vocational Rehabilitation Services - These rules were inadvertently on the log so no action was necessary.

13 NCAC 7A .0302: NC Department of Labor – The Commission objected to the rule due to lack of statutory authority. G.S. 150B-21.6 requires agencies to include in their rules the cost of any materials incorporated by reference. “Contact source for specific cost information” does not meet the requirement.

17 NCAC 5C .0703: Department of Revenue – This rule was approved contingent upon receiving a technical change by the end of the day. The technical change was subsequently received.

The meeting adjourned for a break at 12:11 p.m..

The meet reconvened at 12:23 p.m.

21 NCAC 14P .0116: NC Board of Cosmetic Art Examiners – The Commission objected to the rule due to ambiguity. Paragraph (b) implies that for a least some offenses, a licensee can have a first offense every year, while paragraph (f) states that a licensee must go three years without a violation to have his record cleared. These appear to be contradictory.

21 NCAC 14Q .0101: NC Board of Cosmetic Art Examiners – The Commission objected to the rule due to ambiguity. In (b), it is not clear what other statewide groups or associations have been approved by the Board, or conversely what the standards for approval are. It is also not clear what is meant by “proper control procedures.” Subparagraph (c)(3), makes no sense. Since the rule will not be effective until August 2, 2002, at the earliest, it is impossible to meet the timeline set out.

21 NCAC 14Q .0104: NC Board of Cosmetic Art Examiners – The Commission objected to the rule due to ambiguity. This rule is unclear because as written it is impossible to comply with. It requires action a year before the rule becomes effective.

21 NCAC 14Q .0106: NC Board of Cosmetic Art Examiners – The Commission objected to the rule due to lack of statutory authority and ambiguity. There is no authority cited to set occupational requirements for continuing education instructors as item (1) of this rules does. If authority is found, it is not clear what standards the Board will use in deviating from those listed.

21 NCAC 14Q .0102: NC Board of Cosmetic Art Examiners – The Commission objected to the rule due to ambiguity. It is not clear what format will be approved by the Board.

21 NCAC 14Q .0107: NC Board of Cosmetic Art Examiners – The Commission objected to the rule due to lack of necessity. This rule merely repeats the provision of .0103(1) and is thus unnecessary.

21 NCAC 32B .0101: NC Medical Board – The Commission objected to the rule due to lack of statutory authority, ambiguity and lack of necessity. There does not appear to be any authority to include ACGME in the definition of Board Approved Medical Schools in (19). G.S. 90-9 makes a distinction between AOA and LCME approved schools and other medical schools. Medical schools not approved by AOA or LCME are statutorily unapproved. In (22)(b), it is not clear what would amount to “good” quality. The examination requirements in item (25) are not consistent with those in 32B .0215 and the presence of that rule makes this item unnecessary.

21 NCAC 32B .0104: NC Medical Board – The Commission objected to the rule due to lack of statutory authority, ambiguity and lack of necessity. In (1), it is not clear how an applicant is supposed to prove to the Board his skill, safety and physical and moral fitness to practice medicine. Item (3) does not appear to be consistent with G.S. 90-9. By defining “approved medical school” in Rule 32B .0101 differently than the statute does, the Rule almost certainly reaches a different result than the statute calls for. By mixing “and” and “or” in the list in b., it is not clear what is required when. There does not appear to be authority for the substantially equivalent course content “requirement in (3) b. In (3) b.ii, it is not clear what a “fifth pathway program” is, nor what the authority is to require it. It is not clear how the (3) b. iii. provisions fit in with the statutory requirements. The first sentence in (3) c. repeats provisions in G.S. 90-9 and 90-13 and is therefore unnecessary. In (7) by defining “approved medical school” differently than G.S. 90-9 does, the Rule reaches a different result than statutorily required. The statute requires graduates from all medical colleges other than AOA or LCME approved ones to have three years of graduate medical education. The Rule would allow an applicant from a college approved by ACGME, but not AOA or LCME to only have one year of graduate medical education. In (9) b. ii., it is not clear when the Board will elect to waive the seven year limit. In (11), it is not clear what would constitute “good mental and physical health”. The last sentence in (13) repeats provision in G. S. 90-14 and is unnecessary. Item (7) repeats (although not always consistently) the provisions of 32B .0213(2) and is thus ambiguous and unnecessary. Item (8) repeats (although not always consistently) the provisions of 32B .0207 and is thus ambiguous and unnecessary. Item (9) repeats (although not always consistently) the provisions of 32B .0211 and is thus ambiguous and unnecessary. Item (12) is inconsistent with 32B .0214 by requiring all applicants rather than some to be interviewed. Only one of them is necessary.

RULES REVIEW COMMISSION

21 NCAC 32B .0105: NC Medical Board – The Commission objected to the rule due to lack of statutory authority. There is no authority for the first sentence authorizing North Carolina graduates to apply to some other state's licensing board. There is no authority for item (1). G.S. 90-9 requires the Board to examine every applicant who meets the requirements in that statute, not the Board rules.

21 NCAC 32B .0106: NC Medical Board – The Commission objected to the rule due to ambiguity and lack of necessity. In (2) c., it is not clear what is meant by "CME equivalency." That is not a defined term. Section 32B .0300 contains the requirements for licensure by endorsement. This rule sometimes repeats and at times is inconsistent with those rules. It is thus unnecessary and ambiguous.

21 NCAC 32M .0112: NC Medical Board – The Commission objected to the rule due to ambiguity. In (e), it is not clear what the formula is.

21 NCAC 36 .0109: NC Board of Nursing – The Commission objected to the rule due to lack of statutory authority and ambiguity. There does not appear to be any authority for Paragraph (b) requiring nurses "considering nomination" to attend information sessions. It is also not clear what is meant by "considering nomination". Does it mean "thinking about nominating someone else," "thinking about getting 10 nurses to nominate him," or something entirely different. G.S. 90-171.21 sets the requirements and while the Board can adopt rules to implement the provision, it does not have authority to add requirements. There does not appear to be any authority to the provision in (d)(4) requiring employee acknowledgement of an employee's intent to seek election. Much of paragraph (e) repeats the provisions of G.S. 90-171.21(d)(1) and is unnecessary. There is no authority for the Board to set additional requirements beyond these in the statute. In (l) and (m), it is not clear what standards the Board uses in fixing the latest day and hour for voting. This objection applies to existing language in the rule.

21 NCAC 56 .0501; .0502; .0505; .0602; .0606; .0701; .0804; .0901; .1103; .1605; .1606; .1607; .1608; .1609; .1708; .1713: NC Board of Examiners of Engineers and Surveyors - The Commission extended the period of review at the agency's request to give the Board an opportunity to appropriately adopt them.

COMMISSION PROCEDURES AND OTHER BUSINESS

The next meeting of the Commission is Tuesday, April 30, 2002.

The meeting adjourned 1: 27 p.m.

Respectfully submitted,
Lisa Johnson

AGENDA **RULES REVIEW COMMISSION** **April 30, 2002**

- I. Call to Order and Opening Remarks
- II. Review of minutes of last meeting
- III. Follow Up Matters
 - A. NC Department of Agriculture – 2 NCAC 34 .0102; .0501; .0503; .0505; .0506; .0601; .0604; .0605; .0703; .0803; .0805; .0806; .0904 Extend Period of Review 04/18/02 (DeLuca)
 - B. DHHS/Commission for MH/DD/SAS – 10 NCAC 14J .0206 Objection 04/18/02 (Bryan)
 - C. Department of Labor - 13 NCAC 7A .0302 Objection 04/18/02 (Bryan)
 - D. Board of Cosmetic Art Examiners – 21 NCAC 14P .0116 Objection 04/18/02 (Bryan)
 - E. Board of Cosmetic Art Examiners – 21 NCAC 14Q .0101; .0102; .0104; .0106; .0107 Objection 04/18/02 (Bryan)
 - F. NC Medical Board – 21 NCAC 32B .0101; .0104; .0106 Objection 04/18/02 (Bryan)
 - G. NC Medical Board – 21 NCAC 32M .0112 Objection 04/18/02 (Bryan)
 - H. NC Board of Nursing – 21 NCAC 36 .0109 Objection 04/18/02 (Bryan)
 - I. NC Board of Examiners of Engineers and Surveyors – 21 NCAC 56 .0501; .0502; .0505; .0602; .0606; .0701; .0804; .0901; .1103; .1605; .1606; .1607; .1608; .1609; .1708; .1713 Extend Period of Review 04/18/02 (Bryan)
- IV. Commission Business
- V. Next meeting: Thursday July 18, 2002

CONTESTED CASE DECISIONS

This Section contains the full text of some of the more significant Administrative Law Judge decisions along with an index to all recent contested cases decisions which are filed under North Carolina's Administrative Procedure Act. Copies of the decisions listed in the index and not published are available upon request for a minimal charge by contacting the Office of Administrative Hearings, (919) 733-2698. Also, the Contested Case Decisions are available on the Internet at the following address: <http://www.ncoah.com/hearings>.

OFFICE OF ADMINISTRATIVE HEARINGS

Chief Administrative Law Judge
JULIAN MANN, III

Senior Administrative Law Judge
FRED G. MORRISON JR.

ADMINISTRATIVE LAW JUDGES

*Sammie Chess Jr.
Beecher R. Gray
Melissa Owens Lassiter*

*James L. Conner, II
Beryl E. Wade
A. B. Elkins II*

AGENCY	CASE NUMBER	ALJ	DATE OF DECISION	PUBLISHED DECISION REGISTER CITATION
ALCOHOL BEVERAGE CONTROL COMMISSION				
C's Mini-Mart, Camille Stephens v. NC ABC Commission and City of Charlotte	00 ABC 1264	Lassiter	06/08/01	
NC ABC Commission v. Benjamin Franklin Black, B and M Convenience	01 ABC 0663	Morrison	07/23/01	
Deleon Christopher Izi v. NC Alcoholic Beverage Control Commission	01 ABC 0709	Gray	10/11/01	
NC Alcoholic Beverage Control Commission v. Henry Rudolph Brake T/A Horsin Around Country Club	01 ABC 0811	Lassiter	08/13/01	
NC ABC Commission v. James Okwudili Nwizu, T/A Sahara Mini Mart	01 ABC 1209	Elkins	02/01/02	
NC ABC Commission v. Colap Ent., Inc. T/A Pantana Bobs	01 ABC 1472	Morrison	03/05/02	
NC ABC Commission v. W D B, Inc. T/A Twin Peaks	01 ABC 1962	Wade	03/11/02	
NC ABC Commission v. Fadhole Kassim Hussein T/A Hornes Church Convenient Mart	01 ABC 2294	Lassiter	03/12/01	
BOARD OF MORTUARY SCIENCE				
NC Board of Mortuary Science v. Beasley's Funeral Home, Inc., Odell Beasley, Crystal Beasley-Walker	00 BMS 0469	Mann	07/17/01	
Board of Mortuary Science v. Hunter Funeral Home & Julius Hunter	00 BMS 0505	Reilly	11/01/00	
NC Board of Mortuary Science v. Robert Breece, Jr., and Osborne Owens and Rogers and Breece Funeral Home	00 BMS 1763	Morrison	08/22/01	
NC Board of Mortuary Science v. Kyle Garret Peacock, Philip Smoak and Peggy Peacock	01 BMS 0298	Lassiter	09/20/01	
BOARD OF GEOLOGISTS				
O. Phillip Kimrell, P.G. v. NC Board for the Licensing of Geologists	99 BOG 1254	Conner	05/29/01	
CRIME CONTROL AND PUBLIC SAFETY				
Georgina Joyner v. NC Crime Victims Compensation Commission	95 CPS 0359	Gray	10/23/01	
Jerry W. Taylor v. NC Victims Compensation Commission	00 CPS 1052	Gray	05/23/01	
Clarence Forney v. NC Crime Victims Compensation Commission	00 CPS 1994	Elkins	10/11/01	
Sheree D Sirotnak v. NC Crime Victims Compensation Commission	00 CPS 2209	Wade	06/14/01	
Eddie N McLaughlin v. NC Crime Victims Compensation Commission	01 CPS 0086	Elkins	06/05/01	
Ricardo Darnell Jones v. NC Crime Victims Compensation Commission	01 CPS 0242	Elkins	02/01/02	
Marie King Cutler v. NC Crime Victims Compensation Commission	01 CPS 0926	Gray	01/28/02	
Bobby Holmes, Jr. v. NC Crime Victims Compensation Commission	01 CPS 1095	Gray	10/09/01	
John R. Ackerman v. NC State Highway Patrol	01 CPS 1327	Morrison	09/24/01	
David Nixon v. NC Crime Victims Compensation Commission	01 CPS 1330	Elkins	02/01/02	16:18 NCR 2055
Edna Hunt v. NC Crime Victims Compensation Commission	01 CPS 1434	Chess	01/10/02	
Kiffin Johnson v. NC Dept. of Crime Control & Public Safety	01 CPS 1517	Morrison	03/14/02	
CULTURAL RESOURCES				
Howard W & Rebecca Hoover v. NC Dept. of Cultural Resources State Historic Preservation Office	01 DCR 0243	Wade	06/26/01	
HEALTH AND HUMAN SERVICES				
Wendy Gay Dayberry v. NC Dept. of Health & Human Services	00 DHR 1077 ³	Wade	08/16/01	

CONTESTED CASE DECISIONS

Wendy Gay Dayberry v. NC Dept. of Health & Human Services	00 DHR 1324 ³	Wade	08/16/01	
Salinda Smith v. NC Department of Health & Human Services	00 DHR 1779	Mann	09/20/01	
Kenneth E. Frost v. DHHS, Julian F. Keith, ADATC	00 DHR 2278	Conner	07/30/01	
Ruby L Laughter v. Dept. of Health & Human Services	01 DHR 0108	Gray	06/29/01	
Donna Ray Snow v. NC Dept. of Health & Human Services	01 DHR 0122	Gray	11/27/01	
Merle Marie Kemp v. DHHR, Div. of Child Development	01 DHR 0207	Reilly	11/01/01	
Renita Lewis-Walters v. (ADATC), Dept. of Health & Human Services	01 DHR 0286	Morrison	06/08/01	
Thomas M Poole v. Dept. of Health & Human Services	01 DHR 0335	Lassiter	07/26/01	
Terry Westmoreland v. John Umstead Hospital	01 DHR 0392	Elkins	08/15/01	
Duane E McCoyle v. DHHS, Broughton Hospital	01 DHR 0398	Wade	06/19/01	
Lara Beth Henrick v. DHHS, Dorothea Dix Hospital	01 DHR 0409	Mann	07/19/01	
Terry W Hartsoe v. NC Dept. of Health & Human Services	01 DHR 0420	Chess	07/06/01	
Richard L Foster, Reansia M Foster v. DHHS, Broughton Hospital	01 DHR 0454	Wade	06/25/01	
Yvonne D Cole v. Cherry Hospital, Brenda Wells	01 DHR 0502	Morrison	07/23/01	
Cheryl Holloway v. DHHS, Health Care Register	01 DHR 0513	Morrison	07/27/01	
Gary Keys v. NC DHHS, Jones Co. Dept. of Social Services	01 DHR 0524	Conner	11/07/01	
Adam Query Fisher, Jr. v. DHHS, Julian F Keith, ADATC	01 DHR 0559	Wade	06/19/01	
Dennis E Partridge v. DHHS, Julian F Keith, ADATC	01 DHR 0560	Wade	06/19/01	
Eunice L Walden v. NC DHHS	01 DHR 0589	Gray	09/11/01	
Robert W Dietz & wife, Iris Dietz v. NC Dept. of Health & Human Svcs.	01 DHR 0603	Wade	10/11/01	
Eric L Belton v. Dept. of Health & Human Services, ADATC	01 DHR 0610	Lassiter	06/04/01	
Millsway Healthcare, Inc. v. Blue Ridge Area Authority	01 DHR 0628 ¹	Conner	02/25/02	
Tawn Milteer-Ellerbe v. Dept. of Health & Human Services	01 DHR 0629	Conner	09/04/01	
Blue Ridge Authority v. Millsway Healthcare, Inc.	01 DHR 0640 ¹	Conner	02/25/02	
Charles Anthony Tart v. DHHS, Walter B Jones, ADATC	01 DHR 0665	Lassiter	06/22/01	
Mable Barnes, CNA v. DHHS	01 DHR 0714	Conner	09/14/01	
Calvin Lucas v. Butler Alcohol & Drug Abuse Treatment Center	01 DHR 0738	Morrison	07/02/01	
Mollie Williams v. Dept. of Health & Human Services	01 DHR 0753	Conner	07/10/01	
Elveter Johnson v. Office of Administrative Hearings	01 DHR 0779	Gray	08/16/01	
Fannie Brown v. Caswell Center Healthcare Personnel Registry	01 DHR 0780	Gray	07/02/01	
Helen Yoo, Happy Hill Garden v. NC Dept. of Public Health & Human Svcs.	01 DHR 0781	Conner	09/18/01	
Mrs. Felicia Lash Moore v. NC DHHS	01 DHR 0784	Elkins	11/13/01	
Margaret Rinkel Sanderlin v. NC Dept. of Health & Human Services	01 DHR 0831	Conner	09/12/01	
Donovan Rogers v. Dept. of Health & Human Services	01 DHR 0840	Conner	09/19/01	
Monique S. Warren v. NC Dept. of Health & Human Services	01 DHR 0841	Conner	09/04/01	
Kathy Marie Pollard v. NC Dept. of Human Services	01 DHR 0867	Conner	03/14/02	
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Stephen & Sandra Aycock v. NC DHHS	01 DHR 0947	Gray	03/11/02	
Robert & Shirley Harmon on behalf of Gary Harmon v. NC DMH/DD/SAS	01 DHR 0955	Chess	06/25/01	
Edward D Connor v. Dept. of Health & Human Services	01 DHR 0978	Chess	07/05/01	
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Sallye A. Hardy, Rocker Room Child Care v. Yvette Pollock, Dare Co. DSS	01 DHR 1335	Chess	12/11/01	
Juanita D Blevins v. NC DHHS	01 DHR 1341	Conner	02/13/02	
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Lisa Dupree v. The State Board of Nurse Aid, Debbie Hockaday	01 DHR 1343	Mann	10/12/01	
USA Grocery Store, Yousif Alezi v. NC DHHS	01 DHR 1350	Chess	12/13/01	
Annette Camilla Adams v. Department of Health & Human Services	01 DHR 1353	Chess	01/09/02	
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Kevin Andrew Coleman v. Dept Social Svce, Lexington, NC	01 DHR 1479	Mann	12/13/01	
Daniel Report v. The Guilford Center (The State DMH/DD/SAS	01 DHR 1562	Mann	12/10/01	
Sadio-Tene Lloyd (for client TiNesha Booker) v. The Guilford Center/Child Authorization Team/The State DMH/DD/SAS	01 DHR 1577	Mann	11/15/01	
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Gloria Jean Hairston v. Health Care Personnel Registry	02 DHR 0072	Chess	03/04/02	
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Vickie L. Anderson, Camelot Academy v. DHHS, Division of Child Development	00 DHR 1270	Wade	05/22/01
Esther M Huntley, Treasurer, Rainbow Nursery Parents Club, Inc. v. DHHS, Division of Child Development	00 DHR 1419	Gray	09/24/01
Judy Woods Days Care v. DHHS, Div. of Child Development	01 DHR 0084	Wade	10/05/01
Shirley Campbell, Shirley's Development Center v. State of NC Dept. of Human Resources, Div. of Child Development	01 DHR 0125	Chess	11/08/01
Anna Daley v. DHHS, Div. of Child Development	01 DHR 0386	Morrison	11/07/01
Tiffany D. Lott v. Div. of Child Dev., NC DHHS	01 DHR 0538	Chess	12/10/01
Sarah L Thomas, Sarah's Child Care v. Division of Child Dev.	01 DHR 0818 ²	Gray	12/28/01
Sarah's Child Care Center, Inc. v. NC DHHS, Div. of Child Dev.	01 DHR 0830 ²	Gray	12/28/01
Blackwell and Assoc. & Alamance Child Learning Center v. NC DHHS Div. of Child Development	01 DHR 1281	Chess	02/06/02

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Dr. Mitchell James Lequire, PharmD Realo Drug v. DHHS, Division of Medical Assistance	01 DHR 0989	Chess	07/12/01

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Donna Kay Pittman v. DHHS, Division of Facility Services	00 DHR 0086	Overby	06/29/01
Wendy Denise Callender v. DHHS, Division of Facility Services	00 DHR 0608	Conner	08/17/01
Linda Gail Funke v. DHHS, Division of Facility Services	00 DHR 0625	Wade	06/04/01
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David Mull v. DHHS, Division of Facility Services	00 DHR 1495	Lassiter	06/12/01
Ethlyne Phipps v. DHHS, Division of Facility Services	00 DHR 1505	Conner	07/26/01
Yelton's Healthcare, Inc. v. DHHS, Division of Facility Services	00 DHR 1540	Chess	06/21/01
Jacqueline A Alexander v. DHHS, Division of Facility Services	00 DHR 1586	Gray	06/28/01
Debra Brown v. DHHS, Division of Facility Services	00 DHR 2009	Gray	06/28/01
Kama Kasiah v. DHHS, Division of Facility Services	00 DHR 2203	Lassiter	09/07/01
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Peter Lynn Mosher v. DHHS, Division of Facility Services	01 DHR 0178	Mann	05/30/01
Samuel McKinley Tugman v. DHHS, Division of Facility Services	01 DHR 0512	Gray	07/25/01
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Tabitha Perry v. DHHS, Division of Facility Services	01 DHR 0330	Mann	10/01/01
Tonitia Langley v. DHHS, Division of Facility Services	01 DHR 0359	Lassiter	10/16/01
Davina Brook Grant v. DHHS, Division of Facility Services	01 DHR 0363	Conner	06/08/01
Inez M Stephens v. DHHS, Division of Facility Services	01 DHR 0418	Morrison	09/13/01
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Dogwood Forest, Nicole Faiger Blackwell v. DHHS, Div. of Fac. Services	01 DHR 0737	Conner	09/19/01
Arlene E Jackson v. DHHS, Division of Facility Services	01 DHR 0740	Morrison	07/11/01
Genevieve McLean v. DHHS, Division of Facility Services	01 DHR 0808	Lassiter	07/03/01
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Stephanie M. Propst v. DHHS, Div. of Facility Services, Health Care Personnel Section	01 DHR 0899	Wade	11/20/01
Candice J Smith v. DHHS, Division of Facility Services	01 DHR 0911	Lassiter	07/27/01
Madge B Murray v. NC DHHS, Div. of Facility Services, Health Care Personnel Registry	01 DHR 0953	Conner	09/12/01
Margaret Rose Hiebler v. DHHS, Division of Facility Services	01 DHR 1002	Mann	10/02/01
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Dannette Byrd v. Community Innovations, Health Care Personnel Registry	01 DHR 1016	Wade	11/20/01
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Brenda Garner v. DHHS, Division of Facility Services	01 DHR 1106 ²	Conner	01/24/02
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Rossie Nicole Horne v. DHHS, Division of Facility Services	01 DHR 1198	Gray	10/11/01
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Henry Monroe v. NC DHHS, Division of Facility Services	01 DHR 1306	Wade	11/16/01
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Alice G. Stevenson v. NC DHHS, Division of Facility Services	01 DHR 1567	Mann	12/13/01
Anne Marie Lunsford v. NC DHHS, Division of Facility Services	01 DHR 1590	Gray	02/19/02
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Joseph C. Turay v. DHHS, Division of Facility Services	01 DHR 1617	Elkins	01/29/02
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Courtrina Dawson v. NC DHHS Division of Facility Services	01 DHR 1623	Wade	11/14/01
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Vieta Ann Jamison v. DHHS, Division of Facility Services	01 DHR 1907	Chess	01/30/02
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Elizabeth Winter v. DHHS, Division of Facility Services	01 DHR 1954	Chess	01/17/02
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Angela Roberson v. DHHS, Division of Facility Services	01 DHR 2215	Lassiter	01/07/02
Lisa Marie Burleson v. DHHS, Division of Facility Services	01 DHR 2345	Morrison	02/05/02
Affiah, Ndarake Effiong v. NC DHHS, Div. of Facility Svcs., Health Care Registry Section	01 DHR 2353	Conner	02/26/02
Dorothy Stinson v. DHHS, Division of Facility Services	01 DHR 2370	Mann	03/26/02
Lanella McRae v. DHHS, Division of Facility Services	02 DHR 0065	Gray	02/22/02

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Delie L. Anthony v. Edgecombe Co. Dept. of Social Services Child Abuse and Neglect Dept. Tarsha McCray	01 DHR 0324	Wade	06/18/01
Angel McDowell v. Office of Administrative Hearings	01 DHR 0370	Conner	06/05/01
Kristie N Crabtree v. Greene County Social Services	01 DHR 0401	Lassiter	06/05/01
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Elizabeth Jackson v. DHHS, Dept. of Social Services	01 DHR 0601	Lassiter	06/22/01
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Child Support Enforcement Section

A list of Child Support Decisions may be obtained by accessing the OAH Website – www.ncoah.com/decisions

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Fordion Packaging, Ltd., Bird Bailey v. Dept. of State Purchasing, J. Arthur Leaston	01 DOA 1001	Gray	08/24/01
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Deona Renna Hooper v. Co. Police Program, Co. Police Administrator	00 DOJ 2177	Wade	06/22/01
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Edward James Summers v. Alarm Systems Licensing Board	01 DOJ 0352	Morrison	06/13/01
Joseph Brian Moses v. Alarm Systems Licensing Board	01 DOJ 0582	Wade	06/01/01
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Tamera Ramelle Adams v. Private Protective Services Board	01 DOJ 1817	Morrison	12/06/01
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Larry Russell Jackson v. NC Criminal Justice & Trng. Stds. Comm.	00 DOJ 0721	Gray	07/20/01
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Gary C Daugherty v. NC Sheriffs' Educ. & Trng. Stds. Comm.	01 DOJ 1267	Chess	10/04/01
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Kevin Hoover v. NC Sheriffs' Educ. & Trng. Stds. Comm.	01 DOJ 1601	Elkins	12/04/01
Keith A Riddick v. NC Sheriffs' Educ. & Trng. Stds. Comm	01 DOJ 1602	Chess	03/26/02
Darius Zeb Brevard, Jr. v. NC Criminal Justice & Trng. Stds. Comm.	01 DOJ 2309	Wade	02/27/02
Ollie Rose v. NC Sheriffs' Educ. & Training Stds. Comm.	02 DOJ 0063	Conner	04/10/02

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Gwen A Lindsey v. Timothy S Bryan, State of NC, Dept. of State Treasurer, Retirement Systems	00 DST 0727	Mann	08/06/01
Bruce E. Colvin v. Board of Trustees of the Local Governmental Employees' Retirement System	00 DST 0776	Gray	07/06/01

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Carolyn H. Lancaster v. NC Department of Public Instruction	01 EDC 0054	Morrison	11/08/01	
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Bobby E Hart v. Superintendent Cumberland Co. Sch., Rockfish Elem.	02 EDC 0106	Mann	02/18/02	
Dr. Monroe R Parker, Esq., v. Brock Murray & NC Dept. of Public Inst.	02 EDC 0261	Gray	03/13/02	

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James W and Winnifred King v. Div. of Coastal Management	97 EHR 0791	Gray	11/29/01	16:14 NCR 1618
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Joe Fairlamb, Brenda Fairlamb v. NC DENR, Div. of Water Quality & Mid South Water Systems, Inc.	00 EHR 0440	Conner	08/17/01	
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Paul Blythe, Lori Blythe v. NC DENR, Div. of Water Quality & Mid South Water Systems, Inc.	00 EHR 0448	Conner	08/17/01	
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Lisa Oxidine v. NC DENR, Div. of Water Quality & Mid South Water Systems, Inc.	00 EHR 0450	Conner	08/17/01	
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Shannon M Schram, Alex F Schram v. NC DENR, Div. of Water Quality & Mid South Water Systems, Inc.	00 EHR 0508	Conner	08/17/01	
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Anson County Citizens Against Chemical Toxins in Underground Storage, Blue Ridge Environmental Defense League, Inc., Mary Gaddy, Bobby Smith and Emma Smith v. DENR	00 EHR 0938	Conner	06/05/01	16:01 NCR 40
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David T. Stephenson, Lot 65 v. NC DENR (Brunswick County Health Department)	00 EHR 1250 ¹	Gray	08/07/01	16:05 NCR	463	
David T. Stephenson, Lot 64 v. NC DENR (Brunswick County Health Department)	00 EHR 1251 ¹	Gray	08/07/01	16:05 NCR	463	
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CONTESTED CASE DECISIONS

STATE OF NORTH CAROLINA

COUNTY OF HAYWOOD

**IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
01 DHR 0929/1018**

JAMES AND PATRICIA GALBRAITH
Petitioners,

vs.

**N.C. DEPARTMENT OF HEALTH AND HUMAN
SERVICES**
Respondent.

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DECISION

This contested case was heard before John C. Hunter, Temporary Administrative Law Judge, presiding at the contested case hearing conducted in Buncombe County, Asheville, North Carolina on October 4, 2001.

APPEARANCES

Petitioners: *Pro Se*

Respondent: R. Kirk Randleman
Assistant Attorney General
DHR Western Regional Office
Building 17, BMC Campus
Black Mountain, North Carolina 28711

WITNESSES

Petitioners: James Galbraith
Patricia Galbraith
Shandy Phillips

Respondent: Greta Reath

ISSUE

Do the Petitioners qualify to be licensed as a foster care home by the State of North Carolina pursuant to N.C. Gen. Stat. § 131D, Article 1A and Section 41F of Title 10 of the North Carolina Administrative Code?

FINDINGS OF FACT

1. Petitioners are residents of Haywood County, North Carolina. At the time of this hearing, both were gainfully employed. James Galbraith works for Haywood County in the position of Transit Driver. In this job, he transports dialysis patients to and from their home and their treatment centers. He has held this job for the past three years, and receives very high recommendations from his supervisors for both his dependability and his ability to work well with the dialysis patients he transports. He has received numerous thank you letters and other letters of commendation during his time with the County. Patricia Galbraith is employed as a server-trainer at a local restaurant. She has been in this position for over four years. She also receives high recommendations from her employer for both dependability and quality of work.

2. Currently one adoptive child lives with the Mr. and Mrs. Galbraith in their home. This is Shandy Phillips. Miss Phillips is 17 years old. She first came to live with the Galbraiths as an adolescent foster child who had experienced several failed placements prior to being placed with the Galbraiths. Ms. Phillips is very happy and grateful to have become the adoptive child of Mr. and Mrs. Galbraith. She testified convincingly at the contested case hearing in this matter that Mr. and Mrs. Galbraith had been both fine foster and adoptive parents to her. At the start of the foster placement, she had been mistrustful and angry, as she had been in other foster placement settings. But, as she stated, "they were the only ones who cared enough to come after me when I ran away." While living with Mr. and Mrs. Galbraith, she is completing her education and working part-time.

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3. In early 2001, the Galbraiths completed the training required to become state licensed foster care parents. Concurrent with the training, Mr. and Mrs. Galbraith completed and submitted the appropriate application documents to the Respondent to be licensed by the State of North Carolina as foster care parents.

4. The application by Mr. & Mrs. Galbraith was denied by the Respondent on May 1, 2001. The denial stated, in pertinent part:

PLEASE TAKE NOTICE that the North Carolina Department of Health and Human Services, Division of Social Services, has determined that your home does not comply with the rules for licensure as a family foster home and is, therefore, denying your license to operate as a family foster home.

.....

The rules which your home does not comply with are found at North Carolina Administrative Code 41F.0702(a) that states, *“Foster parents shall be selected on the basis of having personal characteristics and relationships which permit them to undertake and perform the responsibilities of caring for children, in providing continuity of care, and in working with a social agency.”* The rule goes on to list examples of these qualities, *“. . . . who are able to maintain meaningful relationships, free from severe conflict, with members of their own families as well as with others outside the family; who have reputable characters, acceptable values and ethical standards conducive to the well being of children.”* As reported in the social worker’s assessment for the family, Mr. Galbraith has no formal contact with one of his children and limited contact with another. As both potential parents have criminal histories as obtained from Florida records (including aggravating battery charges, simple battery and causing a minor to become a dependant child), have not accepted the parenting role for their biological children, and have substance abuse histories, this application is denied.

5. At the outset, it is noted that the Respondent did not present as evidence in this matter the social worker’s assessment mentioned above; nor did the Respondent introduce any copies of an actual criminal record, certified or otherwise, for the Petitioners; nor did the Respondent introduce into evidence the basis for the claim that both Petitioners had substance abuse histories.

6. The Petitioners testified as to the truth or falsity of each of the claims on which the Respondent based its denial of their application for licensed foster home status. No other evidence was introduced as to those claims.

7. Both Petitioners have children from previous marriages.

8. Mr. Galbraith has four biological children, all are now adults, including a 40 year old daughter who suffers from severe drug addiction. He has not heard from her in a number of years, but would like to hear from her and re-establish contact. He is in constant and close contact with the other three children. During one period of time when he was out of work for six months he was unable to make the required support payments, this led to the charge of causing a minor to become a dependant child, but this episode was not indicative of his efforts to support his children.

9. Mrs. Galbraith is the non-custodial parent of her three biological children, with whom she has some contact.

10. Mrs. Galbraith does have a history of alcohol abuse. This was a contributing factor in her non-custodial parental status. However, she testified that she has been through a rehabilitation program and that she has been sober for over five years. She stated that she had no history of drug abuse.

11. Contrary to the implication in the denial letter, there is no indication that Mr. Galbraith has any history of substance abuse.

12. Both Petitioners admit to having a criminal record in Florida. All the charges arose out of a single incident in which they attempted to remove a man from the bar which they managed. A fight ensued and they were charged with the violations stated above. They received suspended sentences and successfully completed probationary periods.

13. The Haywood County Department of Social Services, which conducted the assessment on the basis of which the Petitioners’ application was denied, supports the granting of a foster home license to the Petitioners.

14. In an April 11, 2001 letter to Ms. Reath, the Respondent’s only witness in this matter, the Director of the Haywood County Department of Social Services, stated:

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I can understand your uncertainty about Mr. & Mrs. Galbraith's suitability to be effective foster parents. I too had concerns when I first read the application material, but after talking to staff about it, I had a better idea of who these people are. They have had a very unstable life until the past 5 or 6 years. They now appear to be much more settled and productive citizens. I had questions about their relationships with their own children and lack of parenting experience. However, sometimes looking back on our past can help us chart a much better future if we learn from our errors. I hope that is the case with the Galbraiths.

.....

I recommend that we license this couple and that our agency provide close supervision of this home. (*Underlining in original*)

15. Independent psychological evaluations of the Petitioners were performed by the New Beginnings Counseling Center of Sylva and Clyde, North Carolina, as part of the social worker assessment. The evaluations for both Mr. & Mrs. Galbraith were positive. While noting their past difficulties, each evaluation indicated that the Petitioners were now stable, well grounded persons who were ready to share their life experiences with foster children.

16. Both Petitioners feel a connection with and desire to help adolescent foster care children, such as their now adoptive daughter, Shandy. They are ready and willing to accept adolescents into their foster home if licensed. The Respondent confirmed that there is an acute shortage of foster care homes for adolescents.

Based upon the Foregoing Findings of Fact, the undersigned makes the following Conclusions of Law:

1. The Social Service Commission is authorized under N.C. Gen. Stat. 131D, Article 1A, to adopt rules governing the licensure of family foster homes.

2. The rules adopted by the Commission and set out above, attempt to define, in general terms, the qualities to be looked for in a foster care home. However, there are many possible personal and family characteristics and backgrounds, which can ultimately contribute to a successful foster home environment. Not all possibilities can be defined or otherwise included in such a rule. The Commission appears to have recognized this and did not draft a rule which would specifically require that any particular set of personal or family backgrounds or experiences disqualify someone from becoming a licensed foster home.

3. Mr. & Mrs. Galbraith have convincingly shown that they are currently stable and caring persons who, in spite of, or maybe because of their past experiences, are now able to provide a suitable home for foster children placed in their care. This is the standard they must meet to be licensed as a foster home.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the undersigned determines that the application by the Petitioners for a license to operate a family foster care home should be GRANTED.

ORDER

It is hereby ordered that the agency serve a copy of the final decision on the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, N.C. 27699-6714, in accordance with North Carolina General Statute 150B-36(b).

NOTICE

The decision of the Administrative Law Judge in this contested case will be reviewed by the agency making the final decision according to the standards found in G.S. 150B036(b)(b1) and (b2). The agency making the final decision is required to give each party an opportunity to file exceptions to the decision of the Administrative Law Judge and to present written argument to those in the agency who will make the final decision. G.S. 150B-36(a).

The agency that will make the final decision in this contested case is the North Carolina Department of Health and Human Services.

This the 26th day of March, 2002.

John C. Hunter
Temporary Administrative Law Judge

STATE OF NORTH CAROLINA
COUNTY OF ASHE

**IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
01 DHR 1342**

CAROLYN M. STEELMAN, Petitioner,)	DECISION
v.)	
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.))

This matter was heard before James L. Conner, II, Administrative Law Judge, on December 4, 2001, in Newton, North Carolina. Respondent filed proposed Findings of Fact and Conclusions of Law on January 30, 2002.

APPEARANCES

For Petitioner: Carolyn M. Steelman, *pro se*
Jefferson, North Carolina

For Respondent: Jane L. Oliver, Assistant Attorney General
Raleigh, North Carolina

ISSUE

Whether Respondent acted erroneously, failed to use proper procedure or acted arbitrarily or capriciously when Respondent determined that, on or about June 13, 2001, Petitioner abused Virginia Brown, a resident of an adult care facility, by confining her in her room for several hours for cussing another resident.

APPLICABLE STATUTES AND RULES

N.C. GEN. STAT. § 131E-256
N.C. GEN. STAT. § 150B-23
10 NCAC 3B .1001(1)
42 CFR Part 488.301

EXHIBITS

The following exhibits were admitted into evidence: Respondent's Exhibits 1, 2, 3A, 3B, 4, 14, and 15.

FINDINGS OF FACT

Based upon the documents filed in this matter, exhibits admitted into evidence and the sworn testimony of the witnesses, the undersigned makes the following findings:

1. In June 2001, Petitioner was employed as a medication technician at Ashe Manor Rest Home. Petitioner also worked at times in the office and as a personal care assistant. As a personal care assistant, Petitioner provided hands-on care to the residents. (T pp 66-67; Resp Exh 1).

2. Ashe Manor Rest Home is an adult care facility in Jefferson, North Carolina and, as such, is a "health care facility" as defined by N.C. Gen. Stat. § 131E-256(b)(1).

3. While at Ashe Manor, Petitioner attended training sessions on resident rights. She did not believe that putting a patient in her room was confinement. (T pp 75-76; Resp Exh 1 and 4).

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4. On June 13, 2000, between 9:00 and 9:30 a.m., Petitioner was in the nurses' station pulling labels. Virginia Brown and some of the other residents were sitting near the nurses' station. Ms. Brown was cussing at Tatsy, one of the other elderly female residents, for coughing. Petitioner talked to Ms. Brown to try to get her to stop cursing the other resident. Instead of desisting, Ms. Brown cussed Petitioner, then started cussing at a male resident, who was a mental patient. Petitioner asked the facility administrator what she could do about the verbal abuse to which Ms. Brown was subjecting the other residents. The administrator told Petitioner she could put Ms. Brown in her room. Petitioner thereupon wheeled Ms. Brown to Ms. Brown's room. Ms. Brown told Petitioner that she wanted to leave the room and Petitioner said no. Petitioner closed the door partway, leaving a crack of about eight inches, and left Ms. Brown in her room alone. Ms. Brown was unable to get out of her room because she could not move her wheelchair effectively by herself. (T pp 12, 18-19, 20, 47-48, 68-69, 82, 86; Resp Exh 1).

5. Virginia Brown had lived at Ashe Manor for approximately four to five years. She had one of her legs amputated and, therefore, she was not able to walk on her own and was confined to a wheelchair. In addition, Ms. Brown had suffered a stroke and one of her hands was crippled secondary to the stroke. Because she only used one hand, she had difficulty moving her wheelchair without assistance. Ms. Brown is incontinent of urine and needed to be cleaned by staff often. She required total care, that is, assistance with toileting, bathing, dressing and eating. The staff described Ms. Brown as being very nice at times. However, sometimes she would resist the staff's attempts to provide care and would yell and holler. For example, if she did not want a shower and the staff gave her a shower anyway, she would holler. Ms. Brown was not combative, she would just holler. (T pp 13, 30, 33-35, 78-79).

6. Betty Redmond, who was an administrative assistant at Ashe Manor, was working in the office on the morning of June 13, 2001. Ms. Redmond testified that, after being in the office all morning, she decided to take a break at approximately 1:00 p.m. Tammy Carpenter called her to Ms. Brown's room. Ms. Redmond testified that Ms. Brown was upset and said that she had been left in her room all day. Ms. Redmond had not been on the floor that day and had no personal observations about when Ms. Brown was put in her room or what care she had received while there. (T pp 89-92).

7. Ms. Redmond went back to the office to report to Judy Miller, the administrator, that Ms. Brown was upset and had reported that she had been in her room all day. Ms. Miller called a meeting that afternoon and told the staff that putting a resident in his or her room and leaving the resident there alone for more than a few minutes is abuse.

8. Petitioner testified that she only left Ms. Brown alone in her room for approximately twelve to fifteen minutes, but she also testified that she put Ms. Brown in her room at approximately 9:00 a.m. or 9:30 a.m. and that she took Ms. Brown out at approximately 10:15 a.m. to go to activities. (T pp 68, 91, 109; Resp Exh 1).

9. Ms. Brown testified that, though her time in the room may have been just a few minutes, it seemed like a long time to her. She testified that, as a result of being left alone in the room, she felt nervous. She did not report this to anyone because she was afraid the staff would hate her. She also testified that Petitioner was not mean to her. (T pp 12, 14, 18, 20).

10. It was the uncontradicted testimony of Ms. Steelman and Ms. Blevins that Ms. Brown went to activities at about 10:15 a.m. Ms. Steelman and Ms. Blevins also testified that Ms. Brown went to get a mammogram between 11:30 and noon, and ate lunch when she came back, at about one o'clock; however, this testimony was a bit confused and was less credible. Nevertheless, it is significant that no one, including Ms. Brown, Ms. Powell, or Ms. Redmond, testified that Ms. Brown missed morning activities or lunch. Lunch was normally served starting at 11:30 or noon. (T pp 79-82, 41-49, 89-103).

11. The strong preponderance of the evidence shows that Petitioner was in her room alone, with Petitioner checking on her, from about 9:00 or 9:30 to about 10:15. While it is possible she was there longer, there is no evidence of a longer stay except Ms. Redmond's hearsay testimony that Ms. Brown said she had been there "all morning" when Ms. Redmond went to her room at 1:00 p.m. on June 13, 2000. Ms. Brown did not make this claim or anything close to it when she testified in person before this court.

12. On June 15, 2001, Petitioner was interviewed by Trish Dawes of the Ashe County Department of Social Services. Petitioner told Ms. Dawes that she had put Ms. Brown in her room for about ten minutes because Ms. Brown was cursing another resident for coughing. Petitioner told Ms. Dawes that she did not shut the door. Petitioner could not tell Ms. Dawes what "confinement" means; she thought it meant "being good to somebody." (Resp Exh 2.).

13. Barbara Powell investigated and substantiated the allegation of abuse on behalf of Respondent. Ms. Powell interviewed Petitioner. During her interview, Petitioner admitted to Ms. Powell that, on the morning of June 13, 2000, she had put Ms. Brown into her room because she had cussed two other residents. Ms. Powell found that the resident, as a result of her physical handicaps, was not able to roll herself in the wheelchair and that the resident was, therefore, confined. Ms. Powell also found that the resident was upset. This finding, again, is supported by Ms. Brown's testimony as well as that of Ms. Redmond. Petitioner did not

CONTESTED CASE DECISIONS

tell Ms. Powell that she put Ms. Brown into her room for her own protection. Rather, Petitioner told Ms. Powell that she put Ms. Brown into her room because of her behavior. (T pp 95-97, 98, 102; Resp Exh 1).

14. By letter dated September 13, 2001, Respondent notified Petitioner that the Department had substantiated allegations of abuse against Petitioner and that the substantiated finding would be entered into the Health Care Personnel Registry. The letter also notified Petitioner of her right to contest the entry of the substantiated finding of abuse in the Health Care Personnel Registry.

15. Betty Redmond was a credible witness. She did not accuse Petitioner of anything but merely testified about her personal observations of being called to Ms. Brown's room at approximately 1:00 p.m. and seeing that Ms. Brown was upset. (T pp 89-91; Resp Exh 1).

Based upon the foregoing Findings of Fact, the undersigned Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter pursuant to Chapters 131E and 150B of the North Carolina General Statutes.

2. All parties have been correctly designated and there is no question as to misjoinder or nonjoinder.

3. The North Carolina Department of Health and Human Services, Division of Facility Services, Health Care Personnel Registry Section is required by N.C. Gen. Stat. § 131E-256 to maintain a Registry that contains the names of all health care personnel working in health care facilities who have a substantiated finding of resident abuse, resident neglect, misappropriation of resident property, misappropriation of facility property, diversion of resident drugs, diversion of facility drugs or fraud against a resident or the facility.

4. Ashe Manor, an adult care home, is a health care facility as defined in N.C. Gen. Stat. § 131E-256(b)(1).

5. As a personal care aide and a medications technician who provides hands-on care, Petitioner is subject to the provisions of N.C. Gen. Stat. § 131E-256.

6. "Abuse" is defined by 42 CFR Part 488.301 to mean: "the willful infliction of injury, unreasonable confinement, intimidation or punishment which results in physical harm, pain, or mental anguish." This definition is incorporated by reference in the definition of abuse found at 10 NCAC 3B.1001(1).

7. The definition is in two parts, the second dependent upon the first. The first part requires that there be willful infliction of one of four things: injury, unreasonable confinement, intimidation, or punishment.

8. North Carolina appellate courts have not yet interpreted this definition. The terms "injury", "unreasonable confinement", "intimidation" and "punishment" are not defined in the applicable State or Federal regulations.

9. It is the State's contention that the facts show that Petitioner abused Ms. Brown by subjecting her to "unreasonable confinement." *See* Exhibit 14; Tr. p 121.

10. "Confine" is defined variously: "1. To keep within bounds; restrict. 2. To shut within an enclosure; imprison. 3. To restrict in movement: *was confined to bed.*" The American Heritage Dictionary, 2d College Edition (1985) at 308 (italics in original).

11. Ms. Brown was naturally and unavoidably "confined" by her medical condition. Ms. Brown's difficulty in moving her wheelchair, combined with the fact that she was otherwise unable to ambulate, meant that she was essentially "confined" to whatever spot she found herself. This "confinement" was a function of her medical condition, not staff action. Since she was thus "confined" to the place she was at any given time, this "confinement" in itself cannot constitute unreasonable confinement on the part of staff. To hold otherwise would mean that Ms. Brown would be abused every time she was put to bed, moved into the lunch room, taken to the bathroom, and every other time she was put anywhere by staff.

12. The question, then, is whether the state of Ms. Brown's natural confinement became unreasonable by some action Petitioner took. The State argues that the confinement became unreasonable because Ms. Brown was in her room—which was by its nature a confined area, because she was alone in her room, because Ms. Brown protested being in her room, and because it had at least the appearance of punishment. Tr. pp 120-127.

CONTESTED CASE DECISIONS

13. “Unreasonable” is not defined by any of the applicable statutes or regulations. The dictionary definition is: “1. Not governed by reason. 2. Exceeding reasonable limits; immoderate.” “Reasonable” is defined, in pertinent part, as “2. Governed by or in accordance with reason or sound thinking. 3. Within the bounds of common sense: *arrive home at a reasonable time*. 4. Not excessive or extreme; fair.” The American Heritage Dictionary, 2d College Edition (1985) at 1324, 1031 (italics in original).

14. Moving Ms. Brown to her room, common sense tells us, is not unreasonable in itself. This was the space assigned to her at Ashe Manor. There was no evidence that it was sub par or uncomfortable in any way. There certainly are spaces that by their very nature would constitute unreasonable confinement—a broomcloset, for example, or a dark, windowless, confined space—but the patient’s own room is not one of those spaces. Neither is the fact that she was put in her room by herself unreasonable. People pay extra money to have private rooms in facilities like this, showing that to many, at least, the ability to be alone in one’s room is a privilege, not abuse. There was no showing of medical necessity—or adequate staffing levels—for a staff member to sit with each patient when the patient is alone in her room.

15. Ms. Brown’s protesting her location is more problematic. The evidence is that she told Petitioner she did not want to be in her room. She did not scream or holler in protest during the time she was in the room, but there was testimony that she was upset when Ms. Redmond went to her room at about 1:00 p.m. However, Ms. Brown was a person who often protested inappropriately—for example, at being bathed. Observing Ms. Brown’s protestations would have resulted in her neglect on at least some occasions. Therefore, the fact that she protested does not in itself mean that the treatment she was receiving was inappropriate or abusive. We know that she had been cussing other residents and Petitioner immediately before being moved; one would assume from that a cantankerous mood. It is more appropriate to look to the objective conditions under which Ms. Brown found herself, than to look to merely whether she protested.

16. Finally, the State urges that the character of this relocation to Ms. Brown’s room as punishment makes the confinement unreasonable. Petitioner steadfastly denies that Ms. Brown was moved as punishment, and Ms. Brown herself does not say it was punishment. Whatever semantics we play with the events in this case, it is clear that Ms. Brown was being separated from the residents she was cussing, and had been cussing for several minutes. Whether for her own protection, as Petitioner claims, or for the protection of the other residents, it seems manifest that separating the two groups was not only reasonable, but required to avoid emotional harm to the other residents. Moving Petitioner—the one with the inappropriate behavior—to her room, a familiar place of comfort, seems clearly reasonable and appropriate.

17. The second part of the definition, which comes into play only when the first part is satisfied, requires that physical harm, pain, or mental anguish result from the acts of the Petitioner. There is no allegation that either physical harm or pain resulted from Petitioner’s acts. That leaves the question whether “mental anguish” resulted from the words of Petitioner. This term is also not defined in the regulation. Our Supreme Court, in an exhaustive review of the law relating to recovery of damages for emotional distress or mental anguish, has provided guidance on what constitutes mental anguish in *Johnson v. Ruark Obstetrics and Gynecology Assoc.*, 327 N.C. 283, 395 S.E.2d 85 (1990). The Court first stated that “severe emotional distress” is equivalent in meaning to “mental anguish”. *Id.* at 304, 395 S.E.2d at 97. The Court stated what the terms do not mean: “mere temporary fright, disappointment or regret will not suffice.” *Id.* The Court then defined the terms:

‘severe emotional distress’ means any emotional or mental disorder, such as, for example, neurosis, psychosis, chronic depression, phobia, or any other type of **severe and disabling emotional or mental condition** which may be generally recognized and diagnosed by professionals trained to do so.

Id. (emphasis added).

18. No evidence was presented in this contested case that Ms. Brown suffered from any “severe and disabling emotional or mental condition” as a result of the acts of Petitioner. Accordingly, this Office is unable to find that any such condition resulted. Even if we were to assume that the appellate courts would apply some lighter standard to the definition for the current purposes, it seems safe to conclude that the Court’s statement would stand that “mere temporary fright, disappointment or regret will not suffice” to constitute mental anguish. The dictionary definition of “anguish” is “an agonizing physical or mental pain; torment.” The American Heritage Dictionary, 2d College Edition (1985) at 110. The testimony in this case establishes that Ms. Brown remembers being “nervous” in the room by herself, and that she was “upset” at the moment when Ms. Redmond went to her room. It is patent that this does not rise to the level of “agonizing mental pain.”

19. The acts of Petitioner do not constitute “unreasonable confinement.” Her acts might be found, though not clearly so, to be within the definition of “punishment.” However, the regulation additionally requires that the patient suffer physical harm, pain, or mental anguish as a result of the confinement or punishment. No evidence establishing the latter having been presented, this Office must find that Respondent erred in finding that “abuse” occurred on June 13, 2001.

20. It must be remembered that the purpose of this contested case is not to determine whether the exactly proper procedures were followed. Rather, the purpose of this contested case is first to determine whether Petitioner did what she was accused of; and,

CONTESTED CASE DECISIONS

second, to determine whether what she did constitutes “abuse” as defined in 42 CFR §488.301. This Office cannot find that Petitioner’s actions meet that statutory definition. That definition is properly drawn to include only very serious occurrences, since the result of falling under the definition is a no-second-chances, permanent black listing from the accused’s chosen profession.⁵

21. Respondent erred in substantiating the finding of abuse committed by the Petitioner.

DECISION

That the North Carolina Department of Health and Human Services, Division of Facility Services, Health Care Personnel Registry Section erred when it notified Petitioner of its intent to enter a substantiated finding of abuse by Petitioner in the Health Care Personnel Registry. The Section should purge the Registry of all references to Petitioner.

ORDER

It is hereby ordered that the agency serve a copy of the FINAL DECISION on the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, NC 27699-6714, in accordance with N.C. Gen. Stat. § 150B-36(b).

NOTICE

The decision of the Administrative Law Judge in this contested case will be reviewed by the agency making the final decision according to the standards found in G.S. 150B-36(b)(b1) and (b2). The agency making the final decision is required to give each party an opportunity to file exceptions to the decision of the Administrative Law Judge and to present written argument to those in the agency who will make the final decision. G.S. 150B-36(a).

The Agency that will make the final decision in this contested case is the North Carolina Department of Health and Human Services, Division of Facility Services.

This the 12th day of March, 2002.

James L. Conner, II
Administrative Law Judge

¹ 42 CFR §483.156(c)(1)(iv)(D) requires that the listing be permanent.

STATE OF NORTH CAROLINA

COUNTY OF ROWAN

**IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
01 EHR 1536**

CLYDE HARKEY, SR., Petitioner,)	
)	
)	
)	
v.)	DECISION
)	
N.C. DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES, DIVISION OF WASTE MANAGEMENT, Respondent.)	
)	

This contested case was heard before Chief Administrative Law Judge Julian Mann, III, on January 28, 2002, in High Point, North Carolina. Petitioner Clyde Harkey, Sr. was represented by John D. Greene of Eisele Ashburn Greene & Chapman, PA, Attorneys at Law. Respondent North Carolina Department of Environment and Natural Resources, Division of Waste Management, was represented by Assistant Attorney General William W. Stewart, Jr.

ISSUE

Did Respondent erroneously determine that Petitioner is an operator within the meaning of the North Carolina underground storage tank (hereinafter "UST") statutes and regulations when Respondent assessed against Petitioner a civil penalty and investigative costs in the total amount of \$7,314.08 for failure to assess the excavation zone of a previously closed UST system pursuant to 15A N.C.A.C. 2N .0804?

WITNESSES

For Petitioner:

1. Clyde Harkey, Sr.

For Respondent:

1. Dan Graham
2. Robert Hodge
3. Ruth Strauss

EXHIBITS RECEIVED INTO EVIDENCE

For Petitioner:

None

For Respondent:

1. August 17, 2001 Assessment of Civil Penalty
2. August 17, 2001 Incident Management Penalty Matrix Worksheet
3. August 17, 2001 DWM Civil Penalty Assessment Worksheet
4. Preliminary ENR/DWQ Laboratory Volatile Analytical Report
5. October 22, 2000 Handwritten Notes
6. October 27, 2000 letter to Mary Powell requesting affidavit
7. November 2, 2000 letter to Robert D. Cline requesting affidavit
8. November 2, 2000 letter to Clyde Harkey, Sr. requesting affidavit
9. November 8, 2000 ENR/DWQ Laboratory Volatile Analytical Report
10. November 13, 2000 Drinking Water Health Risk Evaluation
11. Affidavit of Robert D. Cline
12. Affidavit of Mary Margaret Steele aka Mary Powell
13. Affidavit of Clyde Harkey, Sr.

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14. November 22, 2000 Handwritten Notes of Telephone Conversation
15. November 27, 2000 Notice of Regulatory Requirements
16. December 11, 2000 Notice of Regulatory Requirements
17. State Trust Fund Eligibility Application Form from Robert D. Cline
18. January 18, 2001 Notice of Violation
19. February 5, 2001 Request for Financial Information
20. March 22, 2001 Recommendation for Enforcement Action letter
21. Exhibit Number 21 was voluntarily withdrawn by Respondent.
22. June 11, 2001 Notice of Continuing Violation
23. June 19, 2001 Notice of Violation
24. June 20, 2001 letter enclosing financial information
25. June 27, 2001 Memo with enclosed financial information
26. July 17, 2001 Memo regarding review of financial information
27. July 20, 2001 letter from Dan Graham to Clyde Harkey regarding financial information
28. UST Notification Form dated April 14, 1986
29. License to engage in business of gasoline dated June 17, 1988

STIPULATIONS

The parties filed an Order on Final Pre-Trial Conference prior to the contested case hearing on January 21, 2002 and the stipulations contained therein are part of the record.

Based upon the stipulations of record and the greater weight of the admissible evidence, the undersigned makes the following:

FINDINGS OF FACT

1. The parties stipulated that the sole issue to be tried in this contested case is whether Petitioner is the operator at relevant times of the three UST systems formerly located upon the property known as Mary Powell Property, 11330 Hwy. 801, Mt. Ulla, Rowan County, North Carolina (hereinafter "the Site"). (Order on Final Pre-Trial Conference ¶ 5.a.)

2. The parties also stipulated that the Findings and Decision and Assessment of Civil Penalties issued against Petitioner on August 17, 2001, is not contested except for the finding of fact listed in paragraph B which found that Petitioner is the operator of three petroleum UST systems formerly located at the Site. (Order on Final Pre-Trial Conference ¶ 5.b.; Response to Request for Admission No. 18)

3. Petitioner is a resident of Rowan County and is an individual who leased and operated a convenience store located at the Site from about 1976 until 1988. (T pp. 89, 110, 111, 115; Response to Request for Admission No. 1)

4. Respondent is an agency of the State of North Carolina, established pursuant to N.C. Gen. Stat. § 143B-275 *et seq.* and vested with the statutory authority to enforce the State's environmental pollution laws, including laws enacted to regulate underground storage tank systems and to protect the groundwater quality of the State.

5. Mary Margaret Steele also known as Mary Powell (hereinafter "Ms. Powell") is the record owner of the real estate and building at the Site. (T pp. 89, 111, 112) Petitioner leased the building at the Site from Ms. Powell from approximately 1976 to 1988. (T pp. 111, 112)

6. The three UST Systems located at the Site were removed prior to December 22, 1988. (Resp. Exh. 17)

7. On November 8, 2000, the Division of Waste Management (hereinafter "DWM") received confirmation that a water supply well located at 11260 Highway 801, Mt. Ulla, North Carolina, was contaminated with petroleum constituents. (Resp. Exhs. 1, 9) Analytical results indicate benzene levels in the water supply well exceeding the standard set forth in the 15A N.C.A.C. 2L rules. (Resp. Exh. 9)

8. The DWM thereafter mailed numerous documents to Petitioner, as DWM determined that Petitioner was an operator within the meaning of the UST statutes and regulations.

9. On November 27, 2000, the DWM sent Petitioner by certified mail a Notice of Regulatory Requirements (hereinafter "NORR") stating that the excavation zone must be assessed for the presence of contamination. (Resp. Exhs. 1, 15) In this NORR, the DWM stated that it considered Petitioner to be an operator of the former UST systems at the Site. (Resp. Exh. 15) This

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NORR was received by Petitioner on December 21, 2000. (Resp. Exhs. 1, 15) This NORR established a January 15, 2001, due date for submittal of the results of the site check. (Resp. Exhs. 1, 15)

10. On December 11, 2000, the DWM sent Petitioner by certified mail another NORR stating again that it considered Petitioner to be an operator of the former UST systems at the Site and requesting Petitioner to take certain action under the 15A N.C.A.C. 2L rules. (Resp. Exh. 16) This NORR was received by Petitioner on December 14, 2000. (Resp. Exh. 16)

11. On January 18, 2001, the DWM sent Petitioner by certified mail a Notice of Violation (hereinafter "NOV") stating that the results of the site check had not been received by the due date established in the November 27, 2000 NORR. (Resp. Exhs. 1, 18) This NOV was received by Petitioner on January 24, 2001. (Resp. Exhs. 1, 18)

12. On February 5, 2001, the DWM sent Petitioner by certified mail a Request for Financial Information. (Resp. Exhs. 1, 19) This financial request established a March 19, 2001 due date for the submittal of the requested financial information. (Resp. Exhs. 1, 19) This financial request was received by Petitioner on February 15, 2001. (Resp. Exhs. 1, 19)

13. On March 22, 2001, Petitioner was sent by certified mail a letter notifying him of potential enforcement action. (Resp. Exh. 20) This letter was received by Petitioner on March 29, 2001. (Resp. Exh. 20)

14. On June 11, 2001, the DWM sent Petitioner by certified mail a Notice of Continuing Violation. (Resp. Exh. 22) This Notice was received by Petitioner on June 13, 2001. (Resp. Exh. 22)

15. On June 19, 2001, the DWM sent Petitioner by certified mail a NOV stating that he is in violation of 15A N.C.A.C. 2N .0804 by failing to assess the excavation zone of a previously closed UST system. (Resp. Exhs. 1, 23) The NOV was received by Petitioner on June 25, 2001. (Resp. Exhs. 1, 23) It specifically extended the deadline for submission of the results of the site assessment to July 5, 2001. (Resp. Exhs. 1, 23)

16. On August 17, 2001, Respondent issued a civil penalty assessment against the Petitioner. (Resp. Exh. 1) The penalty consisted of \$7,000.00 for failure to assess the excavation zone of a previously closed UST system in accordance with 15A N.C.A.C. 2N .0804 for the period of time from June 25, 2001 through August 8, 2001. (Resp. Exh. 1) Respondent also assessed investigative costs in the amount of \$314.08. (Resp. Exh. 1) The civil penalty and investigative costs total \$7,314.08. (Resp. Exh. 1)

17. Mr. Daniel Graham is employed as a Hydro Geologist II with the Mooresville Regional Office of the UST Section, DWM, Department of Environment and Natural Resources. (T pp. 29-30) One of Mr. Graham's duties is to determine which persons are considered operators within the UST regulations. (T p. 30)

18. Mr. Graham requested affidavits from certain persons to assist him in determining the responsible parties for the Site. (T p. 40) Requesting such affidavits from persons with knowledge about a site is in accordance with the normal procedure of the Respondent to aid it in its determination of responsible parties. (T p. 40)

19. In an affidavit submitted to the Respondent by Robert Cline on behalf of Cline Oil Company, Inc., Cline Oil Company, Inc. states that it was never the operator of the USTs at the Site. (Resp. Exh. 11; T p. 44) Cline Oil Company, Inc. states that it was the supplier of the product placed in the USTs. (Resp. Exh. 11; T p. 44)

20. In an affidavit submitted to the Respondent by the landowner, Ms. Powell, she states that she believes that the USTs were last used by Clyde Harkey in the summer of 1987. (Resp. Exh. 12; T p. 50)

21. In an affidavit submitted by Petitioner on or about November 21, 2000, Petitioner denied operating the USTs at the Site. (Resp. Exh. 13; T p. 51) Mr. Graham telephoned Petitioner on November 27, 2000, to question him about his affidavit, because in a telephone conversation on October 1, 2000, Petitioner told Mr. Graham that he was the operator of the USTs at the Site. (T pp. 51-52) Petitioner again admitted that he was the operator of the USTs during their November 27, 2000 telephone conversation. (Resp. Exh. 14; T pp. 51-53) Petitioner gave him permission in their November 27, 2000 telephone conversation to change his affidavit to reflect that he was the operator of the USTs. (Resp. Exhs. 13, 14; T p. 53) Mr. Graham then changed Petitioner's affidavit to reflect that he was the operator of the USTs. (Resp. Exhs. 13, 14; T pp. 52-53) Mr. Graham did not define the term "operator" during his telephone conversation with Petitioner on November 27, 2000. (T p. 69) Mr. Graham did not explain any of the legal ramifications of Petitioner being declared an operator of the USTs during their telephone conversation on November 27, 2000. (T p. 69) Mr. Graham made notes during the November 27, 2000 telephone conversation with Petitioner. (Resp. Exh. 14; T pp. 52-53)

22. Mr. Graham received a State Trust Fund Application from Robert Cline on behalf of B & M Investments, Inc. (formerly Cline Oil Company, Inc.) on or about January 9, 2001. (Resp. Exh. 17; T pp. 54-55) In the State Trust Fund Application, Mr. Cline lists Petitioner as the operator of the USTs at the Site. (Resp. Exh. 17; T p. 55)

CONTESTED CASE DECISIONS

23. Robert Cline on behalf of Cline Oil Company, Inc. submitted a UST-8 form to Respondent. (Resp. Exh. 28; T pp. 56-57) The UST-8 form lists Gene Parker as the contact person at the tank location. (Resp. Exh. 28; T p. 72) Gene Parker was an employee of Petitioner. (T pp. 57, 104, 112)

24. A Rowan County privilege license was issued to Petitioner by Rowan County to “engage in the business or practice[,] the trade or profession of gasoline.” (Resp. Exh. 29; T p. 58) The privilege license was issued to cover the time-period from July 1, 1988 to June 30, 1989. (Resp. Exh. 29)

25. Mr. Graham’s review of Petitioner’s Response to Respondent’s First Request for Admissions supports the decision that Petitioner is an operator of the USTs at the Site. (T pp. 59-61) Mr. Graham pointed to the following admissions made by Petitioner as supporting his view that Petitioner is an operator of the USTs at the Site: (1) Petitioner turned the pumps on and off daily at the Site; (2) Petitioner received payment for the sale of gasoline; and (3) the supplier Cline Oil Company, Inc. did not have a representative on site everyday during the hours that gasoline was sold at the Site. (T pp. 59-61, 68)

26 The pumps have to be turned on for the USTs to properly operate. (T p. 59-60)

27. Two documents, both Notices of Regulatory Requirements were sent to Petitioner by certified mail on November 27, 2000 and December 11, 2000. (T pp. 61-63; Resp. Exhs. 15, 16) In both documents, Petitioner was informed that he was determined to be an operator of the USTs at the Site. (T pp. 61-63; Resp. Exhs. 15, 16) Petitioner did not respond to either of these documents. (T pp. 61-63; Resp. Exhs. 15, 16)

28. An employee of Petitioner stuck the tanks and put “Out of Order” signs on the dispensers if they ran out of gas. (T pp. 57, 71-72)

29. Mr. Robert Hodge lived directly across the street from the Site prior to July 1990. (T p. 74) Since July 1990, Mr. Hodge has lived next-door to the Site. (T pp. 73-74) Mr. Hodge has known Petitioner for 25 years. (T p. 74)

30. Mr. Hodge bought gas from Petitioner’s store at the Site from 1979 until December 1988. (T p. 75) Mr. Hodge testified that he bought gas “probably thousands” of times from Petitioner. (T p. 75) Mr. Hodge testified that he would pay Gene Parker when he bought gas at Petitioner’s store. (T p. 75)

31. Mr. Hodge observed Gene Parker placing “Out of Order” or “Out of Gas” signs on the dispensers at the Site. (T pp. 76-77)

32. Mr. Hodge observed Gene Parker “sticking the tanks” at the Site numerous times, probably 50 times. (T pp. 76-77)

33. Mr. Hodge found the privilege license (Respondent’s Exhibit Number 29) in his yard with a handful of documents that appeared to come out of the back of the old store building at the Site. (T pp. 77-78)

34. Ms. Ruth Strauss currently is the head of the Permits & Inspections Branch (formerly Compliance Branch) of the UST Section, DWM. (T p. 81) Ms. Strauss assessed the penalty in question. (T pp. 81-82)

35. Ms. Strauss noted that Petitioner or his employee turned the pumps on and off; that Petitioner or his employee received cash from the sale of gasoline; and that Petitioner was in the business of distributing or basically selling gasoline. (T pp. 85-86)

36. Petitioner paid rent to Ms. Powell on a monthly basis for the lease of the premises and real estate. (T pp. 92, 101, 112) Petitioner made this payment monthly with a check. (T p. 112) Petitioner and Ms. Powell did not have a written lease. (T pp. 92, 112)

37. Petitioner acknowledged that Gene Parker was his employee. (T pp. 57, 104, 112) Gene Parker was the manager of the store at the Site, and was at the Site “most of the time.” (T pp. 100, 112)

38. Petitioner described in detail his business relationship with Cline Oil Company, Inc. Cline Oil Company, Inc. would deliver gasoline every Thursday to the Site. (T pp. 90-91) If Petitioner ran out of gasoline before the next Thursday, either Petitioner or Gene Parker would contact Cline Oil Company, Inc. to inform it that the store was out of gasoline. (T pp. 90, 93, 106) Petitioner paid Cline Oil Company, Inc. for the fuel that was dispensed from the UST systems at the Site. (T pp. 91, 102, 113) Petitioner paid Cline Oil Company, Inc. on a weekly basis when the fuel was delivered by Cline Oil Company, Inc. (T p. 116) Cline Oil Company, Inc. would submit a bill to Petitioner for the fuel and Petitioner would write a check to Cline Oil Company, Inc. (T p. 116) Cline Oil Company, Inc. would determine how much to charge Petitioner and how much fuel to put in the tanks by reading the meter and

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determining how many gallons of gasoline had been sold. (T pp. 113-114) Petitioner then would be charged per gallon. (T p. 114) Petitioner testified that, as far as he knows, this is a fairly normal way for convenience stores to be operated. (T pp. 114-115)

39. Petitioner testified that, if he had not paid Cline Oil Company, Inc. for the fuel, he would not have expected Cline Oil Company, Inc. to deliver any more fuel. (T pp. 116-117)

40. Petitioner made a profit from the sale of gasoline at the Site. (T p. 114) The profit was determined by the difference between the amount that Petitioner charged customers and the amount that Petitioner paid Cline Oil Company, Inc. for the fuel. (T p. 114)

41. Petitioner used the gas equipment for a profit. (T pp. 105)

42. Cline Oil Company, Inc. did not operate the store at the Site. (T p. 101) Cline Oil Company, Inc. did not dictate to Petitioner what hours he could operate the store, and did not tell him not to sell gasoline to certain people. (T p. 101) Petitioner was in charge of “collecting [money] for the gas.” (T p. 105)

43. While Petitioner’s employees did not stick the tanks on a regular basis, Petitioner admitted that his employees would stick the tanks if something happened to the pumps or to determine whether they had run out of fuel. (T pp. 94, 98, 101, 107) Petitioner testified that, as far as he knew, his employee, Gene Parker, did stick the tanks. (T pp. 97-98) However, Petitioner again stated that “we never stuck them on a regular basis.” (T p. 98)

44. When Petitioner or his employees would discover that there was either a problem with the tanks, a problem with the pumps, or that the tanks were out of fuel, he or his employees would call Robert Cline of Cline Oil Company, Inc. (T pp. 94, 104, 107)

45. Petitioner or his employees were responsible for relaying customer complaints about the gasoline to Cline Oil Company, Inc. (T p. 103)

46. If the UST system needed to be repaired, either Petitioner or one of his employees would call Cline Oil Company, Inc. to repair the system. (T p. 117)

47. If there was a spill of gasoline on the Site, Gene Parker would call either Petitioner or Robert Cline of Cline Oil Company, Inc. to report the spill. (T pp. 103-104) If Gene Parker called the Petitioner to report a spill, Petitioner would then attempt to get in contact with Robert Cline. (T p. 103)

48. Either Petitioner or his employees turned the pumps on and off. (T pp. 97, 104) A person could not pump gasoline without the pumps being turned on. (T p. 104) Gasoline can not move out of a UST System without the pumps being turned on. (T p. 104) For gasoline to come out of the tank, the UST system has to be used. (T p. 106)

Based upon the foregoing Stipulations and Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings, and the Office has jurisdiction over the parties and the subject matter.

2. All parties have been correctly designated, and there is no question as to misjoinder or nonjoinder.

3. Petitioner is a “person” within the meaning of N.C. Gen. Stat. § 143-215.6A pursuant to N.C. Gen. Stat. § 143-212(4).

4. Pursuant to N.C. Gen. Stat. § 143-215.94A(8), “operator” means “any person in control of, or having responsibility for, the operation of an underground storage tank.”

5. The UST rules at 15A N.C.A.C. 2N and 2L have been adopted by the Environmental Management Commission pursuant to N.C. Gen. Stat. § 143-215.3(a)(15).

6. 15A N.C.A.C. 2N .0203 defines the term “operator” for the purpose of the 2N rules as “any person in control of, or having responsibility for, the daily operation of the UST system.”

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7. The North Carolina General Statutes and the 2N rules do not define the terms "control" or "responsibility." Accordingly, these terms must be accorded their plain meaning. See Perkins v. Arkansas Trucking Servs., Inc., 351 N.C. 634, 638, 528 S.E.2d 902, ¶4 (2000) (stating unless otherwise indicated, our legislature is presumed to have used words to convey their ordinary meaning) (citation omitted).

8. The ordinary definition of the term "control" not only includes the exercise of restraint or influence, but the power or authority to regulate or manage. See Iowa Comprehensive UST Fund Bd. v. Mobil Oil Corp., 606 N.W.2d 359, 364 (Iowa 2000); Black's Law Dictionary 329 (6th ed. 1990); Webster's New World Dictionary 309 (2d ed. 1974). Moreover, the term "responsibility" means both to be liable to account as the cause and to answer for conduct or obligations. Id. at 364; Black's Law Dictionary 1312 (6th ed. 1990); Webster's New World Dictionary 1211 (2d ed. 1974).

9. Petitioner is an "operator" of the subject UST systems at the Site pursuant to 15A N.C.A.C. 2N .0203 and N.C. Gen. Stat. § 143-215.94A(8). The facts establish that the Petitioner or his employee/agent performed the activities listed below, often routinely and daily, and these activities support the finding that Petitioner had control of, or responsibility for, the daily operation of the UST systems: (1) turning the pumps on and off; (2) informing Cline Oil Company, Inc. when the tanks were empty of gasoline before the regular delivery date so that gasoline could be added to the tanks; (3) paying Cline Oil Company, Inc. for the gasoline so that gasoline could be delivered to the Site; (4) determining the selling price for the gasoline; (5) being responsible for relaying customer complaints about the gasoline to Cline Oil Company, Inc.; (6) reporting problems with the gas, tanks, or pumps to Cline Oil Company, Inc.; (7) reporting spills of gasoline on the Site to Cline Oil Company, Inc.; (8) collecting money from the sale of gasoline; (9) utilizing the gasoline equipment; (10) profiting from the sale of the gasoline and the use of the tanks and pumps; (11) having the power and right to terminate the relationship with Cline Oil Company, Inc. for the supply of gasoline, to contract with competing suppliers, or to cease the retail sale of gasoline products altogether; (12) instructing employees to contact Cline Oil Company, Inc. with customer complaints; (13) sticking the tanks to determine if the pumps were working correctly or if the tanks were empty of gasoline; (14) leasing the premises and real estate which included the underground storage tanks and having exclusive dominion and control over the leased real estate and premises for the leased period; (15) having a privilege license to sell gasoline at the Site; (16) being the on-site person who maintained the immediate influence over the UST systems; (17) maintaining a high frequency of contact with the UST systems; and (18) having the exclusive authority to continue or terminate the daily use and operation of the UST system.

10. From the beginning of the time span relevant to this case, the activities referred to in the preceding paragraph are those activities routinely associated with the daily operations of a UST system. The "daily operation" is to be judged by the standard of time, because there were fewer activities that constituted "daily operation" before federal and state regulation of USTs. See Shell Oil Co. v. Meyer, 705 N.E.2d 962, 977 (Ind. 1998) (interpreting identical definition of operator); Iowa Comprehensive UST Fund Bd. v. Mobil Oil Corp., 606 N.W.2d 359, 367 (Iowa 2000) (same).

11. Petitioner contends he should not be held as the operator because of his limited control over the UST and its operation.* The North Carolina UST statutes and regulations do not require Respondent to find that an operator has control or responsibility for a UST system for a particular purpose. The North Carolina UST statutes and regulations do not require that an operator have control or responsibility for all daily operations of the UST system or that there be only one operator. Under the circumstances presented herein, it is sufficient that Petitioner engaged in the factors outlined in Paragraph 9 of the Conclusions of Law to find that he assumed "having control of" or "having responsibility for" the "daily operation of the underground storage tank." This conclusion is not affected by Petitioner's lack of ownership of the real property or the UST.

12. Because Petitioner is an operator within the meaning of the North Carolina UST statutes and regulations, Petitioner must comply with 15A N.C.A.C. 2N .0804. 15A N.C.A.C. 2N .0804 as incorporating 40 C.F.R. § 280.73 states in part:

When directed by the implementing agency, the owner and operator of an UST system permanently closed before December 22, 1998 must assess the excavation zone and close the UST system in accordance with this subpart if releases from the UST may, in the judgment of the implementing agency, pose a current or potential threat to human health and the environment.

13. The Petitioner violated 15A N.C.A.C. 2N .0804 by failing to assess the excavation zone of previously closed UST systems. This violation occurred from June 25, 2001, through at least August 8, 2001.

* The application of the law to Petitioner (and others similarly situated) may seem illogical to the Petitioner but the factors concluded herein are sufficient under a fair construction of the law to cause that application to this Petitioner.

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14. Respondent has the discretion and authority to assess a civil penalty against Petitioner in this matter pursuant to N.C. Gen. Stat. § 143-215.6A, which provides (as of the date of violation and assessment) that a civil penalty of not more than ten thousand dollars (\$10,000.00) per violation may be assessed against any person who fails to act in accordance with the applicable law and regulations. Each day that a violation continues may be considered a separate violation.

15. Respondent has authority to assess enforcement costs against Petitioner in this matter pursuant to N.C. Gen. Stat. § 143-215.3(a)(9) and N.C. Gen. Stat. § 143B-282.1(b)(8).

16. In determining the amount of the civil penalty, Respondent properly considered the factors set forth in N.C. Gen. Stat. § 143B-282.1, as required by N.C. Gen. Stat. § 143-215.6A. Specifically, Respondent properly assessed \$3,000.00 based upon its review of the degree and extent of harm. (Resp. Exhs. 2, 3) Respondent properly assessed \$500.00 based upon its review of the estimated cost to rectify the damage of not complying. (Resp. Exhs. 2, 3) Respondent properly assessed \$3,000.00 based upon the fact that Petitioner received at least four notices and did not comply with any of the notices. (Resp. Exhs. 2, 3) Respondent properly assessed \$500.00 based upon the duration of non-compliance with 15A N.C.A.C. 2N .0804 of nearly two months. (Resp. Exhs. 2, 3)

17. A \$7,000.00 civil penalty plus \$314.08 in investigative costs for the violation is reasonable and appropriate under the circumstances and is in accordance with the underground storage tank statutes and the rules promulgated thereunder. The \$7,314.08 totals less than two percent of the maximum allowable civil penalty.

18. In assessing this civil penalty, Respondent did not act or exercise its discretion erroneously.

DECISION

The Environmental Management Commission should issue a Final Decision adopting the decision to assess a civil penalty against the Petitioner and assess Petitioner the total amount of \$7,314.08 for his violation of 15A N.C.A.C. 2N .0804.

ORDER

It is hereby ordered that the Environmental Management Commission serve a copy of the final decision on the Office of Administrative Hearings, 6714 Mail Service Center, Raleigh, North Carolina 27699-6417 in accordance with N.C. Gen. Stat. § 150B-36(b3).

NOTICE

The Environmental Management Commission, the agency making the final decision in this contested case, is required to give each party an opportunity to file exceptions to this recommended decision and to present written arguments to those in the agency who will make the final decision. N.C. Gen. Stat. § 150B-36(a). This decision shall be reviewed in accordance with N.C. Gen. Stat. §150B-36(b)-(b3).

The Environmental Management Commission is required by N.C. Gen. Stat. § 150B-36(b) to serve a copy of the final decision on all parties and to the Office of Administrative Hearings.

This the 5th day of April, 2002.

Julian Mann, III
Chief Administrative Law Judge