



# **RULES OF THE NORTH CAROLINA MEDICAL BOARD**

FROM THE NORTH CAROLINA ADMINISTRATIVE CODE: TITLE 21  
OCCUPATIONAL LICENSING BOARDS

NORTH CAROLINA MEDICAL BOARD  
1203 FRONT STREET  
RALEIGH, NC 27609  
(919) 326-1100

DISCLAIMER: The most current modifications to the rules can be found at <http://www.oah.state.nc.us>

December 2012

## **SUBCHAPTER 32A - ORGANIZATION**

### **21 NCAC 32A .0101      LOCATION**

The location of the office of the North Carolina Medical Board is 1203 Front Street, Raleigh, North Carolina 27609.

*History Note:*      *Authority G.S. 90-2;*  
                         *Eff. February 1, 1976;*  
                         *Amended Eff. July 1, 2004; August 1, 2002; September 1, 1995; July 1, 1993; May 1, 1989.*

**21 NCAC 32A .0104      MEETINGS**

The Board customarily meets at regularly scheduled intervals as appropriate to carry out Board business. Other meetings may be called by the President of the Board or upon written request of the majority of the members of the Board.

*History Note:*      *Authority G.S. 90-5;*  
                         *Eff. February 1, 1976;*  
                         *Amended Eff. May 1, 1990; May 1, 1989.*

**21 NCAC 32A .0111      REQUEST FOR DECLARATORY RULING**

(a) All requests for declaratory rulings shall be written and mailed to the Board at 1203 Front Street, Raleigh, North Carolina 27609. The envelope containing the request shall bear the notation: "REQUEST FOR DECLARATORY RULING".

(b) Each Request for Declaratory Ruling must include the following information:

- (1) the name and address of the person requesting the ruling;
- (2) the statute or rule to which the request relates;
- (3) a concise statement of the manner in which the requesting person is affected by the statute or rule or its potential application to that person;
- (4) a statement whether an oral hearing is desired and, if so, the reason therefore.

*History Note:      Authority G.S. 150B-4;  
                             Eff. February 1, 2007.*

(a) Upon receipt of a Request for Declaratory Ruling, the Board shall determine whether a ruling is appropriate under the facts stated.

(c) The Board shall decline to issue a declaratory ruling where:

- History Note:* Authority G.S. 150B-4;  
Eff. February 1, 2007.

**21 NCAC 32A .0113      PROCEDURE FOR DECLARATORY RULING**

Prior to issuing a declaratory ruling, the Board shall give notice of the declaratory ruling proceedings to any person(s) it deems appropriate and shall direct that fact-finding proceedings appropriate to the circumstances of the particular request be conducted. The proceedings may consist of written submissions, an oral hearing, or other proceedings.

*History Note:*      *Authority G.S. 150B-4;*  
                         *Eff. February 1, 2007.*

**21 NCAC 32A .0114      SUSPENSION OF AUTHORITY TO EXPEND FUNDS**

In the event the Board's authority to expend funds is suspended pursuant to G.S. 93B-2(d), the Board shall continue to issue and renew licenses and all fees tendered shall be placed in an escrow account maintained by the Board for this purpose. Once the Board's authority is restored, the funds shall be moved from the escrow account into the general operating account.

*History note:      Authority G.S. 93B-2(d);  
Eff. March 1, 2011.*

## SUBCHAPTER 32B – LICENSE TO PRACTICE MEDICINE

## SECTION .1000 - PRESCRIBING

**21 NCAC 32B .1001      AUTHORITY TO PRESCRIBE**

(a) A license to practice medicine issued under this Subchapter allows the physician to prescribe medications, including controlled substances, so long as the physician complies with all state and federal laws and regulations governing the writing and issuance of prescriptions.

(b) A physician must possess a valid United States Drug Enforcement Administration ("DEA") registration in order for the physician to supervise any other health professional (physician assistant, nurse practitioner, clinical pharmacist practitioner) with prescriptive authority for controlled substances. The DEA registration of the supervising physician must include the same schedule(s) of controlled substances as the supervised health professional's DEA registration.

(c) A physician shall not prescribe controlled substances, as defined by the state and federal controlled substance acts for:

- (1) the physician's own use;
- (2) the use of the physician's immediate family;
- (3) the use of any other person living in the same residence as the licensee; or
- (4) the use of any person with whom the physician is having a sexual relationship.

As used in this Paragraph, "immediate family" means a spouse, parent, child, sibling, parent-in-law, son-in-law or daughter-in-law, brother-in-law or sister-in-law, step-parent, step-child, step-sibling.

*History Note: Authority G.S. 90-2(a); 90-5.1;  
Eff. June 1, 2007;  
Amended Eff. August 1, 2012.*



## SECTION .1300 - GENERAL

### 21 NCAC 32B .1301 DEFINITIONS

The following definitions apply to Rules within this Subchapter:

- (1) ABMS - American Board of Medical Specialties;
- (2) ACGME – Accreditation Council for Graduate Medical Education;
- (3) AMA – American Medical Association;
- (4) AMA Physician's Recognition Award – American Medical Association recognition of achievement by physicians who have voluntarily completed programs of continuing medical education;
- (5) AOA – American Osteopathic Association;
- (6) AOIA – American Osteopathic Information Association;
- (7) Area(s) of Practice – the medical or surgical specialty in which a physician or physician assistant has practiced or intends to practice;
- (8) Board –The North Carolina Medical Board;
- (9) CACMS – Committee for the Accreditation of Canadian Medical Schools;
- (10) CAQ – Certificate of Added Qualification conferred by a specialty board recognized by the ABMS, the AOA, CCFP, FRCP or FRCS;
- (11) CCFP – Certificant of the College of Family Physicians;
- (12) CFPC – College of Family Physicians of Canada;
- (13) COCA – Commission on Osteopathic Colleges Accreditation;
- (14) Core Competencies – patient care; medical knowledge; communication; practice-based learning; systems-based care; and professionalism as defined by the ACGME;
- (15) CME – Continuing Medical Education;
- (16) COMLEX – Comprehensive Osteopathic Medical Licensure Examination;
- (17) COMVEX – Comprehensive Osteopathic Medical Variable-Purpose Examination;
- (18) ECFMG – Educational Commission for Foreign Medical Graduates;
- (19) FCVS – Federation Credential Verification Service;
- (20) Fifth Pathway – an avenue for licensure as defined in the AMA's Council on Medical Education Report 1-I-07;
- (21) FLEX – Federation Licensing Examination;
- (22) FRCP – Fellowship of the Royal College of Physicians of Canada;
- (23) FRCS – Fellowship of the Royal College of Surgeons of Canada;
- (24) FSMB – Federation of State Medical Boards;
- (25) GME – Graduate Medical Education;
- (26) HIPDB – Healthcare Integrity and Protection Data Bank;
- (27) IMG – International Medical Graduate – a physician who has graduated from a medical or osteopathic school not approved by the LCME, the CACMS or COCA;
- (28) Intensity of Practice – the number of hours, the number of years and the responsibilities involved in a person's medical practice;
- (29) LCME – Liaison Commission on Medical Education;
- (30) LMCC – Licentiate of the Medical Council of Canada;
- (31) MCCQE – Medical Council of Canada Qualifying Examination;
- (32) Mentoring Physician – a licensed physician with no public disciplinary record in the last 10 years, who is certified by an American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA") or a board determined by the Medical Board to be equivalent to the ABMS or AOA and who practices in the same or similar area of practice into which the applicant for reentry is reentering. A mentoring physician must have had some experience as a medical educator or mentor, and shall have no conflicts of interest with the reentry applicant that would impair the mentoring physician's ability to provide an objective evaluation of the reentering licensee's competence;
- (33) NBME – National Board of Medical Examiners;
- (34) NBOME – National Board of Osteopathic Medical Examiners;
- (35) NPDB – National Practitioner Data Bank;
- (36) RCPSC – Royal College of Physicians and Surgeons of Canada;

- (37) Reentry Plan – an individualized program of assessment, education and re-assessment intended to confirm the competence to practice in an intended area of practice of an applicant for reentry;
- (38) Reentry Agreement – a public, non-disciplinary agreement which incorporates by reference the Reentry Plan;
- (39) Reentry Period – the duration of Reentry Plan;
- (40) SPEX – Special Purpose Examination; and
- (41) USMLE – United States Medical Licensing Examination.

*History Note: Authority G.S. 90-8.1; 90-14(a)(11a);  
Eff. August 1, 2010;  
Amended Eff. March 1, 2011.*

**21 NCAC 32B .1302      SCOPE OF PRACTICE UNDER PHYSICIAN LICENSE**

A physician holding a Physician License may practice medicine and perform surgery in North Carolina.

*History Note:      Authority G.S. 90-1.1;  
                         Eff. August 1, 2010.*

## **21 NCAC 32B .1303 APPLICATION FOR PHYSICIAN LICENSE**

(a) In order to obtain a Physician License, an applicant shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit a photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (3) submit documentation of a legal name change, if applicable;
- (4) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (5) submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education. The applicant's date of graduation from medical school shall be written in the designated space, and the school seal shall be stamped on the form; the dean or other official of the applicant's medical school shall sign this form, verifying the information;
- (6) for an applicant who has graduated from a medical or osteopathic school approved by the LCME, the CACMS or COCA, meet the requirements set forth in G.S. 90-9.1;
- (7) for an applicant graduating from a medical school not approved by the LCME, meet the requirements set forth in G.S. 90-9.2;
- (8) provide proof of passage of an examination testing general medical knowledge. In addition to the examinations set forth in G.S. 90-10.1 (a state board licensing examination; NBME; USMLE; FLEX, or their successors), the Board accepts the following examinations (or their successors) for licensure:
  - (A) COMLEX,
  - (B) NBOME, and
  - (C) MCCQE;
- (9) submit proof that the applicant has completed graduate medical education as required by G.S. 90-9.1 or 90-9.2, as follows:
  - (A) A graduate of a medical school approved by LCME, CACMS or COCA shall have satisfactorily completed at least one year of graduate medical education approved by ACGME, CFPC, RCPSC or AOA.
  - (B) A graduate of a medical school not approved by LCME shall have satisfactorily completed three years of graduate medical education approved by ACGME, CFPC, RCPSC or AOA.
  - (C) An applicant may satisfy the graduate medical education requirements of Parts (A) or (B) of this Subparagraph by showing proof of current certification by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA;
- (10) submit a FCVS profile:
  - (A) If the applicant is a graduate of a medical school approved by LCME, CACMS or COCA, and the applicant previously has completed a FCVS profile; or
  - (B) If the applicant is a graduate of a medical school other than those approved by LCME, COCA or CACMS;
- (11) if a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:
  - (A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or
  - (B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;
- (12) submit reports from all state medical or osteopathic boards from which the applicant has ever held a medical or osteopathic license, indicating the status of the applicant's license and whether or not any action has been taken against the licensee;
- (13) submit an AMA Physician Profile and, if applicant is an osteopathic physician, also submit an AOA Physician Profile;
- (14) if applying on the basis of the USMLE, submit:
  - (A) a transcript from the FSMB showing a score on USMLE Step 1, both portions of Step 2 (clinical knowledge and clinical skills) and Step 3; and

- (B) proof that the applicant has passed each step within three attempts. However, the Board shall waive this requirement if the applicant has been certified or recertified by an ABMS, CCFP, FRCP, FRCS or AOA approved specialty board within the past 10 years;
  - (15) if applying on the basis of COMLEX, submit:
    - (A) a transcript from the NBOME showing a score on COMLEX Level 1, both portions of Level 2 (cognitive evaluation and performance evaluation) and Level 3; and
    - (B) proof that the applicant has passed COMLEX within three attempts. However, the Board shall waive this requirement if the applicant has been certified or recertified by an ABMS, CCFP, FRCP, FRCS or AOA approved specialty board within the past 10 years;
  - (16) if applying on the basis of any other board-approved examination, submit a transcript showing a passing score;
  - (17) submit a NPDB / HIPDB report, dated within 60 days of submission of the application;
  - (18) submit a FSMB Board Action Data Report;
  - (19) submit two completed fingerprint record cards supplied by the Board;
  - (20) submit a signed consent form allowing a search of local, state, and national files for any criminal record;
  - (21) provide two original references from persons with no family or marital relationship to the applicant. These references must be:
    - (A) from physicians who have observed the applicant's work in a clinical environment within the past three years;
    - (B) on forms supplied by the Board;
    - (C) dated within six months of the submission of the application; and
    - (D) bearing the original signature of the writer;
  - (22) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check; and
  - (23) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.
- (b) In addition to the requirements of Paragraph (a) of this Rule, the applicant shall submit proof that the applicant has:
- (1) within the past 10 years taken and passed either:
    - (A) an exam listed in G.S. 90-10.1 (a state board licensing examination; NBOME; USMLE; COMLEX; or MCCQE or their successors;
    - (B) SPEX (with a score of 75 or higher); or
    - (C) COMVEX (with a score of 75 or higher);
  - (2) within the past 10 years obtained certification or recertification or CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA;
  - (3) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or
  - (4) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.
- (c) All reports must be submitted directly to the Board from the primary source, when possible.
- (d) An applicant shall appear in person for an interview with the Board or its agent, if the Board needs more information to complete the application.
- (e) An application must be completed within one year of submission. If not, the applicant shall be charged another application fee, plus the cost of another criminal background check.

*History note: Authority G.S. 90-8.1; 90-9.1; 90-9.2; 90-13.1;  
 Eff. August 1, 2010;  
 Amended Eff. January 1, 2012; November 1, 2011; October 1, 2011.*

## **21 NCAC 32B .1350 REINSTATEMENT OF PHYSICIAN LICENSE**

(a) Reinstatement is for a physician who has held a North Carolina License, but whose license either has been inactive for more than one year, or whose license became inactive as a result of disciplinary action (revocation or suspension) taken by the Board. It also applies to a physician who has surrendered a license prior to charges being filed by the Board.

(b) All applicants for reinstatement shall:

- (1) submit a completed application, attesting under oath that information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit documentation of a legal name change, if applicable;
- (3) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (4) If a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, shall furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:
  - (A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or
  - (B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;
- (5) submit reports from all state medical or osteopathic boards from which the applicant has ever held a medical or osteopathic license, indicating the status of the applicant's license and whether or not any action has been taken against the license;
- (6) submit the AMA Physician Profile; and, if applicant is an osteopathic physician, also submit the AOA Physician Profile;
- (7) submit a NPDB/HIPDB report dated within 60 days of the application's submission;
- (8) submit a FSMB Board Action Data Bank report;
- (9) submit documentation of CME obtained in the last three years, upon request;
- (10) submit two completed fingerprint cards supplied by the Board;
- (11) submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
- (12) provide two original references from persons with no family or material relationship to the applicant. These references must be:
  - (A) from physicians who have observed the applicant's work in a clinical environment within the past three years;
  - (B) on forms supplied by the Board;
  - (C) dated within six months of submission of the application; and
  - (D) bearing the original signature of the author;
- (13) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check; and
- (14) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) In addition to the requirements of Paragraph (b) of this Rule, the applicant shall submit proof that the applicant has:

- (1) within the past 10 years taken and passed either:
  - (A) an exam listed in G.S. 90-10.1 (a state board licensing examination; NBME; NBOME; USMLE; FLEX; COMLEX; or MCCQE or their successors);
  - (B) SPEX (with a score of 75 or higher); or
  - (C) COMVEX (with a score of 75 or higher);
- (2) within the past ten years obtained certification or recertification of CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA;
- (3) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or
- (4) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.

(d) All reports must be submitted directly to the Board from the primary source, when possible.

(e) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character, if the Board needs more information to complete the application.

(f) An application must be complete within one year of submission. If not, the applicant shall be charged another application fee, plus the cost of another criminal background check.

*History Note: Authority G.S. 90-8.1; 90-9.1; 90-10.1; 90-13.1;  
Eff. August 1, 2010;  
Amended Eff. November 1, 2011.*

## **21 NCAC 32B .1360      REACTIVATION OF PHYSICIAN LICENSE**

(a) Reactivation applies to a physician who has held a physician license in North Carolina, and whose license has been inactive for up to one year except as set out in Rule .1704(e) of this Subchapter. Reactivation is not available to a physician whose license became inactive either while under investigation by the Board or because of disciplinary action by the Board.

(b) In order to reactivate a Physician License, an applicant shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States; (Note: there may be some applicants who are not present in the US and who do not plan to practice physically in the US. Those applicants shall submit a statement to that effect);
- (3) submit a FSMB Board Action Data Bank report;
- (4) submit documentation of CME obtained in the last three years;
- (5) submit two completed fingerprint record cards supplied by the Board;
- (6) submit a signed consent form allowing search of local, state, and national files for any criminal record;
- (7) pay to the Board the relevant, non-refundable fee, plus the cost of a criminal background check; and
- (8) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(c) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

*History Note:*      *Authority G.S. 90-8.1; 90-9.1; 90-12.1A; 90-13.1; 90-14(a)(11a);  
Eff. August 1, 2010.*



## **21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE**

(a) A physician or physician assistant applicant ("applicant" or "licensee") who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for a license from the Board shall complete a reentry agreement as a condition of licensure.

(b) The applicant shall identify a mentoring physician.

(c) The applicant shall propose a reentry plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board. The Board shall review the proposed reentry plan and interview the applicant.

(d) Factors that may affect the length and scope of the reentry plan include:

- (1) The applicant's amount of time out of practice;
- (2) The applicant's prior intensity of practice;
- (3) The reason for the interruption in practice;
- (4) The applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;
- (5) The applicant's previous and intended area(s) of practice;
- (6) The skills required of the intended area(s) of practice;
- (7) The amount of change in the intended area(s) of practice over the time the applicant has been out of continuous practice;
- (8) The applicant's number of years of graduate medical education;
- (9) The number of years since completion of graduate medical education; and
- (10) As applicable, the date of the most recent ABMS, AOA or equivalent specialty board, or National Commission on Certification of Physician Assistant certification or recertification.

(e) If the Board approves an applicant's reentry plan, it shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board and the mentoring physician.

(f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a restricted License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.

(g) The first component of a reentry plan is an assessment of the applicant's current strengths and weaknesses in his or her intended area of practice. The process used to perform the assessment shall be described by the applicant and confirmed by the mentoring physician. The process may include self-reflection, self-assessment, and testing and evaluation by colleagues, educators or others. The applicant and mentoring physician shall evaluate and describe applicant's strengths and areas of needed improvement in regard to the core competencies. The assessment shall continue throughout the reentry period as the licensee and the mentoring physician practice together.

(h) The second component of the reentry plan is education. Education shall address the licensee's areas of needed improvement. Education shall consist of:

- (1) a reentry period of retraining and education under the guidance of a mentoring physician, upon terms as the Board may decide, or
- (2) a reentry period of retraining and education under the guidance of a mentoring physician consisting of the following:
  - (A) Phase I – The observation phase. During the observation phase, the licensee will not practice, but will observe the mentoring physician in practice.
  - (B) Phase II – Direct supervision phase. During the direct supervision phase, the licensee shall practice under the direct supervision of the mentoring physician. Guided by the core competencies, the mentoring physician shall reassess the licensee's progress in addressing identified areas of needed improvement.
  - (C) Phase III – Indirect supervision phase. During the indirect supervision phase, the licensee shall continue to practice with supervision of the mentoring physician. Guided by the core competencies, and using review of patient charts and regular meetings, the mentoring physician shall reassess the licensee's progress in addressing the areas of needed improvement.
  - (D) No later than 30 days after the end of phase I and II, the mentoring physician shall send a report to the Board regarding the licensee's level of achievement in each of the core competencies. At the completion of phase III the mentoring physician shall submit a summary report to the Board regarding the licensee's level of achievement in each of the core competencies and affirm the licensee's suitability to resume practice as a physician or to resume practice as a physician assistant.

(E) If the mentoring physician reassesses the licensee and concludes that the licensee requires an extended reentry period or if additional areas of needed improvement are identified during Phases II or III, the Board, the licensee and the mentoring physician shall amend the reentry agreement.

(i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring physician may terminate his role as the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The licensee's approval is not required for the mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may terminate the relationship with the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The mentoring physician's approval is not required for the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(k) The licensee shall meet with members of the Board at such dates, times and places as directed by the Board to discuss the licensee's transition back into practice and any other practice-related matters.

(l) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.

(m) If the Board determines the licensee has successfully completed the reentry plan, the Board shall terminate the reentry agreement and notify the licensee that the license is no longer restricted.

*History Note: Authority G.S. 90-8.1; 90-14(a)(11a);  
Eff. March 1, 2011.*

## **SECTION .1400 – RESIDENT’S TRAINING LICENSE**

### **21 NCAC 32B .1401      SCOPE OF PRACTICE UNDER RESIDENT'S TRAINING LICENSE**

A physician holding a limited license to practice in a medical education and training program may practice only within the confines of that program and under the supervision of its director.

*History Note:      Authority G.S. 90-12.01;  
Eff. August 1, 2010.*

**21 NCAC 32B .1402      APPLICATION FOR RESIDENT'S TRAINING LICENSE**

(a) In order to obtain a Resident's Training License, an applicant shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit documentation of a legal name change, if applicable;
- (3) submit a photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (4) submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education. The applicant's date of graduation from medical school shall be written in the designated space, and the school seal shall be stamped on the form; the dean or other official of the applicant's medical school shall sign the form verifying the information;
- (5) If a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:
  - (A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or
  - (B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;
- (6) submit an appointment letter from the program director of the GME program or his appointed agent verifying the applicant's appointment and commencement date;
- (7) submit two completed fingerprint record cards supplied by the Board;
- (8) submit a signed consent form allowing a search of local, state, and national files for any criminal record;
- (9) pay a non-refundable fee pursuant to G.S. 90-13.1(b), plus the cost of a criminal background check;
- (10) provide proof that the applicant has taken and passed:
  - (A) the COMLEX Level 1 within three attempts and each component of COMLEX Level 2 (cognitive evaluation and performance evaluation) within three attempts; or
  - (B) the USMLE Step 1 within three attempts and each component of the USMLE Step 2 (Clinical Knowledge and Clinical Skills) within three attempts; and
- (11) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(b) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character, if the Board needs more information to complete the application.

*History Note:      Authority G.S. 90-8.1; 90-12.01; 90-13.1;  
Eff. August 1, 2010;  
Amended Eff. August 1, 2012; November 1, 2011.*

## **SECTION .1500 – FACULTY LICENSE**

### **21 NCAC 32B .1501      SCOPE OF PRACTICE UNDER MEDICAL SCHOOL FACULTY LICENSE**

A physician holding a Medical School Faculty License may practice only within the confines of the medical school or its affiliates. "Affiliates" means the primary medical school hospital(s) and clinic(s), as designated by the ACGME.

*History Note:*      *Authority G.S. 90-12.3;*  
                             *Eff. March 1, 2011.*

## **21 NCAC 32B .1502      APPLICATION FOR MEDICAL SCHOOL FACULTY LICENSE**

(a) The Medical School Faculty License is limited to physicians who have expertise which can be used to help educate North Carolina medical students, post-graduate residents and fellows but who do not meet the requirements for Physician licensure.

(b) In order to obtain a Medical School Faculty License, an applicant shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit the Board's form, signed by the Dean or his appointed representative, indicating that the applicant has received full-time appointment as either a lecturer, assistant professor, associate professor, or full professor at a medical school in the state of North Carolina;
- (3) submit documentation of a legal name change, if applicable;
- (4) submit a photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public as a true likeness of the applicant;
- (5) submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education. The applicant's date of graduation from medical school shall be written in the designated space, and the school seal shall be stamped on the form; the dean or other official of the applicant's medical school shall sign this form, verifying the information;
- (6) supply a certified copy of applicant's birth certificate or a certified copy of a valid and unexpired US passport if the applicant was born in the United States. If the applicant does not possess proof of US citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (7) submit proof of satisfactory completion of at least one year of GME approved by ACGME, CFPC, RCPSC, or AOA; or evidence of other education, training or experience, determined by the Board to be equivalent;
- (8) submit reports from all medical or osteopathic boards from which the applicant has ever held a medical or osteopathic license, indicating the status of the applicant's license and whether or not any action has been taken against the license;
- (9) submit an AMA Physician Profile; and, if applicant is an osteopathic physician, submit an AOA Physician Profile;
- (10) submit a NPDB report, HIPDB report, dated within 60 days of applicant's oath;
- (11) submit a FSMB Board Action Data Bank report;
- (12) submit two completed fingerprint record cards supplied by the Board;
- (13) submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
- (14) provide two original references from persons with no family or marital relationship to the applicant. These letters must be:
  - (A) from physicians who have observed the applicant's work in a clinical environment within the past three years;
  - (B) on forms supplied by the Board;
  - (C) dated within six months of the applicant's oath; and
  - (D) bearing the original signature of the writer.
- (15) pay to the Board a non-refundable fee of three hundred fifty dollars (\$350.00), plus the cost of a criminal background check; and
- (16) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(c) All reports must be submitted directly to the Board from the primary source, when possible.

(d) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(e) An application must be completed within one year of the date of the applicant's oath.

(f) This Rule applies to licenses granted after the effective date of this Rule.

*History Note:*      *Authority G.S. 90-12.3; 90-13.2;*  
                             *Eff. June 28, 2011.*

## **SECTION .1600 – SPECIAL PURPOSE LICENSE**

### **21 NCAC 32B .1601      SCOPE OF PRACTICE UNDER SPECIAL PURPOSE LICENSE**

The Board may limit the physician's scope of practice under a Special Purpose License by geography, term, practice setting, and type of practice.

*History Note:*      *Authority G.S. 90-12.2A;*  
                             *Eff. August 1, 2010.*

## **21 NCAC 32B .1602 SPECIAL PURPOSE LICENSE – VISITING INSTRUCTOR**

(a) The Special Purpose License is for physicians who wish to come to North Carolina for a limited time, scope and purpose, such as to demonstrate a new technique, procedure or piece of equipment, or to educate physicians or medical students in an emerging disease or public health issue.

(b) In order to obtain a Special Purpose License, an applicant shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (3) submit documentation of a legal name change, if applicable;
- (4) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport.. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (5) comply with all requirements of G.S. 90-12.2A;
- (6) submit the Board's form, completed by the mentor, showing that the applicant has received an invitation from a medical school, medical practice, hospital, clinic or physician licensed in the state of North Carolina, outlining the need for the applicant to receive a special purpose license and describing the circumstances and timeline under which the applicant will practice medicine in North Carolina;
- (7) submit an AMA Physician Profile and, if applicant is an osteopathic physician, also submit AOA Physician Profile;
- (8) submit an FSMB Board Action Data Bank report;
- (9) submit two completed fingerprint record cards supplied by the Board;
- (10) submit a signed consent form allowing a search of local, state, and national files for any criminal record;
- (11) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check;
- (12) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(c) All reports must be submitted directly to the Board from the primary source, when possible.

(d) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(e) An application must be completed within one year of submission. If not, the applicant shall be charged another application fee, plus the cost of another criminal background check.

*History Note: Authority G.S. 90-8.1; 90-9.1; 90-12.2A; 90-13.1;  
Eff. August 1, 2010.*



## **SECTION .1700 – OTHER LICENSES**

### **21 NCAC 32B .1701      SCOPE OF PRACTICE UNDER MILITARY LIMITED VOLUNTEER LICENSE**

The holder of a Military Limited Volunteer License may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients, and may not receive any compensation for services rendered, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services.

*History Note:*      *Authority G.S. 90-8.1; 90-12.1A;*  
                         *Eff. August 1, 2010.*

**21 NCAC 32B .1702      APPLICATION FOR MILITARY LIMITED VOLUNTEER LICENSE**

(a) The Military Limited Volunteer License is available to physicians working in the armed services or Veterans Administration who are not licensed in North Carolina, but who wish to volunteer at civilian indigent clinics.

(b) In order to obtain a Military Limited Volunteer License, an applicant shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (3) submit documentation of a legal name change, if applicable;
- (4) submit proof of an active license from a state medical or osteopathic board indicating the status of the license and whether or not any action has been taken against the license;
- (5) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport.. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (6) provide proof that the application is authorized to treat personnel enlisted in the United States armed services or veterans by submitting a letter signed by the applicant's commanding officer;
- (7) submit a FSMB Board Action Data Bank report;
- (8) submit two completed fingerprint record cards supplied by the Board;
- (9) submit a signed consent form allowing a search of local, state, and national files for any criminal record;
- (10) pay a non-refundable fee to cover the cost of a criminal background check;
- (11) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(c) All reports must be submitted directly to the Board from the primary source, when possible.

(d) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(e) An application must be completed within one year of the date of submission.

*History Note:      Authority G.S. 90-8.1; 90-12.1A;  
Eff. August 1, 2010.*

**21 NCAC 32B .1703      SCOPE OF PRACTICE UNDER RETIRED LIMITED VOLUNTEER LICENSE**

The holder of a Retired Limited Volunteer License may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients, and may not receive any compensation for services rendered, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services.

*History Note:*      *Authority G.S. 90-8.1; 90-12.1A;*  
                         *Eff. August 1, 2010.*

## **21 NCAC 32B .1704      APPLICATION FOR RETIRED LIMITED VOLUNTEER LICENSE**

(a) The Retired Limited Volunteer License is available to physicians who have been licensed in North Carolina or another state or jurisdiction, but who wish to volunteer at civilian indigent clinics.

(b) In order to obtain a Retired Limited Volunteer License, an applicant who holds an active license in another state or jurisdiction shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (3) submit documentation of a legal name change, if applicable;
- (4) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (5) submit proof of an active license from another state medical or osteopathic board indicating the status of the license and whether or not any action has been taken against it;
- (6) submit two completed fingerprint record cards supplied by the Board;
- (7) submit a signed consent form allowing a search of local, state and national files for any criminal record;
- (8) pay a non-refundable fee to cover the cost of a criminal background check;
- (9) submit a FSMB Board Action Data Bank report;
- (10) submit documentation of CME obtained in the last three years;
- (11) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.
- (12) All materials must be submitted to the Board from the primary source, when possible.

(c) An applicant who holds an active North Carolina physician license may convert that to a Retired Limited Volunteer License by completing the Board's form.

(d) An applicant who has been licensed in North Carolina but has been inactive less than six months may convert that to a Retired Limited Volunteer License by completing the Board's license renewal questions.

(e) An applicant who has been licensed in North Carolina but who has been inactive for more than six months but less than two years must use the reactivation process set forth in 21 NCAC 32B .1360. An applicant who does not have a North Carolina license, but has an inactive license to practice medicine and surgery in another state or jurisdiction, and who has been inactive for more than six months but less than two years must comply with the requirements for reactivation of physician license under 21 NCAC 32B .1360.

(f) A physician who has been inactive for more than two years will be required to complete a reentry program.

(g) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(h) An application must be completed within one year of the date of submission.

*History Note:      Authority G.S. 90-8.1; 90-12.1A;  
                             Eff. August 1, 2010.*

**21 NCAC 32B .1705 LIMITED PHYSICIAN LICENSE FOR DISASTERS AND EMERGENCIES**

(a) The Board may, pursuant to G.S. 90-12.5, issue a Limited Physician License for Disasters and Emergencies whenever the Governor of the State of North Carolina has declared a disaster or states of emergency, or in the event of an occurrence for which a county or municipality has enacted an ordinance to deal with state of emergency under G.S. 14-288.12, 14-288.13, or 14-288.14, or to protect the public health, safety or welfare of its citizens under Article 22 of Chapter 130A of the General Statutes, G.S. 160A-174(a) or G.S. 153A-12(a).

(b) In order to obtain a Limited Physician License for Disasters and Emergencies, an applicant shall:

- (1) provide government-issued photo identification;
- (2) provide proof of current licensure to practice medicine in another state or jurisdiction; and
- (3) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application.

(c) The Board may obtain any additional information it deems necessary to evaluate the applicant's competence and character.

(d) The Board may limit the physician's scope of practice as to geography; term; type of practice; and prescribing.

(e) A physician holding a Limited Physician License for Disasters and Emergencies shall not receive any compensation, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services.

*History Note:* Authority G.S. 90-12.5;  
Eff. August 1, 2010.

## **SECTION .2000 – EXPEDITED APPLICATION FOR PHYSICIAN LICENSE**

### **21 NCAC 32B .2001 EXPEDITED APPLICATION FOR PHYSICIAN LICENSE**

(a) A specialty board-certified physician who has been licensed in at least one other state, the District of Columbia, U.S. territory or Canadian province for at least five years, has been in active clinical practice the past two years; and who has a clean license application, as defined in Paragraph (c) of this Rule may apply for a license on an expedited basis.

(b) An applicant for an expedited Physician License shall:

- (1) complete the Board's application form, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit documentation of a legal name change, if applicable;
- (3) on the Board's form, submit a photograph taken within the past year, at least two inches by two inches, certified as a true likeness of the applicant by a notary public;
- (4) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport.. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States; (Note: there may be some applicants who are not present in the U.S. and who do not plan to practice physically in the U.S. Those applicants shall submit a statement to that effect);
- (5) provide proof that applicant has held an active license to practice medicine in at least one other state, the District of Columbia, U.S. Territory or Canadian province for at least five years immediately preceding this application;
- (6) provide proof of clinical practice providing patient care for an average of 20 hours or more per week, for at least the last two years;
- (7) provide proof of certification or recertification by an ABMS, CCFP, FRCP, FRCS, or AOA approved specialty board within the past 10 years;
- (8) submit an AMA Physician Profile; and, if applicant is an osteopathic physician, submit an AOA Physician Profile;
- (9) submit a NPDB/HIPDB report dated within 60 days of the applicant's oath;
- (10) submit a FSMB Board Action Data Bank report;
- (11) submit two completed fingerprint record cards supplied by the Board;
- (12) submit a signed consent form allowing a search of local, state and national files to disclose any criminal record;
- (13) pay to the Board a non-refundable fee of three hundred fifty dollars (\$350.00), plus the cost of a criminal background check; and
- (14) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) A clean license application means that the physician has none of the following:

- (1) professional liability insurance claim(s) or payment(s);
- (2) criminal record;
- (3) medical condition(s) which could affect the physician's ability to practice safely;
- (4) regulatory board complaint(s), investigation(s), or action(s) (including applicant's withdrawal of a license application);
- (5) adverse action taken by a health care institution;
- (6) investigation(s) or action(s) taken by a federal agency, the U.S. military, medical societies or associations;
- (7) suspension or expulsion from any school, including medical school.
- (8) graduation from any United States or Canadian medical school that is not LCME or CACMS approved; or
- (9) has passed no licensing examination other than Puerto Rico Written Examination/Revalida.

(d) All reports must be submitted directly to the Board from the primary source, when possible.

(e) The application process must be completed within one year of the date on which the application fee is paid. If not, the applicant shall be charged a new applicant fee.

*History Note: Authority G.S. 90-9.1; 90-5; 90-11; 90-13.1;  
Eff. August 1, 2010.*

## **SUBCHAPTER 32C - PROFESSIONAL CORPORATIONS**

### **21 NCAC 32C .0102 NAME OF PROFESSIONAL CORPORATION**

The following requirements must be met regarding the name of a professional corporation to practice medicine:

- (1) The name shall not include any adjectives or other words not in accordance with ethical customs of the medical profession as defined by the American Medical Association Code of Medical Ethics, and shall not be false, misleading, deceptive or patently offensive.
- (2) The professional corporation may not be identical or so similar in name to an existing registered business entity as to be misleading.
- (3) The professional corporation may not use any name other than its corporate name.
- (4) The professional corporation shall specify its corporate structure in the public domain by the use of the designation "P.C.", "P.A." or "P.L.L.C."
- (5) A shareholder may authorize the retention of his surname in the corporate name after his retirement or inactivity because of age or disability, even though he may have disposed of his stock. The estate of a deceased shareholder may authorize the retention of the deceased shareholder's surname in the corporate name after the shareholder's death.
- (6) If a living shareholder in a professional corporation whose surname appears in the corporate name becomes a "disqualified person" as defined in the Professional Corporation Act, the name of the professional corporation shall be promptly changed to eliminate the name of the shareholder, and the shareholder shall promptly dispose of his stock in the corporation.

*History Note: Authority G.S. 55B-5; 55B-7; 55B-12;  
Eff. February 1, 1976;  
Amended Eff. May 1, 2012; July 1, 1993; May 1, 1989.*

## **21 NCAC 32C .0103      PREREQUISITES FOR INCORPORATION**

(a) Before filing the articles of incorporation for a professional corporation with the Secretary of State, the incorporators shall file with the Board:

- (1) the properly executed original articles of incorporation;
- (2) a registration fee in the maximum allowable amount set forth in G.S. 55B-10;
- (3) a certificate (N.C.M.B.-P.C. Form 1) signed by all shareholders stating that all persons employed by the corporation are licensed to practice medicine in North Carolina, and representing that the business of the corporation will be conducted in compliance with the Professional Corporation Act and the rules in this Subchapter; and
- (4) a signed certificate (N.C.M.B.-P.C. Form 2) certifying that all shareholders are duly licensed to practice medicine in North Carolina or are otherwise qualified to own shares pursuant to G.S. 55B-6, 55B-14(c) or 55B-16.

(b) The Board shall review the articles of incorporation for compliance with the laws relating to professional corporations and with the rules in this Subchapter. If they comply, the Board shall approve N.C.M.B.-P.C. Form 2 and return the original articles of incorporation and the copy to the incorporators for filing with the Secretary of State. An official copy of the articles of incorporation shall be retained in the office of the Board. If the articles of incorporation are subsequently changed before they are filed with the Secretary of State, they shall be re-submitted to the Board and shall not be filed with the Secretary of State until approved by the Board.

*History Note:*      *Authority G.S. 55B-4; 55B-10; 55B-12;*  
                         *Eff. February 1, 1976;*  
                         *Amended Eff. January 1, 2012; September 1, 1995; July 1, 1993; May 1, 1989; November 1, 1985.*



**21 NCAC 32C .0104      CERTIFICATE OF REGISTRATION**

A Certificate of Registration for a professional corporation shall remain effective until December 31 of each year. A Certificate of Registration may be renewed annually thereafter upon written application to the Board, certifying the names and addresses of all licensed officers, directors, shareholders and employees of the corporation and representing that the corporation has complied with the rules in this Subchapter and the Professional Corporation Act. (N.C.M.B-P.C. Form 4) The application shall be accompanied by a renewal fee in the maximum allowable amount set forth in G.S. 55B-10.

*History Note:*      *Authority G.S. 55B-10; 55B-11;*  
                         *Eff. February 1, 1976;*  
                         *Amended Eff. January 1, 2012; September 1, 1995; May 1, 1989; November 1, 1985.*

**21 NCAC 32C .0105      STOCK AND FINANCIAL MATTERS**

- (a) The corporation may acquire and hold its own stock.
- (b) No person other than a licensee of the Board shall exercise any authority or influence over the practice of medicine as defined in Article 1 of Chapter 90.
- (c) Subject to the provisions of G.S. 55B-7, the corporation may make such agreement with its shareholders or its shareholders may make such agreement between themselves as they deem just for the acquisition of the shares of a deceased or retiring shareholder or of a shareholder who becomes disqualified to own shares under the Professional Corporation Act or under the rules in this Subchapter.
- (d) Failure to display on the face of all stock certificates a legend that any stock transfers are subject to the provisions of the Professional Corporations Act and the rules of the Board shall be a violation of G.S. 90-14(a).

*History Note:*      *Authority G.S. 55B-6; 55B-7; 55B-8; 90-1.1(5), 90-2(a); 90-5.1(a)(3); 90-14(a)(6); 90-14(a)(8);*  
                         *Eff. February 1, 1976;*  
                         *Amended Eff. May 1, 2012; May 1, 1989; November 1, 1985.*

**21 NCAC 32C .0106      CHARTER AMENDMENTS AND STOCK TRANSFERS**

The following provisions apply to all professional corporations to practice medicine:

- (1) An agent of the corporation shall ensure all changes to the articles of incorporation of the corporation are filed with the Board for approval before being filed with the Secretary of State. An agent of the corporation shall ensure a copy of the changes filed with the Secretary of State are subsequently sent to the Board within 10 days after filing with the Secretary of State.
- (2) The Board shall issue the certificate (N.C.M.B.-P.C.Form 5) required by G.S. 55B-6 when stock is transferred in the corporation. N.C.M.B.-P.C.Form 5 shall be permanently retained by the corporation. The stock books of the corporation shall be kept at the principal office of the corporation and shall be subject to inspection by the Board during business hours.

*History Note:* Authority G.S. 55B-6; 55B-7; 55B-8; 55B-12; 90-1.1(5); 90-2(a); 90-5.1(a)(3); 90-14(a)(6); 90-14(a)(8);  
Eff. February 1, 1976;  
Amended Eff. May 1, 2012; September 1, 1995; July 1, 1993; May 1, 1989.

**21 NCAC 32C .0108      FEES**

The registration and renewal fees for a professional corporation shall be the maximum allowable amount under G.S. 55B-10 and 55B-11.

*History Note:*      *Authority G.S. 55B-10; 55B-11;*  
                         *Eff. February 1, 1976;*  
                         *Amended Eff. January 1, 2012; May 1, 1989.*

**21 NCAC 32C .0109      REGISTRATION OF FOREIGN PROFESSIONAL CORPORATION**

(a) In addition to the other rules in this Subchapter, foreign professional corporations applying for a Certificate of Authority to Transact Business must meet the following requirements:

- (1) provide proof that shareholders licensed in other states are currently licensed and in good standing with their respective licensing boards;
- (2) at least one shareholder must be currently licensed and in good standing with the Board; and
- (3) no person other than a licensee of the Board shall exercise any authority or influence over the practice of medicine as defined by Article 1 of Chapter 90.

(b) For purposes of this Rule, "in good standing" means has not been disciplined by a licensing Board and is not currently subject to disciplinary proceedings.

*History Note:*      *Authority G.S. 55B-16; 90-1.1(5); 90-2(a); 90-5.1(a)(3);  
Eff. May 1, 2012.*

## SUBCHAPTER 32F - ANNUAL REGISTRATION

## 21 NCAC 32F .0105 FORMS

The following forms are used at the appropriate times regarding biennial registration:

- (1) Notice of Registration - This form requires information as noted in G.S. 90-15.1.
- (2) Notice of Failure to Register - This form gives notice to a physician who has failed to register as required by G.S. 90-15.1.
- (3) Notice of Suspension - This form advises the physician that his North Carolina medical license has been suspended for failure to register with the Board.

*History Note:* Authority G.S. 90-15.1;  
Eff. February 1, 1976;  
Amended Eff. May 1, 1989.

**21 NCAC 32F .0106      WAIVER FOR LICENSEES SERVING ON ACTIVE DUTY IN THE ARMED SERVICES OF THE US**

The Board shall waive continuing education, payment of renewal and other fees, and any other requirements or conditions relating to the maintenance of licensure by an individual who is:

- (1) currently licensed by and in good standing with the Board;
- (2) serving in the armed forces of the United States or serving in support of such armed forces; and
- (3) serving in a combat zone, or serving with respect to a military contingency operation as defined by 10 U.S.C. 101(a)(13).

*History Note: Authority; G.S. 105-249.2; S.L. 2009-458; Section 7508 of the Internal Revenue Code; 10U.S.C. 101; Eff. August 1, 2010.*

## **SUBCHAPTER 32K - NORTH CAROLINA PHYSICIANS HEALTH PROGRAM**

### **SECTION .0100 - GENERAL INFORMATION**

#### **21 NCAC 32K .0101      DEFINITIONS**

The following definitions apply to this Subchapter:

- (1) "Board" or "NCMB" means the North Carolina Medical Board.
- (2) "Compliance Committee" means the committee which meets to coordinate with the NCMB in its oversight of licensees in the PHP. It includes members of the PHP Board of Directors, members of the NCMB, and a Physician Assistant who is on the PHP Board of Directors.
- (3) "Impairment" means the inability to practice medicine or perform acts, tasks and functions with skill and safety to patients by reasons of physical or mental illness or condition, including use of alcohol, drugs, chemicals or any other type of material.
- (4) "Licensee" means a person licensed by the NCMB.
- (5) "Medical Director" means the person employed by the Program to coordinate the activities of the Program.
- (6) "Participant" means a licensee of the NCMB who is permitted to participate and may receive services from PHP, and has executed a monitoring contract with PHP.
- (7) "Program" or "NCPHP" or "PHP" means the North Carolina Physicians Health Program established for promoting a coordinated and effective peer review process.

*History Note: Authority G.S. 90-21.22;  
Eff. August 1, 1988;  
Amended Eff. April 1, 2009; May 1, 1989.*



## **SECTION .0200 - GUIDELINES FOR PROGRAM ELEMENTS**

### **21 NCAC 32K .0201      RECEIPT AND USE OF INFORMATION OF POTENTIAL IMPAIRMENT**

Information concerning potential impairments may be received by the Program through reports from any source. Upon receipt of information of a potential impairment, the Program shall conduct an assessment as soon as possible. This shall not create a physician-patient relationship. A physician assistant selected by the Medical Director shall be present during an assessment of a physician assistant. The Program may conduct routine inquiries regarding potential impairments. Licensees with potential impairments may be required to submit to personal interviews before the Medical Director or a designee.

*History Note:*      *Authority G.S. 90-21.22;*  
                         *Eff. August 1, 1988;*  
                         *Amended Eff. April 1, 2009; May 1, 1989.*

**21 NCAC 32K .0202      ASSESSMENT AND REFERRAL**

When an initial assessment reveals that further assessment, treatment or monitoring is indicated, PHP shall advise the licensee and referral source of the findings and recommendations. The Program shall develop a treatment plan designed to ensure that the recipient is safe to practice.

*History Note:*      *Authority G.S. 90-21.22;*  
                         *Eff. August 1, 1988;*  
                         *Amended Eff. April 1, 2009; May 1, 1989.*

**21 NCAC 32K .0203      MONITORING TREATMENT SOURCES**

The Program shall monitor the cost of treatment. Treatment sources receiving referrals from the Program also shall be monitored as to their ability to provide:

- (1) adequate medical and non-medical staffing;
- (2) appropriate treatment;
- (3) adequate facilities; and
- (4) appropriate post-treatment support.

*History Note:      Authority G.S. 90-21.22;  
                         Eff. August 1, 1988;  
                         Amended Eff. April 1, 2009.*

**21 NCAC 32K .0204      MONITORING REHABILITATION AND PERFORMANCE**

- (a) If a licensee is referred to the Program by the Board, and if the Program finds that treatment or monitoring are appropriate, the Program shall ask the licensee to sign a monitoring contract in order to become an active participant in the Program. If the licensee chooses not to sign a monitoring contract, the Program may refer the licensee to the Board for potential disciplinary action.
- (b) If a licensee is self-referred to the Program, and if the Program finds that treatment or monitoring are appropriate, the Program shall ask the licensee to sign a monitoring contract in order to become a participant in the program.
- (c) Participants shall be required to submit urine or other bodily specimens if requested by PHP.
- (d) Participants may be required to submit to periodic personal interviews with the Medical Director or a designee.
- (e) Treatment providers shall be required to submit reports regarding a licensee's rehabilitation and performance to the Program. Such reports shall be in accordance with state and federal laws. The Program shall maintain case records for each participant or licensee.

*History Note:*      *Authority G.S. 90-21.22;*  
                         *Eff. August 1, 1988;*  
                         *Amended Eff. April 1, 2009; May 1, 1989.*

**21 NCAC 32K .0205      MONITORING POST-TREATMENT SUPPORT**

- (a) The Program may require post-treatment support. Post-treatment support may include family counseling, advocacy, after care support groups, self-help groups and other services and programs deemed appropriate to improve recoveries.
- (b) The Program shall monitor post-treatment support.

*History Note:*      *Authority G.S. 90-21.22;*  
                         *Eff. August 1, 1988;*  
                         *Amended Eff. April 1, 2009; May 1, 1989.*

**21 NCAC 32K .0206      REPORTS OF INDIVIDUAL CASES TO THE BOARD**

Bimonthly, the Program shall submit a report to the Board on the status of all participants under monitoring contracts and all licensees being treated who have not signed monitoring contracts. The Program shall report immediately to the Board information about any licensee as required under G.S. 90-21.22(d).

*History Note:*      *Authority G.S. 90-21.22;*  
                         *Eff. August 1, 1988;*  
                         *Amended Eff. April 1, 2009; May 1, 1989.*

**21 NCAC 32K .0207      PERIODIC REPORTING OF STATISTICAL INFORMATION**

Upon request by the Board, the Program shall provide statistical and demographic information concerning potential impairments, impairments, self-referrals, post-treatment support and other demographic and substantive information collected through Program operations.

*History Note:*      *Authority G.S. 90-21.22;*  
                         *Eff. August 1, 1988;*  
                         *Amended Eff. April 1, 2009; May 1, 1989.*

**21 NCAC 32K .0208**      **CONFIDENTIALITY**

Any nonpublic information acquired, created, or used in good faith by the Program shall be treated according to G.S. 90-21.22.

*History Note: Authority G.S. 90-21.22;  
Eff. August 1, 1988;  
Amended Eff. May 1, 1989.*



## **SUBCHAPTER 32M - APPROVAL OF NURSE PRACTITIONERS**

### **21 NCAC 32M .0101 DEFINITIONS**

The following definitions apply to this Subchapter:

- (1) "Approval to Practice" means authorization by the Medical Board and the Board of Nursing for a nurse practitioner to perform medical acts within her or his area of educational preparation and certification under a collaborative practice agreement (CPA) with a licensed physician in accordance with this Subchapter.
- (2) "Back-up Supervising Physician" means the licensed physician who, by signing an agreement with the nurse practitioner and the primary supervising physician(s), shall provide supervision, collaboration, consultation and evaluation of medical acts by the nurse practitioner in accordance with the collaborative practice agreement when the Primary Supervising Physician is not available. Back-up supervision shall be in compliance with the following:
  - (a) The signed and dated agreements for each back-up supervising physician(s) shall be maintained at each practice site.
  - (b) A physician in a graduate medical education program, whether fully licensed or holding only a resident's training license, shall not be named as a back-up supervising physician.
  - (c) A fully licensed physician in a graduate medical education program who is also practicing in a non-training situation and has a signed collaborative practice agreement with the nurse practitioner and the primary supervising physician may be a back-up supervising physician for a nurse practitioner in the non-training situation.
- (3) "Board of Nursing" means the North Carolina Board of Nursing.
- (4) "Collaborative practice agreement" means the arrangement for nurse practitioner-physician continuous availability to each other for ongoing supervision, consultation, collaboration, referral and evaluation of care provided by the nurse practitioner.
- (5) "Disaster" means a state of disaster as defined in G.S. 166A-4(1a) and proclaimed by the Governor, or by the General Assembly pursuant to G.S. 166A-6.
- (6) "Joint Subcommittee" means the subcommittee composed of members of the Board of Nursing and members of the Medical Board to whom responsibility is given by G.S. 90-8.2 and G.S. 90-171.23(b)(14) to develop rules to govern the performance of medical acts by nurse practitioners in North Carolina.
- (7) "Medical Board" means the North Carolina Medical Board.
- (8) "National Credentialing Body" means one of the following credentialing bodies that offers certification and re-certification in the nurse practitioner's specialty area of practice:
  - (a) American Nurses Credentialing Center (ANCC);
  - (b) American Academy of Nurse Practitioners (AANP);
  - (c) American Association of Critical Care Nurses Certification Corporation (AACN);
  - (d) National Certification Corporation of the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC); and
  - (e) the Pediatric Nursing Certification Board (PNCB).
- (9) "Nurse Practitioner" or "NP" means a currently licensed registered nurse approved to perform medical acts consistent with the nurse's area of nurse practitioner academic educational preparation and national certification under an agreement with a licensed physician for ongoing supervision, consultation, collaboration and evaluation of medical acts performed. Such medical acts are in addition to those nursing acts performed by virtue of registered nurse (RN) licensure. The NP is held accountable under the RN license for those nursing acts that he or she may perform.
- (10) "Primary Supervising Physician" means the licensed physician who shall provide on-going supervision, collaboration, consultation and evaluation of the medical acts performed by the nurse practitioner as defined in the collaborative practice agreement. Supervision shall be in compliance with the following:
  - (a) The primary supervising physician shall assure both Boards that the nurse practitioner is qualified to perform those medical acts described in the collaborative practice agreement.
  - (b) A physician in a graduate medical education program, whether fully licensed or holding only a resident's training license, shall not be named as a primary supervising physician.

- (c) A fully licensed physician in a graduate medical education program who is also practicing in a non-training situation may supervise a nurse practitioner in the non-training situation.
- (11) "Registration" means authorization by the Medical Board and the Board of Nursing for a registered nurse to use the title nurse practitioner in accordance with this Subchapter.
- (12) "Supervision" means the physician's function of overseeing medical acts performed by the nurse practitioner.
- (13) "Volunteer Approval" means approval to practice consistent with this Subchapter except without expectation of direct or indirect compensation or payment (monetary, in kind or otherwise) to the nurse practitioner.

*History Note:* Authority G.S. 90-8.1; 90-8.2; 90-18(c)(14); 90-18.2;  
Eff. January 1, 1991;  
Amended Eff. September 1, 2012; December 1, 2009; December 1, 2006; August 1, 2004; May 1, 1999; January 1, 1996.

## **21 NCAC 32M .0102      SCOPE OF PRACTICE**

A nurse practitioner shall be held accountable by both Boards for the continuous and comprehensive management of a broad range of personal health services for which the nurse practitioner is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in Rule .0110 of this Subchapter. These services include but are not restricted to:

- (1) promotion and maintenance of health;
- (2) prevention of illness and disability;
- (3) diagnosing, treating and managing acute and chronic illnesses;
- (4) guidance and counseling for both individuals and families;
- (5) prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs;
- (6) planning for situations beyond the nurse practitioner's expertise, and consulting with and referring to other health care providers as appropriate; and
- (7) evaluating health outcomes.

*History Note: Authority G.S. 90-18(14);  
Eff. January 1, 1991;  
Amended Eff. August 1, 2004; May 1, 1999; January 1, 1996.*

**21 NCAC 32M .0103      NURSE PRACTITIONER REGISTRATION**

(a) The Board of Nursing shall register an applicant as a nurse practitioner who:

- (1) has an unrestricted license to practice as a registered nurse in North Carolina and, when applicable, an unrestricted approval, registration or license as a nurse practitioner in another state, territory, or possession of the United States;
- (2) has successfully completed a nurse practitioner education program as outlined in Rule .0105 of this Subchapter;
- (3) is certified as a nurse practitioner by a national credentialing body consistent with 21 NCAC 36 .0801(8); and
- (4) has supplied additional information necessary to evaluate the application as requested.

(b) Beginning January 1, 2005, new graduates of a nurse practitioner program, who are seeking first-time nurse practitioner registration in North Carolina shall:

- (1) hold a Master's or higher degree in Nursing or related field with primary focus on Nursing;
- (2) have successfully completed a graduate level nurse practitioner education program accredited by a national accrediting body; and
- (3) provide documentation of certification by a national credentialing body.

*History Note:*      *Authority G.S. 90-18(c)(14); 90-18.2; 90-171.36;*  
                         *Eff. August 1, 2004;*  
                         *Amended Eff. September 1, 2012; November 1, 2008; December 1, 2006.*

## **21 NCAC 32M .0104      PROCESS FOR APPROVAL TO PRACTICE**

- (a) Prior to the performance of any medical acts, a nurse practitioner shall:
- (1) meet registration requirements as specified in 21 NCAC 32M .0103;
  - (2) submit an application for approval to practice;
  - (3) submit any additional information necessary to evaluate the application as requested; and
  - (4) have a collaborative practice agreement with a primary supervising physician.
- (b) A nurse practitioner seeking approval to practice who has not practiced as a nurse practitioner in more than two years shall complete a nurse practitioner refresher course approved by the Board of Nursing in accordance with Paragraphs (o) and (p) of 21 NCAC 36 .0220 and consisting of common conditions and their management directly related to the nurse practitioner's area of education and certification.
- (c) The nurse practitioner shall not practice until notification of approval to practice is received from the Board of Nursing after both Boards have approved the application.
- (d) The nurse practitioner's approval to practice is terminated when the nurse practitioner discontinues working within the approved nurse practitioner collaborative practice agreement or experiences an interruption in her or his registered nurse licensure status, and the nurse practitioner shall so notify the Board of Nursing in writing. The Boards shall extend the nurse practitioner's approval to practice in cases of emergency such as sudden injury, illness or death of the primary supervising physician.
- (e) Applications for approval to practice in North Carolina shall be submitted to the Board of Nursing and then approved by both Boards as follows:
- (1) the Board of Nursing shall verify compliance with Rule .0103 of this Subchapter and Paragraph (a) of this Rule; and
  - (2) the Medical Board shall verify that the designated primary supervising physician holds a valid license to practice medicine in North Carolina and compliance with Paragraph (a) of this Rule.
- (f) Applications for approval of changes in practice arrangements for a nurse practitioner currently approved to practice in North Carolina shall be submitted by the applicants as follows:
- (1) addition or change of primary supervising physician shall be submitted to the Board of Nursing and proceed pursuant to protocols developed by both Boards; and
  - (2) request for change(s) in the scope of practice shall be submitted to the Joint Subcommittee.
- (g) A registered nurse who was previously approved to practice as a nurse practitioner in this state who reapplies for approval to practice shall:
- (1) meet the nurse practitioner approval requirements as stipulated in Rule .0108(c) of this Subchapter; and
  - (2) complete the appropriate application.
- (h) Volunteer Approval to Practice. The North Carolina Board of Nursing shall grant approval to practice in a volunteer capacity to a nurse practitioner who has met the qualifications to practice as a nurse practitioner in North Carolina.
- (i) The nurse practitioner shall pay the appropriate fee as outlined in Rule .0115 of this Subchapter.
- (j) A Nurse Practitioner approved under this Subchapter shall keep proof of current licensure, registration and approval available for inspection at each practice site upon request by agents of either Board.

*History Note: Authority G.S. 90-18(c)(14); 90-18.2; 90-171.20(7); 90-171.23(b); 90-171.42; Eff. January 1, 1991; Paragraph (b)(1) was recodified from 21 NCAC 32M .0104 Eff. January 1, 1996; Amended Eff. December 1, 2006; May 1, 1999; January 1, 1996; Recodified from 21 NCAC 32M .0103 Eff. August 1, 2004; Amended Eff. January 1, 2013; December 1, 2009; November 1, 2008; January 1, 2007; August 1, 2004.*

**21 NCAC 32M .0105      EDUCATION AND CERTIFICATION REQUIREMENTS FOR REGISTRATION AS A NURSE PRACTITIONER**

(a) A nurse practitioner with first-time approval to practice after January 1, 2000, shall provide evidence of certification or recertification as a nurse practitioner by a national credentialing body.

(b) A nurse practitioner applicant who completed a nurse practitioner education program prior to December 31, 1999 shall provide evidence of successful completion of a course of education that contains a core curriculum including 400 contact hours of didactic education and 400 contact hours of preceptorship or supervised clinical experience. The core curriculum shall contain the following components:

- (1) health assessment and diagnostic reasoning including:
  - (A) historical data;
  - (B) physical examination data;
  - (C) organization of data base;
- (2) pharmacology;
- (3) pathophysiology;
- (4) clinical management of common health problems and diseases such as the following shall be evident in the nurse practitioner's academic program:
  - (A) respiratory system;
  - (B) cardiovascular system;
  - (C) gastrointestinal system;
  - (D) genitourinary system;
  - (E) integumentary system;
  - (F) hematologic and immune systems;
  - (G) endocrine system;
  - (H) musculoskeletal system;
  - (I) infectious diseases;
  - (J) nervous system;
  - (K) behavioral, mental health and substance abuse problems;
- (5) clinical preventative services including health promotion and prevention of disease;
- (6) client education related to Subparagraph (b)(4) and (5) of this Rule; and
- (7) role development including legal, ethical, economical, health policy and interdisciplinary collaboration issues.

(c) Nurse practitioner applicants exempt from components of the core curriculum requirements listed in Paragraph (b) of this Rule are:

- (1) Any nurse practitioner approved to practice in North Carolina prior to January 18, 1981, is permanently exempt from the core curriculum requirement.
- (2) A nurse practitioner certified by a national credentialing body prior to January 1, 1998, who also provides evidence of satisfying Subparagraphs (b)(1) – (3) of this Rule shall be exempt from core curriculum requirements in Sub-paragraphs (b)(4) – (7) of this Rule. Evidence of satisfying Subparagraphs (b)(1) – (3) of this Rule shall include:
  - (A) a narrative of course content; and
  - (B) contact hours.

*History Note: Authority G.S. 90-18(c)(14); 90-171.42;  
Eff. January 1, 1991;  
Recodified from 21 NCAC 32M .0005 Eff. January 1, 1996;  
Amended Eff. May 1, 1999; January 1, 1996;  
Recodified from 21 NCAC 32M .0104 Eff. August 1, 2004;  
Amended Eff. December 1, 2009; December 1, 2006; August 1, 2004.*

**21 NCAC 32M .0106      ANNUAL RENEWAL**

(a) Each registered nurse who is approved to practice as a nurse practitioner in this state shall annually renew each approval to practice with the Board of Nursing no later than the last day of the nurse practitioner's birth month by:

- (1) Maintaining current RN licensure;
- (2) Submitting the fee required in Rule .0115 of this Subchapter; and
- (3) Completing the renewal application.

(b) If the nurse practitioner has not renewed by the last day of her or his birth month, the approval to practice as a nurse practitioner shall lapse.

*History Note:      Authority G.S. 90-8.1; 90-8.2; 90-18(14); 90-171.23(b);  
Eff. January 1, 1996;  
Amended Eff. August 1, 2004; May 1, 1999;  
Recodified from Rule .0105 Eff. August 1, 2004;  
Amended Eff. December 1, 2009; November 1, 2008.*

**21 NCAC 32M .0107 CONTINUING EDUCATION (CE)**

In order to maintain nurse practitioner approval to practice, the nurse practitioner shall earn 50 contact hours of continuing education each year beginning with the first renewal after initial approval to practice has been granted. At least 20 hours of the required 50 hours must be those hours for which approval has been granted by the American Nurses Credentialing Center (ANCC) or Accreditation Council on Continuing Medical Education (ACCME), other national credentialing bodies or practice relevant courses in an institution of higher learning. Documentation shall be maintained by the nurse practitioner and made available upon request to either Board.

*History Note: Authority G.S. 90-8.1; 90-8.2; 90-18(14); 90-171.23(14);  
Eff. January 1, 1996;  
Amended Eff. August 1, 2004; May 1, 1999;  
Recodified from Rule .0106 Eff. August 1, 2004;  
Amended Eff. December 1, 2009; April 1, 2008.*



**21 NCAC 32M .0108      INACTIVE STATUS**

- (a) Any nurse practitioner who wishes to place her or his approval to practice on an inactive status shall notify the Board of Nursing in writing.
- (b) A nurse practitioner with an inactive approval to practice status shall not practice as a nurse practitioner.
- (c) A nurse practitioner with an inactive approval to practice status who reapplies for approval to practice shall meet the qualifications for approval to practice in Rules .0103(a)(1), .0104(a) and (b), .0107, and .0110 of this Subchapter and receive notification from the Board of Nursing of approval prior to beginning practice after the application is approved by both Boards.
- (d) A nurse practitioner who has not practiced as a nurse practitioner in more than two years shall complete a nurse practitioner refresher course approved by the Board of Nursing in accordance with Paragraphs (o) and (p) of 21 NCAC 36 .0220 and consisting of common conditions and management of these conditions directly related to the nurse practitioner's area of education and certification in order to be eligible to apply for approval to practice.

*History Note:*      *Authority G.S. 90-18(c)(14); 90-18.2; 90-171.36;*  
                         *Eff. January 1, 1996;*  
                         *Amended Eff. January 1, 2013; December 1, 2009; December 1, 2006; August 1, 2004; May 1, 1999.*

## **21 NCAC 32M .0109      PRESCRIBING AUTHORITY**

(a) The prescribing stipulations contained in this Rule apply to writing prescriptions and ordering the administration of medications.

(b) Prescribing and dispensing stipulations are as follows:

- (1) Drugs and devices that may be prescribed by the nurse practitioner in each practice site shall be included in the collaborative practice agreement as outlined in Rule .0110(b) of this Section.
- (2) Controlled Substances (Schedules II, IIN, III, IIIN, IV, V) defined by the State and Federal Controlled Substances Acts may be procured, prescribed or ordered as established in the collaborative practice agreement, providing all of the following requirements are met:
  - (A) the nurse practitioner has an assigned DEA number which is entered on each prescription for a controlled substance;
  - (B) dosage units for schedules II, IIN, III and IIIN are limited to a 30 day supply; and
  - (C) the supervising physician(s) possesses the same schedule(s) of controlled substances as the nurse practitioner's DEA registration.
- (3) The nurse practitioner may prescribe a drug or device not included in the collaborative practice agreement only as follows:
  - (A) upon a specific written or verbal order obtained from a primary or back-up supervising physician before the prescription or order is issued by the nurse practitioner; and
  - (B) the written or verbal order as described in Part (b)(3)(A) of this Rule shall be entered into the patient record with a notation that it is issued on the specific order of a primary or back-up supervising physician and signed by the nurse practitioner and the physician.
- (4) Refills may be issued for a period not to exceed one year.
- (5) Each prescription shall be noted on the patient's chart and include the following information:
  - (A) medication and dosage;
  - (B) amount prescribed;
  - (C) directions for use;
  - (D) number of refills; and
  - (E) signature of nurse practitioner.
- (6) Prescription Format:
  - (A) All prescriptions issued by the nurse practitioner shall contain the supervising physician(s) name, the name of the patient, and the nurse practitioner's name, telephone number, and approval number.
  - (B) The nurse practitioner's assigned DEA number shall be written on the prescription form when a controlled substance is prescribed as defined in Subparagraph (b)(2) of this Rule.
- (7) A nurse practitioner shall not prescribe controlled substances, as defined by the State and Federal Controlled Substances Acts, for the nurse practitioner's own use or that of a nurse practitioner's supervising physician; or that of a member of the nurse practitioner's immediate family, which shall mean a spouse, parent, child, sibling, parent-in-law, son or daughter-in-law, brother or sister-in-law, step-parent, step-child, step-siblings, or any other person living in the same residence as the licensee; or anyone with whom the nurse practitioner is having a sexual relationship or has a significant emotional relationship.

(c) The nurse practitioner may obtain approval to dispense the drugs and devices other than samples included in the collaborative practice agreement for each practice site from the Board of Pharmacy, and dispense in accordance with 21 NCAC 46 .1703 that is hereby incorporated by reference including subsequent amendments of the referenced materials.

*History Note:*      *Authority G.S. 90-18(14); 90-18.2; 90-171.23(14);  
Eff. February 1, 1991;  
Recodified from 21 NCAC 32M .0106 Eff. January 1, 1996;  
Amended Eff. December 1, 2012; April 1, 2011; November 1, 2008; August 1, 2004; May 1, 1999;  
January 1, 1996; September 1, 1994; March 1, 1994.*

**21 NCAC 32M .0110      QUALITY ASSURANCE STANDARDS FOR A COLLABORATIVE PRACTICE AGREEMENT**

The following are the quality assurance standards for a collaborative practice agreement:

- (1) Availability: The primary or back-up supervising physician(s) and the nurse practitioner shall be continuously available to each other for consultation by direct communication or telecommunication.
- (2) Collaborative Practice Agreement:
  - (a) shall be agreed upon and signed by both the primary supervising physician and the nurse practitioner, and maintained in each practice site;
  - (b) shall be reviewed at least yearly. This review shall be acknowledged by a dated signature sheet, signed by both the primary supervising physician and the nurse practitioner, appended to the collaborative practice agreement and available for inspection by members or agents of either Board;
  - (c) shall include the drugs, devices, medical treatments, tests and procedures that may be prescribed, ordered and performed by the nurse practitioner consistent with Rule .0109 of this Subchapter; and
  - (d) shall include a pre-determined plan for emergency services.
- (3) The nurse practitioner shall demonstrate the ability to perform medical acts as outlined in the collaborative practice agreement upon request by members or agents of either Board.
- (4) Quality Improvement Process:
  - (a) The primary supervising physician and the nurse practitioner shall develop a process for the ongoing review of the care provided in each practice site including a written plan for evaluating the quality of care provided for one or more frequently encountered clinical problems.
  - (b) This plan shall include a description of the clinical problem(s), an evaluation of the current treatment interventions, and if needed, a plan for improving outcomes within an identified time-frame.
  - (c) The quality improvement process shall include scheduled meetings between the primary supervising physician and the nurse practitioner at least every six months. Documentation for each meeting shall:
    - (i) identify clinical problems discussed, including progress toward improving outcomes as stated in Subparagraph (d)(2) of this Rule, and recommendations, if any, for changes in treatment plan(s);
    - (ii) be signed and dated by those who attended; and
    - (iii) be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.
- (5) Nurse Practitioner-Physician Consultation. The following requirements establish the minimum standards for consultation between the nurse practitioner and primary supervising physician(s):
  - (a) During the first six months of a collaborative practice agreement between a nurse practitioner and the primary supervising physician, there shall be monthly meetings for the first six months to discuss practice relevant clinical issues and quality improvement measures.
  - (b) Documentation of the meetings shall:
    - (i) identify clinical issues discussed and actions taken;
    - (ii) be signed and dated by those who attended; and
    - (iii) be available for review by members or agents of either Board for the previous five calendar years and be retained by both the nurse practitioner and primary supervising physician.

*History Note*      *Authority G.S. 90-8.1; 90-8.2; 90-18(14); 90-18.2; 90-171.23(14); Eff. January 1, 1991;*  
*Amended Eff. August 1, 2004; May 1, 1999; January 1, 1996; March 1, 1994;*  
*Recodified from Rule .0109 Eff. August 1, 2004;*  
*Amended Eff. December 1, 2009.*

**21 NCAC 32M .0111      METHOD OF IDENTIFICATION**

When providing care to the public, the nurse practitioner shall identify herself/himself as specified in G.S. 90-640 and 21 NCAC 36 .0231.

*History Note:*      *Authority G.S. 90-18(14); G.S.90-640;*  
*Eff. January 1, 1991;*  
*Recodified from 21 NCAC 32M .0108 Eff. January 1, 1996;*  
*Amended Eff. August 1, 2004; May 1, 1999; January 1, 1996;*  
*Recodified from Rule .0110 Eff. August 1, 2004.*

## **21 NCAC 32M .0112      DISCIPLINARY ACTION**

(a) After notice and hearing in accordance with provisions of G.S. 150B, Article 3A, disciplinary action may be taken by the appropriate Board if one or more of the following is found:

- (1) violation of G.S. 90-18 and G.S. 90-18.2 or the joint rules adopted by each Board;
- (2) immoral or dishonorable conduct pursuant to and consistent with G.S. 90-14(a)(1);
- (3) any submissions to either Board pursuant to and consistent with G.S. 90-14(a)(3);
- (4) the nurse practitioner is adjudicated mentally incompetent or the nurse practitioner's mental or physical condition renders the nurse practitioner unable to safely function as a nurse practitioner pursuant to and consistent with G.S. 90-14(a)(5) and G.S. 90-171.37(3);
- (5) unprofessional conduct by reason of deliberate or negligent acts or omissions and contrary to the prevailing standards for nurse practitioners in accordance and consistent with G.S. 90-14(a)(6) and G.S. 90-171.35(5);
- (6) Conviction in any court of a criminal offense in accordance and consistent with G.S. 90-14(a)(7) and G.S. 90-171.37(2) and G.S. 90-171.48;
- (7) payments for the nurse practitioner practice pursuant to and consistent with G.S. 90-14(a)(8);
- (8) lack of professional competence as a nurse practitioner pursuant to and consistent with G.S. 90-14(a)(11);
- (9) exploiting the client pursuant to and consistent with G.S. 90-14(a)(12) including the promotion of the sale of services, appliances, or drugs for the financial gain of the practitioner or of a third party;
- (10) failure to respond to inquires which may be part of a joint protocol between the Board of Nursing and Medical Board for investigation and discipline pursuant to and consistent with G.S. 90-14(a)(14);
- (11) the nurse practitioner has held himself or herself out or permitted another to represent the nurse practitioner as a licensed physician; or
- (12) the nurse practitioner has engaged or attempted to engage in the performance of medical acts other than according to the collaborative practice agreement.

(b) The nurse practitioner is subject to G.S. 90-171.37; 90-171.48 and 21 NCAC 36 .0217 by virtue of the license to practice as a registered nurse.

(c) After an investigation is completed, the joint subcommittee of both boards may recommend one of the following:

- (1) dismiss the case;
- (2) issue a private letter of concern;
- (3) enter into negotiation for a Consent Order; or
- (4) a disciplinary hearing in accordance with G.S. Chapter 150B, Article 3A. If a hearing is recommended, the joint subcommittee shall also recommend whether the matter should be heard by the Board of Nursing or the Medical Board.

(d) Upon a finding of violation, each Board may utilize the range of disciplinary options as enumerated in G.S. 90-14(a) or G.S. 90-171.37.

*History Note: Authority G.S. 90-18(14); 90-171.37; 90-171.44; 90-171.47;  
Eff. February 1, 1991;  
Recodified from 21 NCAC 32M .0107 Eff. January 1, 1996;  
Amended Eff. August 1, 2004; May 1, 1999; January 1, 1996;  
Recodified from Rule .0111 Eff. August 1, 2004;  
Amended Eff. April 1, 2007.*

**21 NCAC 32M .0115 FEES**

- (a) An application fee of one hundred dollars (\$100.00) shall be paid at the time of initial application for approval to practice and each subsequent application for approval to practice. The application fee shall be twenty dollars (\$20.00) for the volunteer approval.
- (b) The fee for annual renewal of approval shall be fifty dollars (\$50.00).
- (c) The fee for annual renewal of volunteer approval shall be ten dollars (\$10.00).
- (d) No portion of any fee in this Rule is refundable.

*History Note:* Authority G.S. 90-6;  
Eff. January 1, 1996;  
Recodified from 21 NCAC 32M .0111 Eff. January 1, 1996;  
Amended Eff. August 1, 2004; May 1, 1999; January 1, 1996;  
Recodified from Rule .0112 Eff. August 1, 2004;  
Amended Eff. November 1, 2008.

**21 NCAC 32M .0116 PRACTICE DURING A DISASTER**

(a) A nurse practitioner approved to practice in this State or another state may perform medical acts as a nurse practitioner under the supervision of a physician licensed to practice medicine in North Carolina during a disaster in a county in which a state of disaster has been declared or counties contiguous to a county in which a state of disaster has been declared.

(b) The nurse practitioner shall notify the Board of Nursing in writing of the names, practice locations and telephone number for the nurse practitioner and each primary supervising physician within 15 days of the first performance of medical acts as a nurse practitioner during the disaster, and the Board of Nursing shall notify the Medical Board.

(c) Teams of physician(s) and nurse practitioner(s) practicing pursuant to this Rule shall not be required to maintain on-site documentation describing supervisory arrangements and plans for prescriptive authority as otherwise required pursuant to Rules .0109 and .0110 of this Subchapter.

*History Note: Authority G.S. 90-18(c)(13), (14); 90-18.2; 90-171.20(7); 90-171.23(b); 90-171.42;  
Eff. May 1, 1999;  
Recodified from Rule .0105 Eff. August 1, 2004;  
Amended Eff. December 1, 2009; August 1, 2004.*

## SUBCHAPTER 32N - FORMAL AND INFORMAL PROCEEDINGS

### 21 NCAC 32N .0106 DEFINITIONS

As used in this Section:

- (1) "Disciplinary Proceedings" means hearings conducted pursuant to G.S. 90-14.2 through 90-14.7, and Article 3A of Chapter 150B.
- (2) "Good cause" related to motions or requests to continue or for additional time for responding includes:
  - (a) death or incapacitating illness of a party, or attorney of a party;
  - (b) a court order requiring a continuance;
  - (c) lack of proper notice of the hearing;
  - (d) a substitution of the attorney of a party if the substitution is shown to be required;
  - (e) agreement for a continuance by all parties if either more time is demonstrated to be necessary to complete mandatory preparation for the case, such as authorized discovery, and the parties and the Board have agreed to a new hearing date or the parties have agreed to a settlement of the case that has been or is likely to be approved by the Board; and
  - (f) where, for any other reason, either party has shown that the interests of justice require a continuance or additional time.
- (3) "Good cause" related to motions or requests to continue or for additional time for responding shall not include:
  - (a) intentional delay;
  - (b) unavailability of a witness if the witness testimony can be taken by deposition; and
  - (c) failure of the attorney or respondent to use effectively the statutory notice period provided in G.S. 90-14.2(a) to prepare for the hearing.
- (4) "Licensee" means all persons to whom the Board has issued a license as defined in G.S. 90-1.1.
- (5) "Respondent" means the person licensed or approved by the Board who is named in the Notice of Charges and Allegations.

*History Note:* Authority G.S. 90-5.1(a)(3); 90-14.2; 150B-38(h); 150B-40(c)(4);  
Eff. February 1, 2012.



## **21 NCAC 32N .0107      INVESTIGATIONS AND COMPLAINTS**

(a) At the time of first oral or written communication from the Board or staff or agent of the Board to a licensee regarding a complaint or investigation, the Board shall provide the notices set forth in G.S. 90-14(i), except as provided in Paragraph (e) of this Rule.

(b) A licensee shall submit a written response to a complaint received by the Board within 45 days from the date of a written request by Board staff. The Board shall grant up to an additional 30 days for the response where the licensee demonstrates good cause for the extension of time. The response shall contain accurate and complete information. Where a licensee fails to respond in the time and manner provided herein, the Board may treat that as a failure to respond to a Board inquiry in a reasonable time and manner as required by G.S. 90-14(a)(14).

(c) The licensee's written response to a complaint submitted to the Board in accordance with Paragraph (b) of this Rule shall be provided to the complainant upon written request as permitted in G.S. 90-16(e1), except that the response shall not be provided where the Board determines that the complainant has misused the Board's complaint process or that the release of the response would be harmful to the physical or mental health of the complainant who was a patient of the responding licensee.

(d) A licensee shall submit to an interview within 30 days from the date of an oral or written request from Board staff. The Board may grant up to an additional 15 days for the interview where the licensee demonstrates good cause for the extension of time. The responses to the questions and requests for information, including documents, during the interview shall be complete and accurate. Where respondent fails to respond in the time and manner provided herein, the Board may treat that as a failure to respond to a Board inquiry in a reasonable time and manner as required by G.S. 90-14(a)(14).

(e) The licensee who is the subject of a Board inquiry may retain and consult with legal counsel of his or her choosing in responding to the inquiries as set out in G.S. 90-14(i).

*History Note:*      *Authority G.S. 90-5.1(a)(3); 90-14(a)(14); 90-14(i); 90-16(e1);  
Eff. February 1, 2012.*

**21 NCAC 32N .0108      INVESTIGATIVE INTERVIEWS BY BOARD MEMBERS**

(a) In addition to formal hearings pursuant to G.S. 90-14 and G.S. 90-14.2, the Board may ask a licensee to attend a non-public interview with members of the Board and staff to discuss a pending complaint or investigation. The invitation letter shall describe the matters of dispute or concern and shall enclose the notices required by G.S. 90-14(i), if not previously issued. No individual shall be placed under oath to give testimony. Statements made or information provided by a licensee during this interview may, however, be used against such licensee in any subsequent formal hearing.

(b) As a result of the interview, the Board may ask that the licensee take actions as referred to in G.S. 90-14(k), may offer the licensee the opportunity to enter into a consent order or other public agreement that will be a matter of public record, may institute a formal public hearing concerning the licensee, or may take other action as the Board deems appropriate in each case.

(c) Unless ordered by the Board pursuant to G.S. 90-8, attendance at such an interview is not required. A licensee may retain legal counsel and have such counsel present during such interview.

(d) If ordered to appear for an interview, requests for continuances from interviews shall be filed with the President as soon as practicable and shall be granted only upon good cause shown.

*History Note:*      *Authority G.S. 90-5.1(a)(3); 90-8; 90-14(a)(14);  
Eff. February 1, 2012.*

## **21 NCAC 32N .0109      PRE-CHARGE CONFERENCE**

(a) Prior to issuing public Notice of Charges and Allegations against a licensee, the Board shall inform the licensee in writing of the right to request a pre-charge conference as set forth in G.S. 90-14(j). The written notice regarding the pre-charge conference shall be sent by certified mail, return receipt requested to the last mailing address registered with the Board.

(b) A request for a pre-charge conference must be:

- (1) in writing via delivery of a letter or by facsimile or electronic mail;
- (2) addressed to the coordinator identified in the written notice provided as set forth in Paragraph (a) of this Rule; and
- (3) received by the Board no later than 30 days from the date appearing on the written notice provided as set forth in Paragraph (a) of this Rule.

(c) Upon receipt of a request for a pre-charge conference, the coordinator shall schedule the conference to occur within 45 days and serve notice of the date and time of the conference on the licensee or on counsel for licensee, if the Board is aware licensee is represented by counsel.

(d) The pre-charge conference shall be conducted as provided in G.S. 90-14(j). The pre-charge conference will be conducted by telephone conference unless the interests of justice require otherwise or both parties agree to conduct the conference in person. No continuances of the pre-charge conference shall be allowed except when granted by the Board for good cause shown.

(e) The licensee may provide to the Board written documents not previously submitted by delivering those documents in electronic form to the coordinator identified in the written notice up to five days prior to the pre-charge conference.

(f) The Board shall provide information to the licensee during the pre-charge conference regarding the possibility of settlement of the pending matter prior to the issuance of a public notice of charges and allegations.

*History Note:*      *Authority G.S. 90-5.1(a)(3); 90-14(j);*  
                         *Eff. February 1, 2012.*

## **21 NCAC 32N .0110      INITIATION OF DISCIPLINARY HEARINGS**

(a) The Board shall issue a Notice of Charges and Allegations only upon completion of an investigation, a finding by the Board or a committee of the Board that there exists a factual and legal basis for an action pursuant to any subsection of G.S. 90-14(a), and a pre-charge conference, if one was requested by the licensee.

(b) Disciplinary proceedings shall be initiated and conducted pursuant to G.S. 90-14 through G.S. 90-14.7 and G.S. 150B-38 through G.S. 150B-42.

(c) A pre-hearing conference shall be held not less than seven days before the hearing date unless waived by the Board President or designated presiding officer upon written request by either party. The purpose of the conference will be to simplify the issues to be determined, obtain stipulations in regards to testimony or exhibits, obtain stipulations of agreement on undisputed facts or the application of particular laws, consider the proposed witnesses for each party, identify and exchange documentary evidence intended to be introduced at the hearing, and consider such other matters that may be necessary or advisable for the efficient and expeditious conduct of the hearing.

(d) The pre-hearing conference shall be conducted in the offices of the Medical Board, unless another site is designated by mutual agreement of all parties; however, when a face-to-face conference is impractical, the Board President or designated presiding officer may order the pre-hearing conference be conducted by telephone conference.

(e) The pre-hearing conference shall be an informal proceeding and shall be conducted by the Board President or designated presiding officer.

(f) All agreements, stipulations, amendments, or other matters resulting from the pre-hearing conference shall be in writing, signed by the presiding officer, respondent or respondent's counsel and Board counsel, and introduced into the record at the beginning of the disciplinary hearing.

(g) Motions for a continuance of a hearing shall be granted upon a showing of good cause. In determining whether to grant such motions, the Board shall consider the Guidelines for Resolving Scheduling Conflicts adopted by the State-Federal Judicial Council of North Carolina. Motions for a continuance must be in writing and received in the office of the Medical Board no less than 14 calendar days before the hearing date. A motion for a continuance filed less than 14 calendar days from the date of the hearing shall be denied unless the reason for the motion could not have been ascertained earlier. Motions for continuance shall be ruled on by the President of the Board or designated presiding officer.

(h) The Respondent may challenge on the basis of personal bias or other reason for disqualification the fitness and competency of any Board member to hear and weigh evidence concerning the Respondent. Challenges must be in writing accompanied by affidavit setting forth with specificity the grounds for such challenge and must be filed with the President of the Board or designated presiding officer at least 14 days before the hearing except for good cause shown. Nothing contained in this Rule shall prevent a Respondent appearing before the Board at a formal hearing from making inquiry of Board members as to their knowledge of and personal bias concerning that person's case and making a motion based upon the responses to those inquiries that a Board member recuse himself or herself of be removed by the Board President or presiding officer.

(i) In any formal proceeding pursuant to G.S. 90-14.1 and G.S. 90-14.2, discovery may be obtained as provided in G.S. 90-8 and 150B-39 by either the Board or the Respondent. Any discovery request by a Respondent to the Board shall be filed with the Executive Director of the Board. Nothing herein is intended to prohibit a Respondent or counsel for Respondent from issuing subpoenas to the extent that such subpoenas are otherwise permitted by law or rule. The Medical Board may issue subpoenas for the Board or a Respondent in preparation for or in the conduct of a contested case as follows:

- (1) Subpoenas may be issued for the appearance of witnesses or the production of documents or information, either at the hearing or for the purposes of discovery;
- (2) Requests by a Respondent for subpoenas shall be made in writing to the Executive Director and shall include the following:
  - (A) the full name and home or business address of all persons to be subpoenaed; and
  - (B) the identification, with specificity, of any documents or information being sought;
- (3) Where Respondent makes a request for subpoenas and complies with the requirements in Subparagraph (2) of this Paragraph, the Board shall provide subpoenas promptly;
- (4) Subpoenas shall include the date, time, and place of the hearing and the name and address of the party requesting the subpoena. In the case of subpoenas for the purpose of discovery, the subpoena shall include the date, time, and place for responding to the subpoena; and
- (5) Subpoenas shall be served as provided by the Rules of Civil Procedure, G.S. 1A-1. The cost of service, fees, and expenses of any witnesses or documents subpoenaed shall be paid by the party requesting the witnesses.

(j) All motions related to a contested case shall be in writing and submitted to the Medical Board at least 14 calendar days before the hearing. Pre-hearing motions shall be heard at the pre-hearing conference described in Paragraph (c) of this Rule. Motions filed fewer than 14 days before the hearing shall be considered untimely and shall not be considered unless the reason for the motion could not have been ascertained earlier. In such case, the motion shall be considered at the hearing prior to the commencement of testimony. The Board President or designated presiding officer shall hear the motions and any response from the non-moving party and rule on such motions. If the pre-hearing motions are heard by an Administrative Law Judge from Office of Administrative Hearings the provisions of G.S. 150B-40(e) shall govern the proceedings.

*History Note:* Authority G.S. 90-5.1(a)(3); 90-8; 90-14.1; 90-14.2; 90-14.3; 150B-38; 150B-39(c);  
Eff. February 1, 2012.

## **21 NCAC 32N .0111      CONDUCTING DISCIPLINARY HEARINGS**

(a) Disciplinary hearings conducted before a majority of Board members shall be held at the Board's office or, by mutual consent, in another location where a majority of the Board has convened for the purpose of conducting business. For proceedings conducted by an administrative law judge, the venue shall be determined in accordance with G.S. 150B-38(e). All hearings conducted by the Medical Board are open to the public; however, portions are closed to protect the identity of patients pursuant to G.S. 90-16(b).

(b) All hearings by the Medical Board shall be conducted by a quorum of the Medical Board, except as provided in Subparagraph (1) and (2) of this Paragraph. The Medical Board President or his or her designee shall preside at the hearing. The Medical Board shall retain independent legal counsel to provide advice to the Board as set forth in G.S. 90-14.2. The quorum of the Medical Board shall hear all evidence, make findings of fact and conclusions of law, and issue an order reflecting the decision of the majority of the quorum of the Board. The final form of the order shall be determined by the presiding officer, who shall sign the order. When a majority of the members of the Medical Board is unable or elects not to hear a contested case:

- (1) The Medical Board may request the designation of an administrative law judge from the Office of Administrative Hearings to preside at the hearing so long as the Board has not alleged the licensee failed to meet an applicable standard of medical care. The provisions of G.S. 150B, Article 3A shall govern a contested case in which an administrative law judge is designated as the Hearing Officer; or
- (2) The Medical Board President may designate in writing three or more hearing officers to conduct hearings as a hearing committee to take evidence. The provisions of G.S. 90-14.5(a) through (d) shall govern a contested case in which a hearing committee is designated.

(c) If any party or attorney of a party or any other person in or near the hearing room engages in conduct which obstructs the proceedings or would constitute contempt if done in the General Court of Justice, the Board may apply to the applicable superior court for an order to show cause why the person(s) should not be held in contempt of the Board and its processes.

(d) During a hearing, if it appears in the interest of justice that further testimony should be received and sufficient time does not remain to conclude the testimony, the Medical Board may continue the hearing to a future date to allow for the additional testimony to be taken by deposition or to be presented orally. In such situations and to such extent as possible, the seated members of the Medical Board shall receive the additional testimony. If new members of the Board or a different independent counsel must participate, a copy of the transcript of the hearing shall be provided to them prior to the receipt of the additional testimony.

(e) All parties have the right to present evidence, rebuttal testimony, and argument with respect to the issues of law, and to cross-examine witnesses. The North Carolina Rules of Evidence in G.S. 8C apply to contested case proceedings, except as provided otherwise in this Rule, G.S. 90-14.6 and G.S. 150B-41.

*History Note:*      *Authority G.S. 90-5.1(a)(3); 90-14.2; 90-14.5; 90-14.6; 90-14.7; 90-16(b); 150B-38(e)(h); 150B-40; 150B-41; 150B-42;*  
*Eff. February 1, 2012.*

## **21 NCAC 32N .0112 POST HEARING MOTIONS**

(a) Following a disciplinary hearing either party may request a new hearing or to reopen the hearing for good cause as provided in G.S. 90-14.7. For the purposes of this Rule, good cause is defined as any of the grounds set out in Rule 59 of the North Carolina Rules of Civil Procedure and complying with the following requirements:

- (1) Following hearings conducted by a quorum of the Board, a motion for a new hearing or to reopen the hearing to take new evidence shall be served, in writing, on the presiding officer of the disciplinary hearing no later than 20 days after service of the final order upon the respondent. Supporting affidavits, if any, and a memorandum setting forth the basis of the motion together with supporting authorities, shall be filed with the motion. The opposing party has 20 days from service of the motion to file a written response, any reply affidavits, and a memorandum with supporting authorities. A quorum of the Board shall rule on the motion based on the parties' written submissions and oral arguments, if the Board permitted any; and
- (2) Following hearings conducted by a hearing panel pursuant to G.S. 90-14.5, a motion for a new hearing or to reopen the hearing to take new evidence shall be served, in writing, on the presiding officer of the hearing panel no later than 20 days after service of the recommended decision upon the respondent or respondent's counsel. Supporting affidavits, if any, and a memorandum setting forth the basis of the motion together with supporting authorities, shall be filed with the motion. The opposing party has 20 days from service of the motion to file a written response, any reply affidavits, and a memorandum with supporting authorities. The hearing panel shall rule on the motion based on the parties' written submission and oral arguments, if the Board permitted any.

(b) Either party may file a motion for relief from the final order of the Board based on any of the grounds set out in Rule 60 of the North Carolina Rules of Civil Procedure. Relief from the final order of the Board shall not be permitted later than one year after the effective date of the final order from which relief is sought. Motions pursuant to this section will be heard and decided in the same manner as motions submitted pursuant to Subparagraph (a)(1) of this Rule.

(c) The filing of a motion under Subparagraph (a)(1) or Paragraph (b) of this Rule does not automatically stay or otherwise affect the effective date of the final order.

*History Note: Authority G.S. 90-5.1(a)(3); 90-14.7;  
Eff. February 1, 2012.*

**21 NCAC 32N .0113      CORRECTION OF CLERICAL MISTAKES**

Clerical mistakes in orders or other parts of the record from a formal hearing and errors therein arising from oversight or omission may be corrected by the Board President or designated presiding officer at any time on his or her own initiative or on the motion of any party and after such notice, if any, as the Board President or designated presiding officer orders. After the filing by a respondent of an appeal to the Superior Court of the Board's imposition of public disciplinary action as set forth in G.S. 90-14.8, such mistakes may be so corrected before the record of the case is filed by the Board with the clerk of the Superior Court as required by G.S. 90-14.8.

*History Note:*      *Authority G.S. 90-5.1(a)(3); 150B-40;*  
                         *Eff. February 1, 2012.*



## SUBCHAPTER 32P - LIMITED LIABILITY COMPANIES

### **21 NCAC 32P .0101      NAME OF LIMITED LIABILITY COMPANY**

The name of a limited liability company to practice medicine shall not include any adjectives or other words not in accordance with the ethics of the medical profession.

*History Note:*      *Authority G.S. 55B-12; 57C-2-01; 90-14(a)(6);  
Eff. June 1, 1994.*

**21 NCAC 32P .0102 PREREQUISITES FOR ORGANIZATION**

(a) Before filing the articles of organization for a limited liability company with the Secretary of State, the organizing members shall submit the following to the Board:

- (1) a registration fee as set by Rule .0006 of this Subchapter; and
- (2) a certificate certified by all organizing members, setting forth the names and addresses of each person who will be employed by the limited liability company to practice medicine, and stating that all such persons are duly licensed to practice medicine in North Carolina, and representing that the company will be conducted in compliance with the North Carolina Limited Liability Company Act and this Subchapter.

(b) A certification that each of the organizing members is licensed to practice medicine in North Carolina shall be returned to the limited liability company for filing with the Secretary of State.

*History Note:* Authority G.S. 55B-4; 55B-10; 55B-12; 57C-2-01;  
Eff. June 1, 1994.

**21 NCAC 32P .0103      CERTIFICATE OF REGISTRATION**

A Certificate of Registration for a limited liability company shall remain effective until December 31 of each odd-numbered year. A Certificate of Registration shall be renewed biennially on application forms supplied by the Board. The application shall be accompanied by a renewal fee as set by Rule .0006 of this Subchapter.

*History Note:*     *Authority G.S. 55B-10; 55B-11; 57C-2-01;*  
                         *Eff. June 1, 1994.*

**21 NCAC 32P .0104      CHARTER AMENDMENTS AND MEMBERSHIP TRANSFERS**

The Board shall issue the certificate authorizing transfer of membership when membership is transferred in the company. This transfer form shall be permanently retained by the company. The membership books of the company shall be kept at the principal office of the company and shall be subject to inspection by authorized agents of the Board.

*History Note:*      *Authority G.S. 55B-6; 55B-12; 57C-2-01;*  
                         *Eff. June 1, 1994.*

**21 NCAC 32P .0105      DOCUMENTS**

The forms and documents regarding limited liability companies are issued by the Board.

*History Note:      Authority G.S. 55B-2(6);  
                         Eff. June 1, 1994.*

**21 NCAC 32P .0106      FEES**

The initial registration fee for a limited liability company is fifty dollars (\$50.00). The fee for renewal of a Certificate of Registration is twenty-five dollars (\$25.00).

*History Note:      Authority G.S. 55B-10; 55B-11; 57C-2-01;  
Eff. June 1, 1994.*

## **SUBCHAPTER 32R – CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS**

### **SECTION .0100 – CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS**

#### **21 NCAC 32R .0101 CONTINUING MEDICAL EDUCATION (CME) REQUIRED**

(a) Continuing Medical Education (CME) is defined as education, training and activities to increase knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of healthcare to the public. The purpose of CME is to maintain, develop, or improve the physician's knowledge, skills, professional performance and relationships which physicians use to provide services for their patients, their practice, the public, or the profession.

(b) Each person licensed to practice medicine in the State of North Carolina shall complete at least 60 hours of Category 1 CME relevant to the physician's current or intended specialty or area of practice every three years.

(c) The three year period described in Paragraph (b) of this Rule begins on the physician's first birthday following initial licensure.

*History Note: Authority G.S. 90-14(a)(15);  
Eff. January 1, 2000;  
Amended Eff. August 1, 2012; January 1, 2001.*

**21 NCAC 32R .0102      APPROVED CATEGORIES OF CME**

(a) Category 1 CME providers are:

- (1) Institutions or organizations accredited by the Accreditation Council on Continuing Medical Education (ACCME) and reciprocating organizations;
- (2) The American Osteopathic Association (AOA);
- (3) A state medical society or association;
- (4) The American Medical Association (AMA); and
- (5) Specialty boards accredited by the American Board of Medical Specialties (ABMS), the AOA or Royal College of Physicians and Surgeons of Canada (RCPSC).

(b) Category 1 CME education shall be presented, offered, or accredited by a Category 1 provider as defined above and shall include:

- (1) Educational courses;
- (2) Scientific or clinical presentations or publications;
- (3) Printed, recorded, audio, video, online or electronic educational materials for which CME credits are awarded by the publisher;
- (4) Skill development;
- (5) Performance improvement activities; or
- (6) Journal-based CME activities within a peer-reviewed, professional journal.

*History Note: Authority G.S. 90-14(a)(15);  
Eff. January 1, 2000;  
Amended Eff. August 1, 2012; July 1, 2007; January 1, 2001.*



**21 NCAC 32R .0103      EXCEPTIONS**

(a) A physician is exempt from the requirements of Rule .0101 of this Section if the licensee is:

- (1) Currently enrolled in an AOA or Accreditation of Council of Graduate Medical Education (ACGME) accredited graduate medical education program;
- (2) In good standing with the Board, serving in the armed forces of the United States or serving in support of such armed forces, and serving in a combat zone, or serving with respect to a military contingency operation as defined by 10 U.S.C. 101(a)(13); or
- (3) Serving as a member of the General Assembly's House or Senate Health Committee.

(b) A physician who obtains initial certification from an ABMS, AOA or RCPSC specialty board shall be deemed to have satisfied his or her entire CME requirement for the three year cycle in which the physician obtains board certification.

(c) A physician who attests that he or she is continuously engaged in a program of recertification, or maintenance of certification, from an ABMS, AOA or RCPSC specialty board shall be deemed to have satisfied his or her entire CME requirement for that three year cycle.

*History Note:*      *Authority G.S. 90-14(a)(15); 90B-15;*  
                         *Eff. January 1, 2000;*  
                         *Amended Eff. August 1, 2012; January 1, 2001.*

**21 NCAC 32R .0104      REPORTING**

At the time of annual renewal, each Licensee shall report on the Board's annual renewal form compliance with, or exemption from, Rule .0101 of this Section. Records documenting compliance or exemption must be maintained for six consecutive years and may be inspected by the Board or its agents.

*History Note:*      *Authority G.S. 90-14(a)(15);*  
                         *Eff. January 1, 2000;*  
                         *Amended Eff. August 1, 2012; January 1, 2001.*

## **SUBCHAPTER 32S - PHYSICIAN ASSISTANTS**

### **SECTION .0200 – PHYSICIAN ASSISTANT REGISTRATION**

#### **21 NCAC 32S .0201 DEFINITIONS**

The following definitions apply to this Subchapter:

- (1) "Board" means the North Carolina Medical Board.
- (2) "Examination" means the Physician Assistant National Certifying Examination.
- (3) "Family member" means a spouse, parent, grandparent, child, grandchild, sibling, aunt, uncle or first cousin, or persons to the same degree by marriage.
- (4) "Physician Assistant" means a person licensed by the Board under the provisions of G.S. 90-9.3.
- (5) "Physician Assistant License" means approval for the physician assistant to perform medical acts, tasks, or functions under North Carolina law.
- (6) "Physician Assistant Educational Program" is the educational program set out in G.S. 90-9.3(a)(1).
- (7) "License Renewal" means paying the annual fee and providing the information requested by the Board as outlined in this Subchapter.
- (8) "Supervising" means overseeing the activities of, and accepting the responsibility for, the medical services rendered by a physician assistant.
- (9) "Supervisory Arrangement" is the written statement that describes the medical acts, tasks and functions delegated to the physician assistant by the primary supervising physician appropriate to the physician assistant's education, qualification, training, skill and competence.
- (10) "Supervising Physician" means a physician who is licensed by the Board and who is not prohibited by the Board from supervising physician assistants. The physician may serve as a primary supervising physician or as a back-up supervising physician.
  - (a) "Primary Supervising Physician" is the physician who accepts full responsibility for the physician assistant's medical activities and professional conduct at all times, whether the physician personally is providing supervision or the supervision is being provided by a Back-up Supervising Physician. The Primary Supervising Physician shall assure the Board that the physician assistant is qualified by education, training and competence to perform all medical acts required of the physician assistant and is responsible for the physician assistant's performance in the particular field or fields in which the physician assistant is expected to perform medical acts.
  - (b) "Back-up Supervising Physician" means the physician who is responsible for supervision of the physician assistant's activities in the absence of the Primary Supervising Physician and while actively supervising the physician assistant.
- (11) "Volunteer practice" means performance of medical acts, tasks, or functions without expectation of any form of payment or compensation.

*History Note: Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
Eff. September 1, 2009.*

## **21 NCAC 32S .0202      QUALIFICATIONS AND REQUIREMENTS FOR LICENSE**

(a) Except as otherwise provided in this Subchapter, an individual must obtain a license from the Board before practicing as a physician assistant. An applicant for a physician assistant license must:

- (1) submit a completed application to the Board;
- (2) meet the requirements set forth in G.S. 90-9.3 and has not committed any of the acts listed in G.S. 90-14;
- (3) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired U.S. passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (4) submit to the Board proof that the applicant has completed a Physician Assistant Educational Program; if a physician assistant was licensed in North Carolina after June 1, 1994, he/she must also show successful completion of the Physician Assistant National Certifying Examination;
- (5) pay to the Board a non-refundable fee of two hundred dollars (\$200.00) plus the cost of a criminal background check. There is no fee to apply for a physician assistant limited volunteer license;
- (6) submit National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) reports. These reports must be requested by the Applicant and submitted to the Board within 60 days of the request;
- (7) submit a Board Action Data Bank Inquiry from the Federation of State Medical Boards (FSMB). This report must be requested by the Applicant and submitted to the Board within 60 days of the request;
- (8) submit to the Board two complete original fingerprint record cards, on fingerprint record cards supplied by the Board;
- (9) submit to the Board a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
- (10) disclose whether he/she has ever been suspended from, placed on academic probation, expelled or required to resign from any school, including a PA educational program;
- (11) attest that he/she has no license, certificate, or registration as a physician assistant currently under discipline, revocation, suspension or probation or any other adverse action resulting from a health care licensing board;
- (12) certify that he or she is mentally and physically able to safely practice as a physician assistant and is of good moral character;
- (13) provide the Board with three original recommendation forms dated within six months of the application. These recommendations shall come from persons under whom the applicant has worked or trained who are familiar with the applicant's academic competence or clinical skills. At least one reference form must be from a physician and two reference forms must be from peers under whom the applicant has worked or trained. References must be able to evaluate the applicant's academic competence, clinical skills and character as a physician assistant. References shall not be from any family member or in the case of new graduate applicants, references shall not be from fellow students of the applicant's Educational Program;
- (14) if two years or more have passed since graduation from a Physician Assistant Educational Program, document that he/she has successfully completed at least 100 hours of continuing medical education (CME) during the preceding two years, at least 40 hours of which must be American Academy of Physician Assistants Category I CME; and
- (15) supply any other information the Board deems necessary to evaluate the applicant's qualifications.

(b) An applicant may be required to appear in person for an interview with the Board.

*History Note: Authority G.S. 90-3; 90-9.3; 90-11; 90-18(c)(13); 90-18.1;  
Eff. September 1, 2009;  
Amended Eff. March 1, 2011.*

**21 NCAC 32S .0203        MANDATORY NOTIFICATION OF INTENT TO PRACTICE**

(a) Prior to the performance of any medical acts, tasks, or functions under the supervision of a primary supervising physician, a physician assistant shall submit notification of such intent using the Board's Intent to Practice form located on the Board's website. The notification of intent to practice shall include:

- (1) the name, practice addresses, and telephone number of the physician assistant; and
- (2) the name, practice addresses, and telephone number of the primary supervising physician(s).

(b) The physician assistant shall not commence practice until he/she receives acknowledgment from the Board that the Board has received and processed the Intent to Practice Form. By checking the Board's website, the physician assistant can confirm that the primary supervising physician has been added to the physician assistant's personal information page on the Board's website.

(c) The physician assistant shall notify the Board of any changes to the information required in Paragraph (a) of this Rule within 15 days of the occurrence.

*History Note:*     *Authority G.S. 90-9.3; 90-14(a)(11); 90-18(c)(13); 90-18.1;*  
                         *Eff. September 1, 2009.*

**21 NCAC 32S .0204      ANNUAL RENEWAL**

(a) A physician assistant shall renew his/her license each year no later than 30 days after his/her birthday by:

- (1) completing the Board's renewal form; and
- (2) submitting a nonrefundable fee of one hundred twenty dollars (\$120.00), except that a physician assistant who renews not later than 30 days after his/her birthday shall pay an annual renewal fee of one hundred dollars (\$100.00);

(b) If a physician assistant fails to renew his/her license, the Board shall send a certified notice, return receipt requested. If the physician assistant does not renew his/her license within 30 days of the date of the mailing of that notice, his/her license automatically becomes inactive.

*History Note:      Authority G.S. 90-9.3(c);  
                         Eff. September 1, 2009.*

**21 NCAC 32S .0205      INACTIVE LICENSE STATUS**

By notifying the board in writing, a physician assistant may elect to place his/her license on inactive status. A physician assistant with an inactive license shall not practice as a physician assistant. A physician assistant who engages in practice while his/her license is inactive is practicing without a license and is subject to discipline by the Board as well as criminal penalties.

*History Note:      Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
Eff. September 1, 2009.*

(a) A physician assistant may apply to reactivate his/her license if:

- History Note:* Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
Eff. September 1, 2009.

*History Note:* Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
Eff. September 1, 2009.



**21 NCAC 32S .0207      LICENSE REINSTATEMENT**

- (a) A physician assistant may apply to reinstate his/her license if the license has been inactive for more than one calendar year, or if the inactive status resulted from disciplinary action or was taken to avoid disciplinary action.
- (b) A physician assistant requesting reinstatement shall satisfy all the requirements set forth in 21 NCAC 32S .0202.
- (c) An applicant may be required to appear in person for an interview with the Board.

*History Note:*      *Authority G.S. 90-9.3; 90-13(c)(13); 90-18.8;*  
                         *Eff. September 1, 2009.*

**21 NCAC 32S .0209      NON APPLICABILITY**

This Subchapter does not apply to:

- (1) a student enrolled in a Physician Assistant Educational Program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organizations;
- (2) a physician assistant employed by the federal government while performing duties incident to that employment; or
- (3) an agent or employee of a physician who performs delegated tasks in the office of a physician but who is not rendering services as a physician assistant and identifying him/herself as a physician assistant.

*History Note:*      *Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;*  
*Eff. September 1, 2009.*

**21 NCAC 32S .0210 IDENTIFICATION REQUIREMENTS**

A physician assistant shall keep proof of current licensure and renewal available for inspection at the primary place of practice and shall, when engaged in professional activities, wear a name tag consistent with G.S. 90-640.

*History Note:* Authority G.S.90-9.3; 90-18(c)(13); 90-640;  
Eff. September 1, 2009.

**21 NCAC 32S .0211      AGENCY**

Physician assistants are the agents of their supervising physicians in the performance of all medical practice-related activities, including the ordering of diagnostic, therapeutic and other medical services.

*History Note:*      *Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;*  
                         *Eff. September 1, 2009.*

## **21 NCAC 32S .0212      PRESCRIPTIVE AUTHORITY**

A physician assistant may prescribe, order, procure, dispense and administer drugs and medical devices subject to the following conditions:

- (1) The physician assistant complies with all state and federal laws regarding prescribing including G.S. 90-18.1(b);
- (2) Each supervising physician and physician assistant incorporates within his or her written supervisory arrangements, as defined in Rule .0201(8) of this Subchapter, instructions for prescribing, ordering, and administering drugs and medical devices and a policy for periodic review by the physician of these instructions and policy;
- (3) In order to compound and dispense drugs, the physician assistant complies with G.S. 90-18.1(c);
- (4) In order to prescribe controlled substances,
  - (a) the physician assistant must have a valid Drug Enforcement Administration (DEA) registration and prescribe in accordance with DEA rules;
  - (b) all prescriptions for substances falling within schedules II, IIN, III, and IIIN, as defined in the federal Controlled Substances Act, shall not exceed a legitimate 30 day supply; and
  - (c) the supervising physician must possess the same schedule(s) of controlled substances as the physician assistant's DEA registration;
- (5) Each prescription issued by the physician assistant contains, in addition to other information required by law, the following:
  - (a) the physician assistant's name, practice address and telephone number;
  - (b) the physician assistant's license number and, if applicable, the physician assistant's DEA number for controlled substances prescriptions; and
  - (c) the responsible supervising physician's (primary or back-up) name and telephone number;
- (6) The physician assistant documents prescriptions in writing on the patient's record, including the medication name and dosage, amount prescribed, directions for use, and number of refills;
- (7) A physician assistant who requests, receives, and dispenses medication samples to patients complies with all applicable state and federal regulations; and
- (8) A physician assistant shall not prescribe controlled substances, as defined by the state and federal controlled substances acts for:
  - (a) the physician assistant's own use;
  - (b) the use of the physician assistant's supervising physician;
  - (c) the use of the physician assistant's immediate family;
  - (d) the use of any person living in the same residence as the physician assistant; or
  - (e) the use of any anyone with whom the physician assistant is having a sexual relationship.

As used in this Paragraph, "immediate family" means a spouse, parent, child, sibling, parent-in-law, son-in-law or daughter-in-law, brother-in-law or sister-in-law, step-parent, step-child, step-sibling.

*History Note: Authority G.S. 90-18(c)(13); 90-18.1; 90-18.2A; 90-171.23(14); 21 C.F.R. 301; Eff. September 1, 2009; Amended Eff. August 1, 2012.*

(a) A physician assistant may perform medical acts, tasks, or functions only under the supervision of a physician. Supervision shall be continuous but, except as otherwise provided in the rules of this Subchapter, shall not be construed as requiring the physical presence of the supervising physician at the time and place that the services are rendered.

(c) Each supervising physician and physician assistant shall sign a statement, as defined in Rule .0201(8) of this Subchapter, that describes the supervisory arrangements in all settings. Written prescribing instructions are required for each approved site. This statement shall be kept on file at all practice sites, and must be available upon request by the Board.

*History Note:* Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
Eff. September 1, 2009.

**21 NCAC 32S .0214        SUPERVISING PHYSICIAN**

A physician wishing to serve as a primary supervising physician must exercise supervision of the physician assistant in accordance with rules adopted by the Board. The physician shall retain professional responsibility for the care rendered by the physician assistant within the scope of the supervisory arrangement.

*History note:        Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
                             Eff. September 1, 2009.*

**21 NCAC 32S .0215      RESPONSIBILITIES OF PRIMARY SUPERVISING PHYSICIANS IN REGARD TO  
BACK-UP SUPERVISING PHYSICIANS**

(a) The primary supervising physician shall ensure that a supervising physician, either primary or back-up, is readily accessible for the physician assistant to consult whenever the physician assistant is performing medical acts, tasks, or functions.

(b) A back-up supervising physician must be licensed to practice medicine by the Board, not prohibited by the Board from supervising a physician assistant, and approved by the primary supervising physician as a person willing and qualified to assume responsibility for the care rendered by the physician assistant in the absence of the primary supervising physician. An ongoing list of all approved back-up supervising physicians, signed and dated by each back-up supervising physician, the primary supervising physician, and the physician assistant, must be retained as part of the Supervisory Arrangement.

*History Note:*      *Authority G.S. 90-18(c)(13); 90-18.1;*  
                         *Eff. September 1, 2009.*



(a) A physician assistant must complete at least 100 hours of continuing medical education (CME) every two years, at least 40 hours of which must be American Academy of Physician Assistants Category I CME. CME documentation must be available for inspection by the board or its agent upon request. The two year period shall run from the physician assistant's birthday, beginning in the year 1999, or the first birthday following initial licensure, whichever occurs later.

(b) A physician assistant who possesses a current certification with the National Commission on Certification of Physician Assistants (NCCPA) will be deemed in compliance with the requirement of Paragraph (a) of this Rule. The physician assistant must attest on his or her annual renewal that he or she is currently certified by the NCCPA.

*History Note: Authority G.S. 90-5.1(a)(3) and (10); 90-9.3; 90-18(c)(13); 90-18.1; Eff. September 1, 2009; Amended Eff. November 1, 2010.*

**21 NCAC 32S .0217 VIOLATIONS**

The Board may take disciplinary action against a supervising physician or a physician assistant, pursuant to G.S. 90-14. It is unprofessional or dishonorable conduct for a physician assistant to violate the rules of this Subchapter, or to represent him/herself as a physician.

*History Note: Authority G.S. 90-9.3; 90-14; 90-14.2;  
Eff. September 1, 2009.*

**21 NCAC 32S .0218      TITLE AND PRACTICE PROTECTION**

(a) Any person not licensed by the Board violates G.S. 90-18.1 if he or she:

- (1) falsely identifies him/herself as a physician assistant;
- (2) uses any combination or abbreviation of the term "physician assistant" to indicate or imply that he or she is a physician assistant; or
- (3) acts as a physician assistant without being licensed by the Board.

(b) An unlicensed physician may not use the title of "physician assistant" or practice as a physician assistant unless he/she fulfills the requirements of this Subchapter.

*History Note:*      *Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;*  
                         *Eff. September 1, 2009.*

**21 NCAC 32S .0219 LIMITED PHYSICIAN ASSISTANT LICENSE FOR DISASTERS AND EMERGENCIES**

- (a) The Board shall, pursuant to G.S. 90-12.5, issue a limited physician assistant license under the following conditions:
- (1) the Governor of the State of North Carolina has declared a disaster or state of emergency, or in the event of an occurrence for which a county or municipality has enacted an ordinance to deal with states of emergency under G.S. 14-288.12, 14-288.13, or 14-288.14, or to protect the public health, safety or welfare of its citizens under Article 22 of Chapter 130A of the General Statutes, G.S. 160A-174(a) or G.S. 153A-121(a);
  - (2) the applicant provides government-issued photo identification;
  - (3) the applicant provides proof of licensure, certification or authorization to practice as a physician assistant in another state, the District of Columbia, US Territory or Canadian province;
  - (4) applicant affirms under oath that such license is in good standing; and
  - (5) no grounds exist pursuant to G.S. 90-14(a) for the Board to deny a license.
- (b) In response to the specific circumstances presented by a declared disaster or state of emergency and in order to best serve the public interest, the Board may limit the physician assistant's scope of practice including, but not limited to, the following: geography; term; type of practice; prescribing, administering and dispensing therapeutic measures, tests, procedures and drugs; supervision; and practice setting.
- (c) The physician assistant must practice under the direct supervision of an on-site physician. The supervising physician must be licensed in this State or approved to practice in this State during a disaster or state of emergency pursuant to G.S. 90-12.5 and 21 NCAC 32B .1705. The physician assistant may perform only those medical acts, tasks, and functions delegated by the supervising physician and not limited by the physician assistant's scope of practice as set out in Paragraph (b) of this Rule.
- (d) A team of physician(s) and physician assistant(s) practicing pursuant to this Rule is not required to maintain on-site documentation describing supervisory arrangements and instructions for prescriptive authority as otherwise required by 21 NCAC 32S .0213.
- (e) A physician assistant holding a Limited Physician Assistant License for Disasters and Emergencies shall not receive any other or additional compensation outside his or her usual compensation, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services during a disaster or emergency.

*History Note: Authority G.S. 90-9.3; 90-12.5; 90-18(c)(13); 166A-6;  
Eff. September 1, 2009;  
Amended Eff. November 1, 2010.*

## **21 NCAC 32S .0220      EXPEDITED APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE**

(a) An physician assistant who has been licensed, certified, or authorized to practice in at least one other state, the District of Columbia, U.S. Territory or Canadian province for at least five years, has been in active clinical practice during the past two years and who has a clean license application, as defined in Paragraph (c) of this Rule, may apply for a license on an expedited basis.

(b) In order to apply for an expedited Physician Assistant License, an applicant shall:

- (1) submit a completed application, using the Board's form, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit documentation of a legal name change, if applicable;
- (3) on the Board's form, submit a recent photograph, at least two inches by two inches, certified as a true likeness of the applicant by a notary public;
- (4) supply a certified copy of applicant's birth certificate if applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status, which the Board will use to verify applicant's ability to work lawfully in the United States;
- (5) provide proof that applicant had held an active license, certification or authorization as a physician assistant in at least one other state or jurisdiction for the last five years immediately preceding this application;
- (6) submit proof of successful completion of the Physician Assistant National Certifying Examination;
- (7) submit proof of current certification by the National Commission on Certification of Physician Assistants;
- (8) provide proof of an active clinical practice, providing patient care for an average of 20 hours or more per week, for at least the last two years;
- (9) submit a NPDB/HIPDB report dated within 60 days of applicant's oath;
- (10) submit a FSMB Board Action Data Bank report;
- (11) submit two completed fingerprint cards supplied by the Board;
- (12) submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
- (13) pay to the Board a non-refundable fee of two hundred dollars (\$200.00), as required by 21 NCAC 32S .0202, plus the cost of a criminal background check;
- (14) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.

(c) A clean license application means that the physician assistant has none of the following:

- (1) professional liability insurance claim(s) or payment(s);
- (2) criminal record;
- (3) medical condition(s) which could affect the physician assistant's ability to practice safely;
- (4) regulatory board complaint(s), investigation(s), or action(s) (including applicant's withdrawal of a license application);
- (5) adverse action taken by a health care institution;
- (6) investigation(s) or action(s) taken by a federal agency, the US military, medical societies or associations; or
- (7) suspension or expulsion from any school, including an educational program for physician assistants.

(d) All reports must be submitted directly to the Board from the primary source, when possible.

(e) An application must be completed within one year of the date on which the application fee is paid. If not, the applicant shall be charged a new application fee.

*History Note: Authority G.S. 90-9.3; 90-13.1;  
Eff. November 1, 2010.*

## **21 NCAC 32S .0221 LIMITED VOLUNTEER LICENSE**

(a) A physician assistant who holds a regular license in North Carolina may convert that license to a Limited Volunteer License by notifying the Board in writing.

(b) The Board may issue a Limited Volunteer License to a physician assistant who holds an active license or registration in another state. In order to obtain a Limited Volunteer License, an applicant shall;

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (3) submit documentation of a legal name change, if applicable;
- (4) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired U.S. passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (5) submit proof of active licensure from another state or jurisdiction indicating the status of the license and whether or not any action has been taken against it;
- (6) submit two completed fingerprint record cards supplied by the Board;
- (7) submit a signed consent form allowing a search of local, state and national files for any criminal record;
- (8) pay a non-refundable fee to cover the cost of a criminal background check;
- (9) submit a FSMB Board Action Data Bank report;
- (10) submit a NPDB/HIPDB report, dated within 60 days of submission of the application;
- (11) submit documentation of CME obtained in the last three years;
- (12) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(c) All materials must be submitted to the Board from the primary source, when possible.

(d) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(e) An application must be completed within one year of the date of submission.

*History Note: Authority G.S. 90-9.3; 90-18(c)(13); 90-18.1;  
Eff. December 1, 2012.*

## **21 NCAC 32S .0222 RETIRED LIMITED VOLUNTEER LICENSE**

(a) The Retired Limited Volunteer License is available to a physician assistant who has been licensed in North Carolina or another state or jurisdiction, has an inactive license, and wishes to volunteer at civilian indigent clinics.

(b) A physician assistant with an inactive North Carolina license who wishes to return to practice on a volunteer basis must first reactivate or reinstate his or her license, whichever applies, by complying with 21 NCAC 32S .0206 or 21 NCAC 32S .0207. Once reactivated or reinstated, a physician assistant may convert that license to a limited volunteer license without paying an additional fee. A physician assistant who has been inactive for more than two years will be required to complete a reentry program.

(c) In order to obtain a Retired Limited Volunteer License an applicant who has not held a North Carolina license shall:

- (1) submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
- (3) submit documentation of a legal name change, if applicable;
- (4) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired U.S. passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (5) submit proof of licensure from another state or jurisdiction indicating the status of the license and whether or not any action has been taken against it;
- (6) submit two completed fingerprint record cards supplied by the Board;
- (7) submit a signed consent form allowing a search of local, state and national files for any criminal record;
- (8) pay a non-refundable fee to cover the cost of a criminal background check;
- (9) submit a FSMB Board Action Data Bank report;
- (10) submit a NPDB/HIPDB report, dated within 60 days of submission of the application;
- (11) submit documentation of CME obtained in the last three years; and
- (12) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character

(c) All materials must be submitted to the Board from the primary source, when possible.

(d) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(e) An application must be completed within one year of the date of submission.

*History Note: Authority G.S. 90-8.1; 90-12.1B;  
Eff. December 1, 2012.*

**21 NCAC 32S .0223 SCOPE OF PRACTICE**

The holder of a Limited Volunteer License or a Retired Limited Volunteer License may perform medical acts, tasks, or functions as a physician assistant under the supervision of a physician only at clinics that specialize in the treatment of indigent patients, and may not receive any compensation for services rendered, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services.

*History Note:* Authority G.S. 90-8.1; 90-12.4B;  
Eff. December 1, 2012.



## **SUBCHAPTER 32T – CLINICAL PHARMACIST PRACTITIONER**

### **SECTION .0100 – CLINICAL PHARMACIST PRACTITIONER**

#### **21 NCAC 32T .0101 CLINICAL PHARMACIST PRACTITIONER**

(a) Definitions as used in the Rule:

- (1) "Medical Board" means the North Carolina Medical Board.
- (2) "Pharmacy Board" means the North Carolina Board of Pharmacy.
- (3) "Joint Subcommittee" means the subcommittee composed of four members of the Pharmacy Board and four members of the Medical Board to whom responsibility is given by G.S. 90-6(c) to develop rules to govern the provision of drug therapy management by the Clinical Pharmacist Practitioner in North Carolina.
- (4) "Clinical Pharmacist Practitioner or CPP" means a licensed pharmacist who is approved to provide drug therapy management under the direction of, or under the supervision of a licensed physician who has provided written instructions for a patient and disease specific drug therapy which may include ordering, changing, substituting therapies or ordering tests. Only a pharmacist approved by the Pharmacy Board and the Medical Board may legally identify himself as a CPP.
- (5) "Supervising Physician" means a licensed physician who, by signing the CPP agreement, is held accountable for the on-going supervision and evaluation of the drug therapy management performed by the CPP as defined in the physician, patient, pharmacist and disease specific written agreement.
- (6) "Approval" means authorization by the Medical Board and the Pharmacy Board for a pharmacist to practice as a CPP in accordance with this Rule.
- (7) "Continuing Education or CE" is defined as courses or materials which have been approved for credit by the American Council on Pharmaceutical Education.
- (8) "Clinical Experience approved by the Boards" means work in a pharmacy practice setting which includes experience consistent with the following components as listed in Parts (b)(2)(A), (B), (C), (D), (E), (H), (I), (J), (N), (O), and (P) of this Rule. Clinical experience requirements must be met only through activities separate from the certificate programs referred to in Parts (b)(1)(B) of this Rule.

(b) CPP application for approval.

- (1) The requirements for application for CPP approval include that the pharmacist:
  - (A) has an unrestricted and current license to practice as a pharmacist in North Carolina;
  - (B) meets one of the following qualifications:
    - (i) has earned Certification from the Board of Pharmaceutical Specialties, is a Certified Geriatric Pharmacist as certified by the Commission for Certification in Geriatric Pharmacy, or has completed an American Society of Health System Pharmacists (ASHP) accredited residency program, which includes two years of clinical experience approved by the Boards;
    - (ii) has successfully completed the course of study and holds the academic degree of Doctor of Pharmacy and has three years of clinical experience approved by the Boards and has completed a North Carolina Center for Pharmaceutical Care (NCCPC) or American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice covered by the CPP agreement; or
    - (iii) has successfully completed the course of study and holds the academic degree of Bachelor of Science in Pharmacy and has five years of clinical experience approved by the Boards and has completed two NCCPC or ACPE approved certificate programs with at least one program in the area of practice covered by the CPP agreement;
  - (C) submits the required application and the fee to the Medical Board;
  - (D) submits any information deemed necessary by the Medical Board in order to evaluate the application; and
  - (E) has a signed supervising physician agreement.

If for any reason a CPP discontinues working in the approved physician arrangement, the clinical pharmacist practitioner shall notify both Boards in writing within ten days and the CPP's approval shall automatically terminate or be placed on an inactive status until such time as a new application is approved in accordance with this Subchapter.

- (2) All certificate programs referred to in Subpart (b)(1)(B)(i) of this Rule must contain a core curriculum including the following components:
    - (A) communicating with healthcare professionals and patients regarding drug therapy, wellness, and health promotion;
    - (B) designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to insure effective, safe, and economical patient care;
    - (C) identifying, assessing and solving medication-related problems and providing a clinical judgment as to the continuing effectiveness of individualized therapeutic plans and intended therapeutic outcomes;
    - (D) conducting physical assessments, evaluating patient problems, ordering and monitoring medications and laboratory tests;
    - (E) referring patients to other health professionals as appropriate;
    - (F) administering medications;
    - (G) monitoring patients and patient populations regarding the purposes, uses, effects and pharmacoeconomics of their medication and related therapy;
    - (H) counseling patients regarding the purposes, uses, and effects of their medication and related therapy;
    - (I) integrating relevant diet, nutritional and non-drug therapy with pharmaceutical care;
    - (J) recommending, counseling, and monitoring patient use of non-prescription drugs, herbal remedies and alternative medicine practices;
    - (K) ordering of and educating patients regarding proper usage of devices, and durable medical equipment;
    - (L) providing emergency first care;
    - (M) retrieving, evaluating, utilizing, and managing data and professional resources;
    - (N) using clinical data to optimize therapeutic drug regimens;
    - (O) collaborating with other health professionals;
    - (P) documenting interventions and evaluating pharmaceutical care outcomes;
    - (Q) integrating pharmacy practice within healthcare environments;
    - (R) integrating national standards for the quality of healthcare; and
    - (S) conducting outcomes and other research.
  - (3) The completed application for approval to practice as a CPP shall be reviewed by the Medical Board upon verification of a full and unrestricted license to practice as a pharmacist in North Carolina.
    - (A) The application shall be approved and at the time of approval the Medical Board shall issue a number which shall be printed on each prescription written by the CPP; or
    - (B) the application shall be denied; or
    - (C) the application shall be approved with restrictions.
- (c) Annual Renewal.
- (1) Each CPP shall register annually on the anniversary of his or her birth date by:
    - (A) verifying a current Pharmacist license;
    - (B) submitting the renewal fee as specified in Subparagraph (j)(2) of this Rule;
    - (C) completing the Medical Board's renewal form; and
    - (D) reporting continuing education credits as specified by the Medical Board.
  - (2) If the CPP has not renewed within 30 days of the anniversary of the CPP's birth date, the approval to practice as a CPP shall lapse.
- (d) Continuing Education.
- (1) Each CPP shall earn 35 hours of practice relevant CE each year approved by the Pharmacy Board.
  - (2) Documentation of these hours shall be kept at the CPP practice site and made available for inspection by agents of the Medical Board or Pharmacy Board.
- (e) The supervising physician who has a signed agreement with the CPP shall be readily available for consultation with the CPP; and shall review and countersign each order written by the CPP within seven days.
- (f) The written CPP agreement shall:
- (1) be approved and signed by both the supervising physician and the CPP and a copy shall be maintained in each practice site for inspection by agents of either Board upon request;
  - (2) be specific in regards to the physician, the pharmacist, the patient and the disease;

- (3) specify the predetermined drug therapy which shall include the diagnosis and product selection by the patient's physician; any modifications which may be permitted, dosage forms, dosage schedules and tests which may be ordered;
  - (4) prohibit the substitution of a chemically dissimilar drug product by the CPP for the product prescribed by the physician without first obtaining written consent of the physician;
  - (5) include a pre-determined plan for emergency services;
  - (6) include a plan and schedule for weekly quality control, review and countersignature of all orders written by the CPP in a face-to-face conference between the physician and CPP;
  - (7) require that the patient be notified of the collaborative relationship; and
  - (8) be terminated when patient care is transferred to another physician and new orders shall be written by the succeeding physician.
- (g) The supervising physician of the CPP shall:
- (1) be fully licensed with the Medical Board and engaged in clinical practice;
  - (2) not be serving in a postgraduate medical training program;
  - (3) be approved in accordance with this Subchapter before the CPP supervision occurs; and
  - (4) supervise no more than three pharmacists.
- (h) The CPP shall wear a nametag spelling out the words "Clinical Pharmacist Practitioner".
- (i) The CPP may be censured or reprimanded or the CPP's approval may be restricted, suspended, revoked, annulled, denied or terminated by the Medical Board or the Pharmacy Board and the pharmacist may be censured or reprimanded or the pharmacist's license may be restricted, suspended, revoked, annulled, denied, or terminated by the Pharmacy Board, in accordance with provisions of G.S. 150B if either Board finds one or more of the following:
- (1) the CPP has held himself or herself out or permitted another to represent the CPP as a licensed physician;
  - (2) the CPP has engaged or attempted to engage in the provision of drug therapy management other than at the direction of, or under the supervision of, a physician licensed and approved by the Medical Board to be that CPP's supervising physician;
  - (3) the CPP has performed or attempted to provide medical management outside the approved drug therapy agreement or for which the CPP is not qualified by education and training to perform;
  - (4) The CPP commits any act prohibited by any provision of G.S. 90-85.38 as determined by the Pharmacy Board or G.S. 90-14(a)(1), (a)(3) through (a)(14) and (c) as determined by the Medical Board; or
  - (5) the CPP has failed to comply with any of the provisions of this Rule.
- Any modification of treatment for financial gain on the part of the supervising physician or CPP shall be grounds for denial of Board approval of the agreement.
- (j) Fees:
- (1) An application fee of one hundred dollars (\$100.00) shall be paid at the time of initial application for approval and each subsequent application for approval to practice.
  - (2) The fee for annual renewal of approval, due on the CPP's anniversary of birth date is fifty dollars (\$50.00).
  - (3) No portion of any fee in this Rule is refundable.

*History Note*      *Authority* G.S. 90-6(c); 90-18(c)3a; 90-18.4;  
                          *Eff.* April 1, 2001;  
                          *Amended Eff.* March 1, 2007; October 1, 2001.

## **SUBCHAPTER 32U - PHARMACISTS VACCINATIONS**

### **SECTION .0100 - PHARMACISTS VACCINATIONS**

#### **21 NCAC 32U .0101 ADMINISTRATION OF VACCINES BY PHARMACISTS**

(a) Purpose. The purpose of this Rule is to provide standards for pharmacists engaged in the administration of influenza, pneumococcal and zoster vaccines as authorized in G.S. 90-85.3(r) of the North Carolina Pharmacy Practice Act.

(b) Definitions. The following words and terms, when used in this Rule, have the following meanings, unless the context indicates otherwise.

- (1) "ACPE" means Accreditation Council for Pharmacy Education.
- (2) "Administer" means the direct application of a drug to the body of a patient by injection, inhalation, ingestion, or other means by:
  - (A) a pharmacist, an authorized agent under the pharmacist's supervision, or other person authorized by law; or
  - (B) the patient at the direction of a physician or pharmacist.
- (3) "Antibody" means a protein in the blood that is produced in response to stimulation by a specific antigen. Antibodies help destroy the antigen that produced them. Antibodies against an antigen usually equate to immunity to that antigen.
- (4) "Antigen" means a substance recognized by the body as being foreign; it results in the production of specific antibodies directed against it.
- (5) "Board" means the North Carolina Board of Pharmacy.
- (6) "Confidential record" means any health-related record that contains information that identifies an individual and that is maintained by a pharmacy or pharmacist such as a patient medication record, prescription drug order, or medication order.
- (7) "Immunization" means the act of inducing antibody formation, thus leading to immunity.
- (8) "Medical Practice Act" means G.S. 90-1, et seq.
- (9) "Physician" means a currently licensed M.D. or D.O. with the North Carolina Medical Board who is responsible for the on-going, continuous supervision of the pharmacist pursuant to written protocols between the pharmacist and the physician.
- (10) "Vaccination" means the act of administering any antigen in order to induce immunity; is not synonymous with immunization since vaccination does not imply success.
- (11) "Vaccine" means a specially prepared antigen, which upon administration to a person may result in immunity.
- (12) "Written Protocol" means a physician's written order, standing medical order, or other order or protocol. A written protocol must be prepared, signed and dated by the physician and pharmacist and contain the following:
  - (A) the name of the individual physician authorized to prescribe drugs and responsible for authorizing the written protocol;
  - (B) the name of the individual pharmacist authorized to administer vaccines;
  - (C) the immunizations or vaccinations that may be administered by the pharmacist;
  - (D) procedures to follow, including any drugs required by the pharmacist for treatment of the patient, in the event of an emergency or severe adverse reaction following vaccine administration;
  - (E) the reporting requirements by the pharmacist to the physician issuing the written protocol, including content and time frame;
  - (F) locations at which the pharmacist may administer immunizations or vaccinations; and
  - (G) the requirement for annual review of the protocols by the physician and pharmacist.

(c) Policies and Procedures.

- (1) Pharmacists must follow a written protocol as specified in Subparagraph (b)(12) of this Rule for administration of influenza, pneumococcal and zoster vaccines and the treatment of severe adverse events following administration.
- (2) The pharmacist administering vaccines must maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies.
- (3) The pharmacist or pharmacist's agent must give the appropriate, most current vaccine information regarding the purpose, risks, benefits, and contraindications of the vaccine to the patient or legal

representative with each dose of vaccine. The pharmacist must ensure that the patient or legal representative is available and has read, or has had read to him or her, the information provided and has had his or her questions answered prior to administering the vaccine.

- (4) The pharmacist must report adverse events to the primary care provider as identified by the patient.
- (5) The pharmacist shall not administer vaccines to patients under 18 years of age.
- (6) The pharmacist shall not administer the pneumococcal or zoster vaccines to a patient unless the pharmacist first consults with the patient's primary care provider. The pharmacist shall document in the patient's profile the primary care provider's order to administer the pneumococcal or zoster vaccines. If the patient does not have a primary care provider, the pharmacist shall not administer the pneumococcal or zoster vaccines to the patient.
- (7) The pharmacist shall report all vaccines administered to the patient's primary care provider and report all vaccines administered to all entities as required by law, including any State registries which may be implemented in the future.

(d) Pharmacist requirements. Pharmacists who enter into a written protocol with a physician to administer vaccines shall:

- (1) hold a current provider level cardiopulmonary resuscitation (CPR) certification issued by the American Heart Association or the American Red Cross or an equivalent certification organization;
- (2) successfully complete a certificate program in the administration of vaccines accredited by the Centers for Disease Control, the ACPE or a health authority or professional body approved by the Board as having a certificate program similar to the programs accredited by either the Centers for Disease Control or the ACPE;
- (3) maintain documentation of:
  - (A) completion of the initial course specified in Subparagraph (2) of this Paragraph;
  - (B) three hours of continuing education every two years beginning January 1, 2006, which are designed to maintain competency in the disease states, drugs, and administration of vaccines;
  - (C) current certification specified in Subparagraph (1) of this Paragraph;
  - (D) original written physician protocol;
  - (E) annual review and revision of original written protocol with physician;
  - (F) any problems or complications reported; and
  - (G) items specified in Paragraph (g) of this Rule.

A pharmacist who, because of physical disability, is unable to obtain a current provider level CPR certification may administer vaccines in the presence of a pharmacy technician or pharmacist who holds a current provider level CPR certification.

(e) Supervising Physician responsibilities. Pharmacists who administer vaccines shall enter into a written protocol with a supervising physician who agrees to meet the following requirements:

- (1) be responsible for the formulation or approval and periodic review of the physician's order, standing medical order, standing delegation order, or other order or written protocol and periodically review the order or protocol and the services provided to a patient under the order or protocol;
- (2) be accessible to the pharmacist administering the vaccines or be available through direct telecommunication for consultation, assistance, direction, and provide back-up coverage;
- (3) review written protocol with pharmacist at least annually and revise if necessary; and
- (4) receive a periodic status report on the patient, including any problem or complication encountered.

(f) Drugs. The following requirements pertain to drugs administered by a pharmacist:

- (1) Drugs administered by a pharmacist under the provisions of this Rule shall be in the legal possession of:
  - (A) a pharmacy, which shall be the pharmacy responsible for drug accountability, including the maintenance of records of administration of the immunization or vaccination; or
  - (B) a physician, who shall be responsible for drug accountability, including the maintenance of records of administration of the immunization or vaccination;
- (2) Drugs shall be transported and stored at the proper temperatures indicated for each drug;

- (3) Pharmacists, while engaged in the administration of vaccines under written protocol, shall have in their custody and control the vaccines identified in the written protocol and any other drugs listed in the written protocol to treat adverse reactions; and
  - (4) After administering vaccines at a location other than a pharmacy, the pharmacist shall return all unused prescription medications to the pharmacy or physician responsible for the drugs.
- (g) Record Keeping and Reporting.
- (1) A pharmacist who administers any vaccine shall maintain the following information, readily retrievable, in the pharmacy records regarding each administration:
    - (A) The name, address, and date of birth of the patient;
    - (B) The date of the administration;
    - (C) The administration site of injection (e.g., right arm, left leg, right upper arm);
    - (D) Route of administration of the vaccine;
    - (E) The name, manufacturer, lot number, and expiration date of the vaccine;
    - (F) Dose administered;
    - (G) The name and address of the patient's primary health care provider, as identified by the patient; and
    - (H) The name or identifiable initials of the administering pharmacist.
  - (2) A pharmacist who administers vaccines shall document the annual review with the physician of written protocol in the records of the pharmacy that is in possession of the vaccines administered.
- (h) Confidentiality.
- (1) The pharmacist shall comply with the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 and any rules adopted pursuant to this act.
  - (2) The pharmacist shall comply with any other confidentiality provisions of federal or state laws.

*History Note:* Authority G.S. 90-85.3(r);  
Emergency Adoption Eff. September 10, 2004;  
Temporary Adoption Eff. December 29, 2004;  
Eff. November 1, 2005;  
Amended Eff. February 1, 2008;  
Emergency Amendment Eff. October 9, 2009;  
Temporary Amendment Eff. December 29, 2009;  
Temporary Amendment Expired on October 12, 2010.  
Amended Eff. March 1, 2012.

## SUBCHAPTER 32V – PERFUSIONIST REGULATIONS

**21 NCAC 32V .0101 SCOPE**

The rules of this Subchapter are designed to implement Article 40 of Chapter 90.

*History Note:* Authority G.S. 90-681; 90-682; 90-685(1)(3);  
Eff. September 1, 2007.

## **21 NCAC 32V .0102      DEFINITIONS**

The following definitions apply to this Subchapter:

- (1) Approved educational program – Any program within the United States approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accreditation Committee for Perfusion Education (AC-PE), or any Canadian educational program recognized by the Conjoint Committee on Accreditation of the Canadian Medical Association (CMA).
- (2) Board – The entity referred to in G.S. 90-682(5) and its agents.
- (3) Committee – The entity referred to in G.S. 90-682(2) and its agents.
- (4) Provisional licensed perfusionist - The person who is authorized to practice perfusion pursuant to 90-698.
- (5) Registering - Renewing the license by paying the biennial fee and complying with Rule .0104 of this Subchapter.
- (6) Supervising - Overseeing the activities of, and accepting the responsibility for, the perfusion services rendered by a provisional licensed perfusionist. Supervision shall be continuous but, except as otherwise provided in the rules of this Subchapter, shall not be construed as requiring the physical presence of the supervising perfusionist at the time and place that the services are rendered. Supervision shall not mean direct, on-site supervision at all times, but shall mean that the supervising perfusionist shall be readily available for consultation and assistance whenever the provisional licensee is performing or providing perfusion services.
- (7) "Supervising Perfusionist" means a perfusionist licensed by the Committee and who serves as a primary supervising perfusionist or as a back-up supervising perfusionist.
  - (a) The "Primary Supervising Perfusionist" is the perfusionist who, by signing the designation of supervising perfusionist form provided by the Committee, accepts responsibility for the provisional licensed perfusionist medical activities and professional conduct at all times, whether the perfusionist is personally providing supervision or the supervision is being provided by a Back-up Supervising Perfusionist.
  - (b) The "Back-up Supervising Perfusionist" means the perfusionist who accepts the responsibility for supervision of the provisional licensed perfusionist's activities in the absence of the Primary Supervising Perfusionist. The Back-up Supervising Perfusionist is responsible for the activities of the provisional licensed perfusionist only when providing supervision.

*History Note:*      *Authority G.S. 90-681; 90-682; 90-685(1)(3);  
Eff. September 1, 2007.*



**21 NCAC 32V .0103      QUALIFICATIONS FOR LICENSE**

(a) Except as otherwise provided in this Subchapter, an individual shall obtain a license from the Committee before the individual may practice as a licensed perfusionist. The Committee may grant a license or a provisional license to an applicant who has met the following criteria:

- (1) satisfies the requirements of G.S. 90-686;
- (2) is not disqualified for any reason set out in G.S. 90-691; and
- (3) submits to the Committee any information the Committee deems necessary to evaluate the application;  
and

(b) An applicant may be required to appear, in person, for an interview with the Committee.

*History Note      Authority G.S. 90-685(1)(3) and (5); 90-686;  
Eff. September 1, 2007.*

**21 NCAC 32V .0104      REGISTRATION**

(a) Each person who holds a license as a perfusionist in this state, other than a provisional licensed perfusionist, shall register his or her perfusionist license every two years prior to its expiration date by:

- (1) completing the Committee's registration form;
- (2) submitting the required fee.

(b) A perfusionist who indicates on the registration form that he or she is not currently certified by the American Board of Cardiovascular Perfusion (ABCP) may be asked to appear before the Committee.

*History Note:      Authority G.S. 90-685(1)(3)(5) and (6); 90-690;  
Eff. September 1, 2007.*

(a) The licensed perfusionist must maintain documentation of 30 hours of continuing education (CE) completed for every two year period. Of the 30 hours, at least 10 hours must be Category I hours as recognized by the American Board of Cardiovascular Perfusion (ABCP), the remaining hours may be Category II or III hours as recognized by the ABCP. CE documentation must be available for inspection by the Committee or Board or an agent of the Committee or Board upon request.

*History Note: Authority G.S. 90-685(3) and (8);  
Eff. September 1, 2007;  
Amended Eff. November 1, 2011.*

**21 NCAC 32V .0106      SUPERVISION OF PROVISIONAL LICENSED PERFUSIONISTS**

The supervising perfusionist shall exercise supervision of a provisional licensed perfusionist as defined in Rule .0102(6) of this Subchapter, assume responsibility for the services provided by the provisional licensee, be responsible for determining the nature and level of supervision required for the provisional licensee, and be responsible for evaluating and documenting the professional skill and competence of the provisional licensee.

*History Note:*      *Authority G.S. 90-685(1)(2) and (3);*  
                         *Eff. September 1, 2007.*

**21 NCAC 32V .0107      SUPERVISING PERFUSIONIST**

(a) A licensed perfusionist wishing to serve as a primary supervising perfusionist must be licensed to practice perfusion by the Board and not prohibited by the Board from supervising a provisional licensed perfusionist.

(b) A perfusionist wishing to serve as a back-up supervising perfusionist must be licensed to practice perfusion by the Board, not prohibited by the Board from supervising a provisional licensed perfusionist, and approved by the primary supervising perfusionist as a person willing and qualified to assume responsibility for the care rendered by the provisional licensed perfusionist in the absence of the primary supervising perfusionist. The primary supervising perfusionist must maintain an ongoing list of all approved back-up supervising perfusionist(s), signed and dated by each back-up supervising perfusionist, the primary supervising perfusionist, and the provisional licensed perfusionist, and this list must be retained and made available for inspection upon request by the Committee or Board.

*History Note:      Authority G.S. 90-685 (1)(2) and (3);  
Eff. September 1, 2007.*

**21 NCAC 32V .0108      DESIGNATION OF PRIMARY SUPERVISING PERFUSIONIST FOR  
PROVISIONAL LICENSEE**

(a) Prior to the performance of perfusion under the supervision of any primary supervising perfusionist, or new primary supervising perfusionist, a provisional licensed perfusionist shall submit a designation of primary supervising perfusionist(s) on forms provided by the Committee. The provisional licensed perfusionist shall not commence practice until acknowledgment of the designation of primary supervising perfusionist(s) form is received from the Committee. Such designation shall include:

- (1) the name, practice addresses, and telephone number of the provisional licensed perfusionist; and
- (2) the name, practice addresses, and telephone number of the primary supervising perfusionist(s).

(b) The primary supervising perfusionist shall notify the Committee of any terminations or cessations of practice of a provisional licensed perfusionist under his or her supervision in a previously acknowledged designation within 15 days of the occurrence.

*History Note:*      *Authority G.S. 90-685(1) and (3);  
Eff. September 1, 2007.*

## **21 NCAC 32V .0109      CIVIL PENALTIES**

(a) In carrying out its duties and obligations under G.S. 90-691 and G.S. 90-693, the following shall constitute aggravating factors:

- (1) Prior disciplinary actions
- (2) Patient harm
- (3) Dishonest or selfish motive
- (4) Submission of false evidence, false statements, or other deceptive practices during the disciplinary process
- (5) Vulnerability of victim
- (6) Refusal to admit wrongful nature of conduct
- (7) Willful or reckless misconduct
- (8) Pattern of misconduct (repeated instances of the same misconduct)
- (9) Multiple offenses (more than one instance of different misconduct)

(b) The following shall constitute mitigating factors:

- (1) Absence of a prior disciplinary record
- (2) No patient harm
- (3) Absence of a dishonest or selfish motive
- (4) Full cooperation with the Committee
- (5) Physical or mental disability or impairment
- (6) Rehabilitation or remedial measures
- (7) Remorse
- (8) Remoteness of prior discipline

(c) Before imposing and assessing a civil penalty, the Committee shall make a determination of whether the aggravating factors outweigh the mitigating factors, or whether the mitigating factors outweigh the aggravating factors. After making such a determination, and if the Committee decides to impose a civil penalty, the Committee shall impose the civil penalty consistent with the following schedule:

- (1) First Offense:  
Presumptive Fine - \$250.  
Finding of Mitigation \$0 to \$249.  
Finding of Aggravation \$251 to \$1,000.
- (2) Second Offense:  
Presumptive Fine - \$500.  
Finding of Mitigation \$0 to \$499.  
Finding of Aggravation \$501 to \$1,000.
- (3) Third or More Offense:  
Presumptive Fine - \$1000.  
Finding of Mitigation \$0 to \$999.  
Finding of Aggravation \$1,000.

*History Note:* Authority G.S. 90-685(1) and (3); 90-693(b)(4);  
Eff. September 1, 2007.

**21 NCAC 32V .0110 IDENTIFICATION REQUIREMENTS**

A licensed perfusionist shall keep proof of current licensure and registration available for inspection at the primary place of practice and shall, when engaged in professional activities, wear a name tag identifying the licensee as a perfusionist consistent with G.S. 90-640(a).

*History Note:* Authority G.S. 90-640(a); 90-685(3);  
Eff. September 1, 2007.



**21 NCAC 32V .0111      PRACTICE DURING A DISASTER**

In the event of a declared disaster or state of emergency that authorizes the Board to exercise its authority under G.S. 90-12.2, and if the Board does exercise its authority pursuant to G.S. 90-12.2, the Board may allow a perfusionist licensed in any other state, or a current, active certified clinical perfusionist who practices in a state where licensure is not required, to perform perfusion during a disaster within a county in which a disaster or state of emergency has been declared or counties contiguous to a county in which a disaster or state of emergency has been declared (in accordance with G.S. 166A-6). The perfusionist who enters the State for purposes of this Rule shall notify the Board within three business days of his or her work site and provide proof of identification and current licensure or certification.

*History Note:*      *Authority G.S. 90-12.2; 90-685(3);*  
                         *Eff. September 1, 2007.*

## **21 NCAC 32V .0112      TEMPORARY LICENSURE**

The Board may grant temporary licensure to a licensed or certified clinical perfusionist in good standing from another state who appears to be qualified for licensure in this State pursuant to G.S. 90-686 and who enters North Carolina to work on an emergency basis. The temporary license shall be valid for a period not to exceed 60 days. Within 10 days of receiving a temporary license, the temporary licensed perfusionist must make application for a full license, including payment of the requisite application fee. If the temporary licensed perfusionist fails to submit a full application within the 10 day period, his or her temporary license shall immediately expire. After making application for a full license, the Committee and Board must decide the application before the expiration of the temporary license. For purposes of this Rule, "emergency" shall mean the sudden death or illness, or unforeseen and unanticipated absence, of a licensed perfusionist working at a North Carolina hospital that leaves the hospital unable to provide surgical care to patients in a manner that compromises patient safety. As part of the temporary license process, the hospital must certify to the Committee, on forms provided by the Committee that an emergency exists. "Good standing" for purposes of this Rule shall mean that the applicant is currently able to practice perfusion in another state without any restriction or condition.

*History Note:*      *Authority G.S. 90-685(3); 90-686;*  
                         *Eff. September 1, 2007.*

**21 NCAC 32V .0113      ORDERS FOR ASSESSMENTS AND EVALUATIONS**

(a) The Committee and Board may require a perfusionist or applicant to submit to a mental or physical examination by physicians designated by the Committee or Board before or after charges may be presented against the perfusionist if the Committee or Board has reason to believe a perfusionist may be unable to perform perfusion with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical, mental or behavioral abnormality.

(b) The results of the examination shall be admissible in evidence in a hearing before the Committee.

(c) The Committee or Board may require a perfusionist to submit to inquiries or examinations, written or oral, by members of the Committee or by other perfusionists, as the Committee or Board deems necessary to determine the professional qualifications of such licensee.

*History Note:*      *Authority G.S. 90-685(3)(5)(11);*  
                         *Eff. September 1, 2007.*

**21 NCAC 32V .0114      PROVISIONAL LICENSE TO FULL LICENSE**

A provisional licensed perfusionist who becomes a certified clinical perfusionist as defined by G.S. 90-682(1) at any time while he or she holds a provisional license may request that his or her provisional license be converted to a full license. The provisional licensee must make the request upon forms provided by the Committee and must make payment of an additional one hundred seventy-five dollars (\$175.00) fee. The Committee may request additional information or conduct an interview of the applicant to determine the applicant's qualifications.

*History Note:      Authority G.S. 90-685(3)(5); 90-689;  
                         Eff. December 12, 2007.*

(a) A fee of three hundred and fifty dollars (\$350.00) is due at the time of application for a perfusion license and a fee of one hundred and seventy five dollars (\$175.00) is due at the time of application for a provisional perfusion license. No portion of the application fee is refundable.

(c) A late fee of one hundred dollars (\$100.00) shall be charged to those who fail to renew timely a perfusion license or a provisional perfusion license.

*Eff. March 1, 2008;*

*Amended Eff. November 1, 2011.*

## SUBCHAPTER 32W - ANESTHESIOLOGIST ASSISTANT REGULATIONS

### 21 NCAC 32W .0101 DEFINITIONS

The following definitions apply to this Subchapter:

- (1) "Anesthesiologist" means a physician who has successfully completed an anesthesiology training program approved by the Accreditation Committee on Graduate Medical Education or the American Osteopathic Association or who is credentialed to practice anesthesiology by a Hospital or an Ambulatory Surgical Facility.
- (2) "Anesthesiologist Assistant" means a person licensed by and registered with the Board pursuant to Rule .0102 of this Subchapter to provide anesthesia services under the supervision of a Supervising Anesthesiologist.
- (3) "Anesthesiologist Assistant License" means the authority for the Anesthesiologist Assistant to provide anesthesia services under North Carolina law.
- (4) "Board" means the North Carolina Medical Board.
- (5) "Certifying Examination" means the Certifying Examination for Anesthesiologist Assistants administered by the National Commission for Certification of Anesthesiologist Assistants or its successor organization.
- (6) "Primary Supervising Anesthesiologist" means the Supervising Anesthesiologist who accepts primary responsibility for the Anesthesiologist Assistant's professional activities, including developing and implementing the Anesthesiologist Assistant's Supervision Agreement and assuring the Board that the Anesthesiologist Assistant is qualified by education and training to perform all anesthesia services delegated to the Anesthesiologist Assistant.
- (7) "Renewal" means paying the annual renewal fee and providing the information requested by the Board as outlined in Rule .0104 of this Subchapter.
- (8) "Supervising Anesthesiologist" means an anesthesiologist who is responsible for supervising the Anesthesiologist Assistant in providing anesthesia services. A Supervising Anesthesiologist must be licensed by the Board, actively engaged in clinical practice as an anesthesiologist, and immediately available onsite to provide assistance to the Anesthesiologist Assistant.
- (9) "Supervision" means overseeing the activities of, and accepting responsibility for, the anesthesia services rendered by an Anesthesiologist Assistant.
- (10) "Supervision Agreement" means a written agreement between the Primary Supervising Anesthesiologist(s) and an Anesthesiologist Assistant that describes the anesthesia services delegated to the Anesthesiologist Assistant consistent with the Anesthesiologist Assistant's qualifications, training, skill, competence, and the rules in this Subchapter.

*History Note:* Authority G.S. 90-9.4; 90-18(c)(20); 90-18.5;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008.

(a) Except as otherwise provided in this Subchapter, an individual shall obtain a license from the Board before practicing as an Anesthesiologist Assistant. An applicant for an anesthesiologist assistant license shall:

- History Note: Authority G.S. 90-9.4; 90-18(c)(20); 90-18.5;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008;  
Amended Eff. March 1, 2011.*

## **21 NCAC 32W .0103      INACTIVE LICENSE STATUS**

(a) By notifying the Board in writing, any Anesthesiologist Assistant may elect to place his or her license on inactive status. An Anesthesiologist Assistant with an inactive license shall not practice as an Anesthesiologist Assistant. Any Anesthesiologist Assistant who engages in practice while his or her license is on inactive status shall be considered to be practicing without a license.

(b) An Anesthesiologist Assistant who has been inactive for less than six months may request reactivation of his or her license. He or she shall pay the current annual fee as defined in Rule .0113 of this Subchapter, provide documentation to the Board verifying current certification by the National Commission for Certification of Anesthesiologist Assistants and shall complete the Board's registration form.

(c) An Anesthesiologist Assistant who has been inactive for more than six months shall submit an application for a license and pay the application fee as defined in Rule .0113 of this Subchapter. The Board may deny any such application for any enumerated reason contained in G.S. 90-14 or for any violation of the Rules of this Subchapter.

*History Note:*      *Authority G.S. 90-18(c)(20); 90-18.5;*  
                         *Temporary Adoption Eff. January 28, 2008;*  
                         *Eff. April 1, 2008.*



**21 NCAC 32W .0104      ANNUAL RENEWAL**

(a) Each person who holds a license as an Anesthesiologist Assistant in this state shall renew his or her Anesthesiologist Assistant License each year no later than 30 days after his or her birthday by:

- (1) completing the Board's registration form;
- (2) verifying that he or she is currently certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or its successor organization; and
- (3) submitting the annual renewal fee under Rule .0113 of this Subchapter.

(b) The license of any Anesthesiologist Assistant who does not renew for a period of 30 days after certified notice of the failure to the licensee's last known address of record shall automatically become inactive.

*History Note:*      *Authority G.S. 90-9.4; 90-13.1(f); 90-18(c)(20); 90-18.5;*  
                          *Temporary Adoption January 28, 2008;*  
                          *Eff. April 1, 2008.*

**21 NCAC 32W .0105      CONTINUING MEDICAL EDUCATION**

(a) In order to maintain Anesthesiologist Assistant licensure, each Anesthesiologist Assistant shall complete at least 40 hours of continuing medical education (CME) as required by the National Commission for Certification of Anesthesiologist Assistants (NCCAA), or its successor organization, for every two year period. CME documentation must be available for inspection by the Board or an agent of the Board upon request.

(b) Each licensed Anesthesiologist Assistant shall comply with all recertification requirements of the NCCAA, or its successor organization, including registration of CME credit and successful completion of the Examination for Continued Demonstration of Qualifications of Anesthesiologist Assistants administered by the NCCAA.

*History Note:      Authority G.S. 90-18(c)(20); 90-18.5;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008.*

**21 NCAC 32W .0106      STUDENT ANESTHESIOLOGIST ASSISTANTS**

Student Anesthesiologist Assistants may provide anesthesia services under the supervision of a Supervising Anesthesiologist, provided a qualified anesthesia provider is present at all times while the patient is under anesthesia care.

*History Note:*      *Authority G.S. 90-18.5;*  
                         *Temporary Adoption Eff. January 28, 2008;*  
                         *Eff. April 1, 2008.*

## **21 NCAC 32W .0107      EXEMPTION FROM LICENSE**

Nothing in this Subchapter shall be construed to require licensure for:

- (1) a Student Anesthesiologist Assistant enrolled in an Anesthesiologist Assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization; or
- (2) agents or employees of physicians who perform delegated tasks in the office of a physician consistent with G.S. 90-18(c)(13) and who are not rendering services as Anesthesiologist Assistants or identifying themselves as Anesthesiologist Assistants.

*History Note:*      *Authority G.S. 90-18.5;*  
                         *Temporary Adoption Eff. January 28, 2008;*  
                         *Eff. April 1, 2008.*

**21 NCAC 32W .0108      SCOPE OF PRACTICE**

(a) Anesthesiologist Assistants may provide anesthesia services only under the supervision of a Supervising Anesthesiologist and consistent with the Anesthesiologist Assistant's Supervision Agreement as defined by Rule .0101(10) of this Subchapter and the rules of this Subchapter. No Anesthesiologist Assistant shall practice where a Supervising Anesthesiologist is not immediately available onsite to provide assistance to the Anesthesiologist Assistant.

(b) Anesthesiologist Assistants may perform those duties and responsibilities that are delegated by their Supervising Anesthesiologist(s). The duties and responsibilities delegated to an Anesthesiologist Assistant shall be consistent with the Anesthesiologist Assistant's Supervision Agreement and the rules of this Subchapter.

*History Note:*      *Authority G.S. 90-18(c)(20); 90-18.5;*  
                         *Temporary Adoption Eff. January 28, 2008;*  
                         *Eff. April 1, 2008.*

**21 NCAC 32W .0109      SUPERVISION OF ANESTHESIOLOGIST ASSISTANTS**

(a) The Primary Supervising Anesthesiologist shall ensure that the Anesthesiologist Assistant's scope of practice is identified; that delegation of anesthesia services is appropriate to the level of competence of the Anesthesiologist Assistant; that the relationship of, and access to, each Supervising Anesthesiologist is defined; and that a process for evaluation of the Anesthesiologist Assistant's performance is established.

(b) The Supervision Agreement defined in Rule .0101(10) of this Subchapter must be signed by the Primary Supervising Anesthesiologist(s) and Anesthesiologist Assistant and shall be made available upon request by the Board or its agents. A list of all Supervising Anesthesiologists, signed and dated by each Supervising Anesthesiologist, the Primary Supervising Anesthesiologist, and the Anesthesiologist Assistant, must be retained as part of the Supervision Agreement and shall be made available upon request by the Board or its representatives.

(c) A Supervising Anesthesiologist, who need not be the Primary Supervising Anesthesiologist, shall supervise the Anesthesiologist Assistant and ensure that all anesthesia services delegated to the Anesthesiologist Assistant are consistent with the Anesthesiologist Assistant's Supervision Agreement.

(d) A Supervising Anesthesiologist may supervise up to four Anesthesiologist Assistants at one time.

(e) Entries by an Anesthesiologist Assistant into patient charts of inpatients (hospital, long term care institutions) must comply with the rules and regulations of the institution.

*History Note:      Authority G.S. 90-18(c)(20); 90-18.5;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008;  
Amended Eff. April 1, 2010.*

**21 NCAC 32W .0110      LIMITATIONS ON PRACTICE**

An Anesthesiologist Assistant shall not:

- (1) perform a task which has not been listed and delegated in the Supervision Agreement;
- (2) prescribe drugs, medications, or devices of any kind; however, this Rule does not preclude the Anesthesiologist Assistant from implementing or administering a treatment or pharmaceutical regimen prescribed by the Supervising Anesthesiologist.

*History Note:*      *Authority G.S. 90-18.5;*  
                          *Temporary Adoption Eff. January 28, 2008;*  
                          *Eff. April 1, 2008.*

**21 NCAC 32W .0111      TITLE AND PRACTICE PROTECTION**

Any person who is licensed to provide anesthesia services as an Anesthesiologist Assistant under this Subchapter may use the title "Anesthesiologist Assistant," "AA," "Anesthesiologist Assistant–Certified," or "AA-C." An Anesthesiologist Assistant who is doctorally prepared shall not use the title "Doctor," or the appellation "Dr.," on a name badge or other form of identification when practicing in a clinical setting.

*History Note:*      *Authority G.S. 90-18(c)(20); 90-18.5; 90-640;*  
                         *Temporary Adoption Eff. January 28, 2008;*  
                         *Eff. April 1, 2008.*



## **21 NCAC 32W .0112 IDENTIFICATION REQUIREMENTS**

An Anesthesiologist Assistant licensed under this Subchapter shall keep proof of current licensure and registration available for inspection at the primary place of practice and shall, when engaged in professional activities, wear a name tag identifying the licensee as an "Anesthesiologist Assistant," which may be abbreviated as "AA," or as an "Anesthesiologist Assistant – Certified," which may be abbreviated as "AA-C."

*History Note: Authority G.S. 90-18.5; 90-640;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008.*

**21 NCAC 32W .0113 FEES**

The Board requires the following fees:

- (1) Anesthesiologist Assistant License Application Fee—one hundred fifty dollars (\$150.00).
- (2) Annual Renewal Fee—one hundred fifty dollars (\$150.00), except that an Anesthesiologist Assistant who registers not later than 30 days after his or her birthday shall pay an annual registration fee of one hundred twenty-five dollars (\$125.00).

*History Note: Authority G.S. 90-13.1(f); 90-18.5;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008.*

## **21 NCAC 32W .0114 VIOLATIONS**

The Board pursuant to G.S. 90-14 may place on probation with or without conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke the license, or other authority to function as a anesthesiologist assistant in this State. The following acts constitute violations:

- (1) Failure to function in accordance with the rules of this Subchapter or with any provision of G.S. 90-14;
- (2) Representing oneself as a physician; or
- (3) Allowing one's certification with the National Commission for Certification of Anesthesiologist Assistants (NCCAA) or its successor organization to lapse at any time.

*History Note:* Authority G.S. 90-18.5;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008.

## **21 NCAC 32W .0115      PRACTICE DURING A DISASTER**

An Anesthesiologist Assistant licensed in this State or in any other state may practice as an Anesthesiologist Assistant under the supervision of an Anesthesiologist licensed to practice medicine in North Carolina during a disaster within a county in which a state of disaster has been declared or counties contiguous to a county in which a state of disaster has been declared (in accordance with G.S. 166A-6). A team of Anesthesiologist(s) and Anesthesiologist Assistant(s) practicing pursuant to this Rule shall not be required to maintain on-site documentation describing supervisory arrangements as otherwise required in Rules .0109 of this Subchapter. The Board may waive other regulatory requirements regarding licensure and practice to facilitate an Anesthesiologist Assistant practicing during a disaster consistent with G.S. 90-12.2.

*History Note:      Authority G.S. 90-12.2; 166A-6;  
Temporary Adoption Eff. January 28, 2008;  
Eff. April 1, 2008.*

## Subchapter 32X – Practitioner Information

## 21 NCAC 32X .0101 REQUIRED INFORMATION

(a) All physicians and physician assistants licensed by the Board or applying for licensure by the Board shall provide the information required by G.S. 90-5.2(a) on an application for licensure or annual renewal. Additionally, all physicians and physician assistants shall provide the Board with notice of any change in the information within 60 days.

(b) In addition to the information required by G.S. 90-5.2, a physician or physician assistant shall inform the Board about any misdemeanor convictions other than minor traffic offenses. "Minor traffic offenses" shall not include driving while intoxicated, driving under the influence, careless or reckless driving, or any other offense involving serious injury or death. The report must include the nature of the conviction, the jurisdiction in which the conviction occurred, and the punishment imposed. A person shall be considered convicted for purposes of this rule if they pled guilty, were found guilty by a court of competent jurisdiction, or entered a plea of nolo contendere.

*History Note:* Authority G.S. 90-5.2; 90-14.3;  
Eff. August 11, 2009.

**21 NCAC 32X .0102      VOLUNTARY INFORMATION**

Physicians and physician assistants may provide additional information such as hours of continuing education earned, subspecialties obtained, academic appointments, volunteer work in indigent clinics, and honors or awards received.

*History Note:*      *Authority G.S. 90-5.2; 90-14.3;*  
                         *Eff. August 11, 2009.*

## 21 NCAC 32X .0103      CONTENTS OF THE REPORT

A physician or physician assistant shall report the following information about a judgment, award, payment or settlement:

- (1) The date of judgment, award, payment or settlement;
- (2) The specialty in which the physician or physician assistant was practicing at the time the incident occurred that resulted in the judgment, award, payment or settlement;
- (3) The city, state, and country in which the judgment, award, payment or settlement occurred; and
- (4) The date of the occurrence of the events leading to the judgment, award, payment or settlement.

*History Note:* Authority G.S. 90-5.2; 90-14.3;  
Eff. August 11, 2009.

**21 NCAC 32X .0104 PUBLISHING CERTAIN MISDEMEANOR CONVICTIONS**

- (a) The Board shall publish misdemeanor convictions involving offenses against a person including manslaughter, assault, battery, sexual crimes, hazing, false imprisonment, stalking, abuse and neglect.
- (b) The Board shall publish misdemeanor convictions involving moral turpitude including fraud, arson, blackmail, burglary, embezzlement, extortion, false pretenses, forgery, larceny, malicious destruction of property, receiving stolen goods with guilty knowledge, robbery, theft, transporting stolen goods with guilty knowledge, bribery, counterfeiting, tax fraud, mail fraud, perjury, harboring a fugitive from justice with guilty knowledge, tax evasion, abandonment of a minor child, bigamy, gross indecency, incest, solicitation, and prostitution; attempting, aiding and abetting, or serving as an accessory in the commission of a crime involving moral turpitude; and taking part in or attempting to take part in a conspiracy involving moral turpitude where the underlying crime would not involve moral turpitude.
- (c) The Board shall publish all misdemeanor convictions involving drugs or alcohol where the conviction was entered after the licensee's enrollment in medical school or a Physician Assistant education program.
- (d) The Board shall publish misdemeanor convictions involving violations of public health and safety codes.
- (e) The Board shall publish misdemeanor convictions for failure to file state and federal tax returns.
- (f) The Board shall publish misdemeanor convictions set forth above for ten years from the date of conviction.
- (g) Publish means publishing on the Board's website or any other way the Board deems appropriate.

*History Note: Authority G.S. 90-5.2; 90-14.3;  
Eff. August 11, 2009;  
Amended Eff. April 1, 2011.*



**21 NCAC 32X .0105      NONCOMPLIANCE OR FALSIFICATION OF INFORMATION**

Failure to provide the information as required by this subchapter or knowingly providing false information to the Board shall constitute unprofessional conduct.

*History Note:*      *Authority G.S. 90-5.2; 90-14.3;*  
                         *Eff. August 11, 2009.*