

The Doctor is Out:

A Physician's Guide to Closing a Practice



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Introduction

Closing a medical practice temporarily or permanently, leaving one medical practice to go to another, or having a colleague leave practice suddenly - these are major changes in a licensee's professional life. The purpose of this document is to provide guidance to licensees¹ to help make these transitions as smooth as possible for both licensees and patients. The North Carolina Medical Board ("the Board") also offers this document to help licensees avoid pitfalls.

Most of the areas covered in this guide can be found on the Board's website, www.ncmedboard.org. A predecessor to this document was created by the North Carolina Medical Society Foundation's PractEssentials program, and the Board thanks the Foundation for allowing the use of "Closing a Medical Practice: What Physicians Should Know." The Board also thanks Curi, a Medical Mutual Company, the North Carolina Academy of Physician Assistants and the physicians and attorneys who lent their knowledge and experience to this project.

The practice of medicine is a complex professional and business endeavor. Increasing numbers of physicians now work outside the traditional model of independent professionals, instead being employed by practices or hospitals. Employment contracts and covenants not to compete may determine a physician's contractual obligations upon leaving a practice (which could conflict with the physician's ethical obligations). There are numerous business and legal issues not addressed here; this guide is intended to help only with the professionalism aspects of the closure. This document is not intended to provide legal advice. You are strongly advised to seek independent business or legal advice as well.

Plan Ahead

All physicians or independently practicing advanced practice practitioners should have a departure plan in place before they need it. This is especially true for solo practitioners, in case someone else must carry out that plan. Otherwise, a deceased physician's estate might not fulfill professional obligations in the way the physician would have wanted. Physicians joining or creating a practice arrangement should have employment agreements, partnership agreements, buy-sell agreements and other business arrangements in place at the beginning. These should be reviewed and updated over time. All of the items discussed in this guide should be considered, including ownership of medical records and the duty to provide advance notice to existing partners of the departure. Advance planning helps all parties meet professional obligations, maintain the solvency of the continuing practice, and minimize animosity about the departure.

¹ The majority of this document is directed at physicians: MDs and DOs, rather than other licensees of the North Carolina Medical Board. Special provisions relating to Physician Assistants and Nurse Practitioners are mentioned specifically.

Maybe you are thinking about retiring, selling your practice, or closing the doors. Perhaps you are moving to another medical practice – one that competes with your current one. Or you may be in a difficult situation where your practice must close: you need to get medical treatment, or you have lost the authority to practice by order or agreement with the Medical Board. Finally, this document may also be of use to individuals who have stepped in to help when another licensed medical professional must close shop. The resources referenced in this guide will help licensees grappling with all these scenarios.

Several of the Board’s Position Statements concern the relationship between licensee and patient, and what to do when that relationship comes to an end. Position Statements may be found on the Board’s website at: www.ncmedboard.org/positionstatements. Position Statements are neither laws nor rules but are designed to provide guidance to licensees as to the Board’s expectations on certain issues of practice and professionalism. (Attachment 1.)

The Board’s Position Statement “*Departures from or closings of medical practices*” (Attachment 2) outlines the Board’s expectations for licensees. The Board requires two things of individuals who are leaving or closing a practice: to assure continuity of care for patients and to allow patients the freedom to choose their health care provider.

Professional Obligations

Basic Fact Patterns of Physician Practice Closings or Departures

Practically speaking, there are five scenarios that involve departures from practice:

1. A solo practitioner is retiring or closing a practice. The retiring physician should send a letter to patients with sufficient time to allow them to seek alternative care (thirty days, at a minimum), and an opportunity to pick up their medical records or request that they be transferred to another provider. Samples of these types of letters are Attachments 3 and 4.
2. A physician in a multi-physician practice is retiring or leaving the geographic practice area. In this instance, the departing physician and/or practice should send a letter notifying patients of the change, and offering to provide continuous care for the patients, or offering to transfer records to another provider upon request. Again, at least a thirty-day notice should be provided. If a physician in a continuing practice dies, the practice may send a letter offering to provide continuing care or transfer records. Please see Attachment 5 for a sample.
3. A physician is leaving to join a competing practice. Often, these situations are acrimonious. The Position Statements do not specify whose duty it is to notify the patients, only that it must be done. The best approach is for the continuing practice and the departing physician to send a joint letter notifying patients of the departure, the departing physician's new practice location; and the willingness of the continuing practice to see the patients, transfer the patient's records to the departing physician or transfer the records to another physician. If it is not possible to send a joint letter, remember that the ultimate responsibility to inform the patients falls on the continuing practice. Bottom line: please do not allow a professional divorce to supersede one's professional duty. Please see Attachments 6 and 7 for sample letters. Attachment 8 is a sample Authorization for Transfer of Medical Records.
4. A physician in a solo practice must stop seeing patients at short notice. This may be due to the sudden onset of a health condition which makes it difficult for the physician to practice well. It may also arise from the physician's need to seek treatment for substance or alcohol abuse; the physician's execution of a non-practice agreement with the Medical Board; or because the Medical Board has suspended the physician's medical license.¹ (A variation of Attachment 3 may be used.)
5. A physician in a solo practice dies or abandons his practice. In this situation, members of the local medical community, professional society, specialty group or hospital may need to step in, as a service to the public, to provide notice to the patients and arrange storage and retrieval of medical records. In this situation, which fortunately is quite rare, it may be impracticable to provide notice by phone, email or U.S. mail. Instead, constructive notice may be made by placing a letter on the office door, and by placing an advertisement in the local newspaper. The duty to provide this notice and secure patient records is not imposed on

¹ A physician who has lost his license may still notify patients that the practice has been closed and may return patient records, or oversee that effort, since these acts, by themselves, do not constitute the practice of medicine.

anyone in particular. In the past, other local physicians, the county medical society, the physician's specialty group, or the Medical Board have stepped in to assist the patients. Please see Attachment 9 for a sample notice.

Precipitous Medical Practice Closings

When a physician must close or leave his medical practice suddenly or without warning due to illness, injury, business failures, professional disputes, or Medical Board discipline it is important to recognize that the physician retains important responsibilities to make reasonable provisions for an orderly transition or transfer of patient care. Many of the same guidelines and principles discussed in other sections of this document are equally applicable to the precipitous practice closure and do not need to be repeated here, but there are additional considerations which the physician, office staff, or physicians remaining in the practice must consider under these circumstances. The best approach is anticipatory. No physician expects they will find themselves in a position to cease practice without warning, either temporarily or permanently. Developing written policies and procedures beforehand which address this issue will go a long way toward easing a very difficult transition.

While this may be somewhat less of a problem for larger group practices or the employed physician, and the unanticipated or precipitous practice closure burdens will fall most heavily on smaller or solo practitioners, all medical practices should anticipate that the unexpected may occur. Arrangements for orderly continuation or transfer of care depend to some degree on the duration the physician will be away from the practice.

- Practice office or business managers should be provided authority to efficiently allow patients access to their medical records and facilitate transfer of copies of patient medical records to other physicians.
- If possible, the physician should do anything he can to facilitate continuity of care and allow for patient choice on where to receive further care. Physicians should be familiar with the medical record retrieval and archiving policies for their particular electronic health records. For instance, if medical records are cloud-based, the physician should know what will happen to those medical records if the physician suddenly stops paying his monthly network fees and maintenance.
- Public notices to patients about the practice closure should provide full and forthright information about the expected duration of the practice closure and what patients can do to receive necessary or emergency interim medical care or transfer care to another physician.
- In the case of group practices, the remaining physicians should willingly accept responsibility for aspects of patient care such as medication refills; lab, x-ray, and consultant follow-up; completion of death certificates; and all of the other complex components of patient care that will result from this situation.
- If controlled substances are stored at the practice, the office staff should contact the DEA so that these drugs may be safely secured.
- Consider how ongoing, routine bills - such as rent, EHR monthly fees, and malpractice

insurance – will be paid. Physicians may want to consider obtaining business continuity insurance to cover these ongoing aspects of a medical practice during such emergencies.

Communication with Patients

Provide Notice to Patients

Because eventually all physicians will leave or close their practice, written policies and procedures regarding this matter should be developed in advance and should be included in every practice's policy and procedure manual. New and current patients should be provided with a copy of those materials.

The Board's Position Statements are explicit on the duty to notify "patients" but are lacking on details about exactly who those patients are. Is a retiring physician required to reach out to every patient he has ever seen? Is it sufficient to provide notice only to those patients treated within the past year? Are there different standards for different treatment options – for example, patients at an urgent care center compared to those in a chronic care setting? Can a physician or practice notify more recent patients directly, and put others on constructive notice by placing an advertisement in a local newspaper or on the practice's website? Unfortunately, there are no black and white answers here. The Medical Board's expectation is that a departing physician will make a reasonable effort, given the current situation, to notify patients so that they are not put in a situation where their care is interrupted, or they have no opportunity to obtain their records.

The North Carolina Medical Society advises physicians to notify "current" patients about a physician leaving a practice. Obviously, this differs according to the type of practice; a surgical practice may see a patient for a limited span of time; an internist may see a patient over years.

Curi recommends that a departing physician or closing practice notify all patients seen within the past two years. However, they also have specific guidance for particular specialties.

- Place a notice at the door and/or in the waiting room about the change that is about to occur, including an effective date ("Dr. Smith will no longer be with this practice effective _____. He will no longer be taking new patients as of _____.") In surgical practices, a notice should be posted in the waiting room, and letters should be sent to current patients. The practice should establish a "cut off" date for surgical patients after which the departing physician will not be able to provide follow up care. If the departing physician generally performs procedures with a six to eight-week post-op follow up, decide that he/she will not perform surgery within six to eight weeks of his departure.
- If the departing physician will continue to perform surgery until he/she departs, make sure that patients know that they may receive follow up care from another physician in the practice. The patient should have the choice of having the physician perform the surgery and receive follow up care from another physician in the same practice, or have the surgery

performed by a different surgeon or practice altogether.

- For patients in emergent or high-risk situations, like nephrology, notice that a physician is closing a practice or leaving a practice should be given both by telephone and mail. Curi recommends sending high risk patients notice by certified mail, return receipt requested. Again, sufficient time should be provided so that the patient may receive continuous treatment.
- If diagnostic tests are ordered but will not be completed before the departing physician leaves, that should also be addressed in advance. The patient should be informed that another provider will provide follow-up based on those tests. None of these changes should come as a surprise to the patients.

Continuity of Care

In order to provide continuity of care, the physician must provide reasonable advance notice to patients. Through its Position Statement, the Board defines “reasonable” as at least thirty days. Continuity of care and the amount of advance notice may depend upon the type of medical care provided, as noted in the section below. Continuity of Care, Notice to Patients, and Access to Medical Records also are discussed in the Board’s Position Statement, *“The physician-patient relationship”* (Attachment 10).

Permit Patient Choice of Healthcare Provider

To effectuate patient choice, the departing physician must provide adequate communication to patients that they may choose their healthcare provider, and that they may obtain their medical records or have them transferred as they choose. They must also be told how to contact a departing practitioner, if that person will continue to practice elsewhere, at least upon the patient’s request.

Finally, “Departures from or closings of medical practices” recommends that practices develop written policies in advance of such situations to guide the practice in the event of a departure or closing.

The second Position Statement which is relevant to practice closure issues is *“The physician-patient relationship”* (Attachment 10). The final section of this Position Statement deals with terminations of patients from being treated by one or more particular physicians or an entire practice. While this is different from a practice closure situation, the guidelines set out there are on point: the patient must be given reasonable advance notice of the termination (at least thirty days) to allow the patient to seek other care, and the patient must be notified of his/her right to obtain medical records and instructed on how to do so.¹

¹ Curi, a Medical Mutual Company, advises that if a practice believes that a current patient may endanger the safety of staff or other patients, the thirty-day notice of termination may be waived. There should be strong documentation in the medical record to support such action.

Another source of guidance on this is the American Medical Association. AMA Opinion 3.3.1 (Attachment 11) speaks to the requirements of making medical records available upon the retirement or departure of a physician.

Special Issues Concerning Advanced Practice Practitioners

As a general rule, the Board has felt that an on-site physician assistant or nurse practitioner who is part of a physician's practice does not need to provide notice to patients and meet the other obligations discussed in this guide. However, the NC Academy of Physician Assistants advises that a "best practice" is to post a note at the practice site and the practice's website (if any), advising patients that the PA or NP is departing. The patients' expectations are important, and the relationships between PAs, NPs and their patients may be long term and very important to the patients.

However, the expectations are different for a physician assistant or nurse practitioner who practices independently with an offsite supervisor or has an ownership interest in a practice. For those PAs or NPs who are closing or leaving a practice, the obligations outlined in this document about notice to patients, continuity of care, provision of records, etc. also would apply. An advanced practice practitioner in this situation is strongly advised to seek legal advice about this.

What if a Supervising or Back-up Supervising Physician is departing a practice? In many multi-physician practices, when a particular physician leaves, a PA is often reassigned to another MD/DO, likely one who served as a Back-up Physician previously. This doctor may not want the responsibility or liability of serving as a Supervising Physician. It is the duty of the PA or NP continuing with the practice to find an appropriate Supervising or Back-up Physician and update their practice information with the Medical Board.

Medical Records

Retention of Medical Records

Records retention is a challenging issue. There is no "bright line" consistent with federal and state law which establishes how long medical records must be maintained in every case. Instead, a practice must try to harmonize a hodgepodge of statutes, regulations, case law and Board Position Statements. As electronic medical recordkeeping becomes more universal, the problem should be alleviated, as electronic data storage is relatively inexpensive and accessible. The current situation places physicians and practices in a confusing, expensive situation where cumbersome paper records must be stored indefinitely.

That being said, every medical practice should create a policy on record retention, based primarily

on medical considerations and continuity of care. You should check with your medical liability insurance carrier and legal representative prior to finalizing it. You may wish to provide this policy to new patients as part of their “introduction to the practice” materials. When patients are informed in advance about how their medical records will be handled there is substantially less likelihood of a complaint to the Medical Board if and when a physician must close his practice. This is simply another aspect of “informed consent.”

The Board’s Position Statement, “*MEDICAL RECORDS-Documentation, Electronic Health Records, Access, and Retentions*” (Attachment 12) provides guidance for physicians to determine how long to keep medical records. Generally, a continuing practice should retain original medical records as long as possible. There are multiple reasons for retaining medical records: to provide patients with the information, should they wish to access it; to protect the physician in case a legal claim is made in the future; and to comply with federal regulations. If a physician is retiring or moving out of the area, it is more challenging to figure out what to do with the medical records. After providing patients with a sufficient time to pick up copies or have them transferred to another health care provider, the departing physician still will have reasons to retain the records. What are some options for storage of medical records? It may be possible to pay for storage at a neighboring medical office. Another option is to use a secure document storage facility. A departing solo physician may ask a fellow physician still practicing in the community to serve as custodian of the records.

The NCMS defines the “designated record set” as the medical record itself, plus records obtained by other providers (if used in the decision making), and financial records, including Explanation of Benefits. The NCMS and Curi provide these additional recommendations for records retention:

- Diagnostic images: five years from the date of procedure
- Adult patients: eleven years from last contact
- Fetal heart monitor: ten years after the infant reaches the age of majority (eighteen years old)
- Minor patient: when he/she reaches the age of majority (eighteen years old) plus seven years
- Operative notes, register of surgical procedures, chemotherapy records, immunization records, master patient indexes, birth and death records, and basic statistical data should be retained permanently. If this is not possible for indices and statistical data, the guideline should be compiled and maintained permanently.
- Deceased patients: five years after the patient’s death.

There is no state statutory requirement for the retention of physician office medical records, but it is advisable to maintain these records at least according to the statute of limitations in North Carolina. The statute of limitations is the time frame in which a plaintiff may bring a legal action against someone for a civil wrong, such as alleged medical malpractice. The basic statute of

limitations is three years following a wrongful injury, but there are several exceptions to this rule as outlined below.

- If an injury is not readily apparent, the patient may bring suit up to four years after the last act of treatment.
- If a foreign object with no therapeutic purpose is left in the patient's body, the patient can file suit up to two years from the last act of the physician.
- A minor may wait until the age of nineteen to file an action.
- There is the "continued course of treatment" exception that states that if a patient is treated over an extended period of time, the statute of limitations does not start until the date of the last treatment.
- Overall, the longest possible time period for a malpractice action to be filed is ten years for adults and nineteen years for minors.

The North Carolina Health Information Management Association is another source of guidance on this issue (www.nchima.org). That organization recommends that whenever possible, medical records should be retained permanently either in their original form, microfilm, optical disk, or an electronic data storage medium. This recommendation is based on the increasing importance of the medical records to the health care provider, not only for continued care but for legal purposes. In the event you transfer original medical records to another physician, you should have a written agreement to ensure that the other physician will permit you to have access to the medical records for a reasonable period of time (and will maintain the records in accordance with all federal and state requirements).

Patient Access to Medical Records

The Board's Position Statement, "*MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention*" (Attachment 12) reiterates that the information in medical records belong to the patient; the practice is advised to retain the original records. N.C. Gen. Stat. § 90-411 (Attachment 13), allows health care practitioners to charge a fee for providing medical records to a patient who requests them. Often a practice will only charge a fee when the patient chooses to switch health care providers, in the absence of a departure from or closing of a practice.

The Board's Position Statements do not make it explicit how patients can get their medical records, or how long they have to do so. Typically, practices send a letter to patients about a departure or closing and inform patients that they have a certain period of time (at least thirty days) in which to pick up their records or ask the practice to transfer them to another healthcare provider. If the practice is truly closing, it may be impracticable for an office to remain open very long. A practice which is closing permanently can provide its patients with the original medical records, upon receipt of the patient's signed authorization.

Email and Electronic Records

The Board's Position Statements and policies generally pre-date the widespread adoption of email communication between physicians and patients and electronic medical recordkeeping. However, communication between patients and practices using electronic mail should suffice and should take the place of mailed communications.

The North Carolina General Assembly has equated the legal rights and responsibilities relating to electronic records to those created on paper or other media. N.C. Gen. Stat. § 90-412 (Attachment 14). If the medical records have been generated and maintained electronically, and can be transferred to another provider electronically, that will suffice. If EHRs cannot be transmitted (for example, the recipient provider uses a different EHR system) then the records may have to be printed onto paper, a CD, or zip drive.

A question that frequently arises is: who owns the medical records? Are they the property of the physician or the practice? If the practice is an equal partnership of two physicians and one leaves, there is no remaining practice. In the absence of other agreements, each physician retains ownership of the medical records of those patients for whom he was primarily responsible. If the continuing practice takes over postoperative care or future care of patients, then they are considered active patients of the practice or remaining partner and are no longer a patient of the departing physician.

Balance Between Record Retention, Patient Access and Privacy

There must be a balance between providing medical records to the patient and preserving patient privacy. If you have tried to contact the patient by email or by sending a letter to the patient's last known address, then you might place a notice on the practice's website and in the local newspaper notifying patients of how and where to pick up their records. If continued, secure storage is not reasonably possible and if you have allowed a reasonable time for patients to get their records, you should destroy the records to protect confidential patient information. Incineration or shredding by a bonded company is the preferred method to destroy medical records, so that confidential patient information is not disclosed. As stated in Attachment 12, "Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records."

There have been some situations where no one has come forward to responsibly secure, distribute and retain medical records, and by default, the North Carolina Medical Board has appointed a custodian of them. The Board is permitted to do this by statute, N.C. Gen. Stat. § 90-5.1, (Attachment 15) but is reluctant to do so except where there are extenuating circumstances,

such as a physician abandoning a practice. In challenging circumstances, such as the death of a solo practitioner, the Board often seeks assistance from the local medical community, medical society, or hospital in handling patient records.

Appropriate Updates and Notices

Licensee Information Page

The North Carolina Medical Board's Licensee Information Pages provide a service to the public and are mandated by statute, N.C. Gen. Stat. § 90-5.2 (Attachment 16). A physician who is departing a practice for whatever reason can go to the Board's website to update his or her information, such as address and phone number of the primary practice setting. For more information, go to: <https://www.ncmedboard.org/LicenseeInformation>.

Corporate Records with the NCMB and The Secretary of State

A physician who is a shareholder in a corporate medical practice, who is departing that practice, must inform the North Carolina Medical Board of the changes. The Board's website includes a guide to Professional Corporations and Professional Limited Liability Companies, including what must be done upon dissolution or the death of a shareholder.

Please reference the Handbook for Managing Professional Corporations, Professional Associations and Professional Liabilities at www.ncmedboard.org/images/uploads/other_pdfs/CorpsHandbook-Dec2018.pdf. For more information on this subject, contact the Board's Corporations Coordinator at (919) 326-1109 ext. 231.

The Center for Medicare and Medicaid Services

Physicians leaving practice for whatever reason who have treated patients on Medicare or Medicaid should advise CMS of the change in their practice.

The Drug Enforcement Administration

If you are retiring or terminating your prescription of controlled substances, you must notify the Drug Enforcement Administration (DEA) in writing to request that your DEA number be deleted from the DEA system. In addition, you must return your original DEA certificate of registration for cancellation and any unused "222 forms." It is advisable to send this notice and certificate by certified mail, return receipt requested. If you are moving to a new practice within North Carolina, you must update your address with the DEA before beginning to dispense or prescribe controlled substances. For more information, contact the DEA at 1801 Stanley Road, Suite 201, Greensboro, NC 27407 or by phone: (336) 547-4219. Visit their website at www.dea.gov/.

The NC Controlled Substance Reporting System

If you have been registered with the NC Controlled Substance Reporting System and are leaving

practice, you should notify them. For more information, contact the NC Controlled Substance Reporting System by mail: 3008 Mail Service Center, Raleigh, NC 27699-3008 or by phone: (919) 733-1765. Visit their website at www.ncdhhs.gov/divisions/mhddsas/ncdcu/csrs.

The NC Board of Pharmacy

If you are a dispensing physician, and will no longer be dispensing medications, you must provide notice to the NC Board of Pharmacy to cancel your state drug dispensing license. In addition, you will need to dispose of any unwanted drugs. Non-controlled substance pharmaceuticals may be returned to their manufacturer, incinerated at a proper facility, or disposed of by other means which will preclude unauthorized use or possession.

The disposition of controlled substances is more rigorously regulated.

- The permit holder must file a request with the NC Board of Pharmacy for authority to do so and to receive instructions;
- If the destruction occurs on the permit holder's premises, it must be jointly witnessed by two licensed pharmacists;
- The destruction must be documented;
- The documentation must be retained by the permit holder for at least three years;
- A copy of the documentation shall be sent to the DEA.

Please see Attachment 17, 21 NCAC 46.3001, "Procedure for disposing of drugs." The Board of Pharmacy also provides a "Drug Disposal Form" that must be submitted when disposing of drugs. [Instructions](http://www.ncbop.org/faqs/Pharmacist/faq_DrugDisposal.html) are available here: www.ncbop.org/faqs/Pharmacist/faq_DrugDisposal.html. The federal government has proposed new rules about disposal of controlled substances. For more information, please go to: www.deadiversion.usdoj.gov/fed_regs/rules/2012/fr1221_8.htm.

A significant problem frequently encountered when a physician closes (or is forced to close) his practice is ongoing prescription refills for his patients. The Board of Pharmacy has a rule which can temporarily mitigate the adverse health consequences of this situation. The Board of Pharmacy takes the position that a prescriber's death, retirement or loss of license does not void an existing prescription: www.ncbop.org/faqs/Pharmacist/faq_PrescribersLossOfLicense.htm For more information, contact the Board at 6015 Farrington Road, Suite 201, Chapel Hill, North Carolina 27517. They may also be reached by phone: (919) 246-1050 or fax: (919) 246-1056. Visit their website at www.ncbop.org/.

Retirement

In most instances, there are parallel requirements for physicians and PAs in regard to the issues covered in this section. Because there are fewer PAs in our state who are nearing retirement age, the numbers of PAs retiring is currently very low. To see the rules, license applications and other documents pertaining to PAs and volunteer licenses, reactivation, reinstatement and reentry, please contact the NC Medical Board’s Licensing department at (919) 326-1109 or visit the Board’s website at www.ncmedboard.org.

Retired and Inactive

If you are retiring from practicing medicine or practicing as a PA, you should consider the status of your medical license or PA license. It is your choice as to whether to inactivate your license (“go inactive”) or retain your active physician or PA licensure status, and there are positives and negatives to both.

“Going inactive” requires notifying the NC Medical Board that you are no longer going to practice medicine or surgery. As noted in the Board’s Position Statement, *“The retired physician/licensee”* (Attachment 18), once your license is inactive, you may not practice medicine, which means you may not:

- Provide patient services;
- Order tests or therapies;
- Prescribe, dispense, or administer drugs;
- Perform any other medical and/or surgical acts; or
- Receive income from the provision of medical and/or surgical services performed following retirement.

However, neither do you have to renew your license annually, pay the Board’s renewal fee, or stay current with your Continuing Medical Education. Although you lose your mailed subscription to the *The Forum*, anyone can access that free via the Board’s website.

www.ncmedboard.org/newsletter

Retired with Active License

If you simply stop working but retain your full, active license, you must renew that license annually, pay the Board’s renewal fee, maintain your CME, and abide by the Board’s Position Statements, rules, and statutes. Some physicians and PAs misguidedly consider maintaining their active license status after retirement so that they may treat themselves and their family members. In general, this is not an acceptable practice and such treatment may violate the Board’s Position Statement, *“Self-Treatment and Treatment of Family Members.”*

License for Volunteer Work

Another alternative for the retired physician or PA is to work at clinics serving indigent patients. You may not receive any type of compensation whatsoever for your services in this capacity. A

physician holding a limited volunteer licensee may not work more than thirty days in a calendar year. However, the retired volunteer licensee is not so limited. More information can be found on the Board's website at: www.ncmedboard.org/VolunteerApplication.

If you are a licensed NC physician who wishes to convert your "full" active license to a retired limited license, you must simply inform the Board of this by going to the Board's website, and completing the online form at www.ncmedboard.org/retire. A copy of this form is Attachment 19.

If you have converted your license status from "active" to "inactive," but then wish to do volunteer work, you must reapply for a license. The Board has two special license categories for such physicians and allows them to volunteer their services in association with clinics serving the indigent. How a physician applies for a volunteer license depends upon whether the physician ever held a North Carolina license, how long the physician has been out of practice, and how many days in a calendar year the physician plans to volunteer. Physicians holding these licenses do not have to pay annual renewal fees but do have to maintain their CME. Please see administrative rules 21 NCAC 32B .1701, .1702, .1703 and .1704, which follow as Attachments 21, 22, 23 and 24. If you have questions about which application process applies to you, please contact the Board's Licensing Department at Licensing@ncmedboard.org.

Returning to Practice

If you retire from practice, ask the NC Medical Board to make your license "inactive," and then change your mind, what are your options? You may seek to regain a full physician license; you may wish to obtain a retired limited license; or you may seek a limited volunteer license. The requirements for the Board's retired physician limited license and limited volunteer physician license may be found at: www.ncmedboard.org/VolunteerApplication. The administrative rules covering those two licensees are Attachments 20, 21, 22 and 23.

Where you initially were licensed, how long you have been out of practice, and the reason you went out of practice are key determinants in how you go about regaining your medical license. If you wish to return to compensated medical practice, you need a full, "active" physician license to do so.

Reactivation

The first approach for regaining your full, active medical license is called Reactivation. This process is available to a physician whose license status has been inactive for less than one year, without any disciplinary Board action (or threat thereof) being involved. This is a simple and short application; the physician must still show current CME. Please see administrative rule 21 NCAC 32B .1360, which follows as Attachment 24.

Reinstatement

The second avenue for applying for a full, active physician license is called Reinstatement. Guidelines surrounding this process can be found in Attachment 25. This is the process you should take if you have held a medical license in this state, but have been:

- Inactive for more than one year, or
- Your license became inactive because of disciplinary action by the Board, or
- You surrendered your license prior to having charges filed against you by the Board.

The application is very similar to the one which you originally completed to get your medical license, and requires up to date CME, and other proof of current competence to practice. Please see administrative rule 21 NCAC 32B. 1350, which follows as Attachment 25.

Reentry

A more difficult path lies ahead for the physician or PA who has been out of practice with an inactive license for more than two years. At that point, in order to obtain a physician or PA license of any kind (active, retired, or limited volunteer), the applicant may be required to complete a *Reentry Program*.

A frequent area of misunderstanding concerns the physician or PA who has been out of practice for more than two years, who has maintained an active license, and then decides to return to clinical work. As long as the physician's license has remained "active," the Board cannot compel the licensee to participate in a Board-approved or supervised reentry program. However, the best approach is for anyone, regardless of license status, who has been out of practice for over two years, to participate in a reentry program. This ensures that the physician's fund of knowledge and clinical skills are current and up to par.

Reentry is a structured system that takes steps to ensure that physicians and physician assistants who return to medical practice after a significant period of inactivity can practice safely. To view more information about the reentry requirements for physicians and PAs, please visit:

www.ncmedboard.org/licensure/reentry.

Materials found both online and, in this document, include:

- The Board's reentry rule (Attachments 26)

Conclusion

Physicians and other licensees may leave practice for any number of reasons: to relax; to concentrate on their health; to move to a different practice group, state, or area of specialty; or in response to a disciplinary action. Complexities about what else a departing physician may need to do include: whether or not to purchase ongoing professional liability, or “tail” coverage; whether or not to stay involved in organized medical societies; whether or not to maintain one’s status in specialty boards, and more. Physicians are encouraged to seek advice from their state medical society, their professional liability insurance carrier, their attorney, or their business advisor about these and other issues. Please also keep in mind that this document is based on laws, regulations, Position Statements and policies which change frequently. The Board will update this document as frequently as possible but be aware that you should check the Board’s website for the most current versions of the authorities cited herein.

The hope this document has been helpful to you. For more information, feel free to contact the NC Medical Board with your questions.

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Attachments

1. “What are the position statements of the Board and to whom do they apply?” (NCMB Position Statement)
2. “*Departures from or closings of medical practices*” (NCMB Position Statement)
3. “*The physician-patient relationship*” (NCMB Position Statement)
4. American Medical Association Opinion 3.3.1 Management of Medical Records
5. Sample patient letter 1: Letter for physician retiring or discontinuing practice
6. Sample patient letter 2: Letter for physician retiring or discontinuing practice, multiple provider practice
7. Sample patient letter: From continuing practice which physician is leaving
8. Sample patient letter: From continuing practice which physician is leaving to go to a competitor
9. Sample patient letter: From physician entering new practice to former patients
10. Authorization to transfer records
11. Notice for door of practice, advertisement in newspaper, or posting on the practice’s website
12. “*Medical Records – Documentation, Electronic Health Records, Access, and Retention*” (NCMB Position Statement)
13. N.C. Gen. Stat. § 90-411. Record copy fee
14. N.C. Gen. Stat. § 90-412. Electronic medical records
15. N.C. Gen. Stat. § 90-5.1. Powers and duties of the Board
16. N.C. Gen. Stat. § 90-5.2. Board to collect and publish certain data
17. 21 NCAC 46 .3001 Procedure for disposing of drugs
18. “*The retired physician/licensee*” (NCMB Position Statement)
19. Online conversion of full license to retired volunteer license form
20. 21 NCAC 32B .1701 Scope of practice under limited volunteer license and retired limited volunteer license
21. 21 NCAC 32B .1702 Application for limited volunteer license
22. 21 NCAC 32B .1703 Scope of practice under retired limited volunteer license
23. 21 NCAC 32B .1704 Application for retired limited volunteer license
24. 21 NCAC 32B .1360 Reactivation of physician license
25. 21 NCAC 32B .1350 Reinstatement of physician license
26. 21 NCAC 32B .1370 Reentry to active practice

Attachment 1

“What are the position statements of the Board and to whom do they apply?” (NCMB Position Statement)

The North Carolina Medical Board’s Position Statements are interpretive statements that attempt to define or explain the meaning of laws or rules that govern the practice of physicians,* physician assistants, and nurse practitioners in North Carolina, usually those relating to discipline. They also set forth criteria or guidelines used by the Board’s staff in investigations and in the prosecution or settlement of cases.

When considering the Board’s Position Statements, the following four points should be kept in mind.

- 1) In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to the other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.
- 2) The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement’s silence on certain matters should not be construed as the lack of an enforceable standard.
- 3) The existence of a Position Statement should not necessarily be taken as an indication of the Board’s enforcement priorities.
- 4) A lack of disciplinary actions to enforce a particular standard mentioned in a Position Statement should not be taken as an abandonment of the principles set forth therein.

The Board will continue to decide each case before it on all the facts and circumstances presented in the hearing, whether or not the issues have been the subject of a Position Statement. The Board intends that the Position Statements will reflect its philosophy on certain subjects and give licensees some guidance for avoiding Board scrutiny. The principles of professionalism and performance expressed in the Position Statements apply to all persons licensed and/or approved by the Board to render medical care at any level.

*The words “physician” and “doctor” as used in the Position Statements refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina

(Adopted: November 1999)

(Reviewed: May 2010, November 2017)

Attachment 2

“Departures from or closings of medical practices” (NCMB Position Statement)

Practitioners may have continuing obligations toward patients during and after their departure from or closing of a medical practice. A practitioner’s specific obligations will vary depending on several factors including employment or practice partnership status, contractual based obligations, practice venue, and other considerations. Nevertheless, the patient’s welfare, autonomy, and continuity of care must be the foremost consideration for all parties involved. Patients should therefore be given reasonable advance notice (at least 30 days) to allow other medical care to be secured. Good continuity of care includes preserving and providing appropriate access to medical records and may include making appropriate referrals. The practitioner(s) and other parties, such as group practices or physician employers, should work cooperatively to ensure requirements for continuity of care and patient autonomy are effectively attended to.

During these times practitioners and other parties involved must consider how their actions affect patients. Practitioners and other parties have the following obligations.

It is the patient’s decision from whom to receive care. Therefore, it is the responsibility of all practitioners and other parties to ensure that:

- Patients are notified in a timely fashion of changes in the practice and given the opportunity to seek other medical care, sufficiently far in advance (at least 30 days), to allow other medical care to be secured. The Board does not have specific rules on which patients should receive this notification or how it should be accomplished, but a reasonable option would be to notify active patients the physician has seen within the past 1-2 years. Methods of notification which might be considered include newspaper notices, posting an announcement in public locations in the office, website announcements, front desk flyers, etc. Each medical practice and patient population is unique and the Board would expect practitioners to utilize the most effective means of patient notification for their particular situation.
- Patients should clearly understand they have a choice of health care providers and notice to patients of the departing physician should include an unambiguous statement that patients have a choice of from whom to receive medical care. It is unethical to withhold information upon request of a patient. If the responsibility for notifying patients falls to the departing practitioner rather than to the group or employer there should be no interference in discharge of this responsibility by withholding essential information.
- Patients should be told both how to contact practitioner(s) remaining in practice, and when specifically requested, how to contact departing practitioners.
- Patients are told how to obtain copies of or transfer their medical records and how long their medical records will be available.

Written Policies:

The Board recommends that practitioners and practices prepare written policies regarding the secure maintenance, storage, transfer, data sharing, and retrieval of patient medical records recognizing that separate policies may be necessary for the storage of and access to paper and electronic medical records. Practitioners and practices should notify patients of these policies. At a minimum, the Board recommends that such written policies include:

- A procedure and timeline that describes how the practitioner or practice will notify each patient about (1) a pending practice closure or practitioner departure, (2) how medical records are to be accessed, and (3) how future notices of the location of the practice's medical records will be provided.
- How long medical records will be retained and the procedure by which the practitioner or practice will dispose of unclaimed medical records.
- How the practitioner or practice will respond to requests from patients for copies of or access to their medical records.
- In the event of a practitioner's death or incapacity, how the deceased practitioner's executor, administrator, personal representative, or survivor will notify patients of the location of their medical records, how patients can access those records, and how and when unclaimed medical records will be destroyed after a specified period of time.
- The procedure by which the practitioner or practice will maintain medical record confidentiality and data integrity. Practice transitions are also times when there is increased risk of privacy breaches or inappropriate disclosure. HIPAA rules require that patients must be promptly informed about any security breach or unauthorized disclosure describing what information was breached, what steps patients may take to minimize adverse consequences of inappropriate disclosure of their personal health information placing the interests of patients above those of the physician, medical practice, or institution.

The Board further expects its licensees to comply with all applicable state and federal laws and regulations pertaining to a patient's protected healthcare information.

*NOTE: The Board's Position Statement on the Retention of Medical Records applies, even when practices close permanently due to the retirement or death of the practitioner.

(Adopted: January 2000)

(Reviewed: May 2014)

(Amended: August 2003, July 2009, March 2018)

Attachment 3

Sample patient letter 1: Letter for physician retiring or discontinuing practice

Date
Patient Name
Address

Dear Patient:

Please be advised that because of _____ (retirement, illness, etc), I am discontinuing the practice of medicine on _____ (date). I will not be able to provide you with medical care after that date.

I recommend that you find another physician to take care of you. If you do not know another physician, you may contact the North Carolina Medical Society or visit the North Carolina Medical Board website at www.ncmedboard.org for resources.

You may wish to obtain copies of your medical records, and you have a few options. If you like, you may come to the office and pick them up between now and _____ (date). Or, I will transfer my records of your care to a physician you designate. Since these records are confidential, I need your written authorization to make them available to another physician. For this reason, I am enclosing an authorization form. Please complete the form and return it to me by _____ (date).

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Sincerely,
Physician's Signature

Attachment 4

Sample patient letter 2: Letter for physician retiring or discontinuing practice, multiple provider practice

Place practice letterhead here

Date
Patient Name
Address

Dear Patient:

The purpose of this letter is to let you know of my plans for retirement. On _____ (date) I will be retiring from the practice of medicine.

I enjoyed my years of service to my patients and my community as a practicing _____ (name of specialty: physician or surgeon) in _____ (city). Thank you for entrusting me with your medical care.

My last day to see patients will be _____ (date). Therefore, you will need to make arrangements to find another physician to provide your medical care. You may find another physician from the community by searching the yellow pages under _____ (name of specialty), by contacting the county Medical Society, or if available, consulting a local physician locator service for a list of physicians. You may also remain with _____ (name of practice) and continue your medical care with any one of the practice's physicians.

Until my retirement, your medical records will be available _____ (location of records). Upon proper authorization, you may have a copy of your medical record or have a copy sent to the physician of your choice. For your convenience a Medical Record Release form is enclosed. Complete the form and send it to _____ (person/company responsible for release of patient's medical record and provide contact information). (If applicable advise patient of fees for record copies.)

After my retirement, you may contact _____ (contact information of person/company responsible for release of patient's medical record and provide contact information) to obtain your records.

It has been my pleasure and privilege to treat you during the course of my practice. I wish you and your family well.

Sincerely,
Physician's Signature

Enclosure: Medical Record Release Form

Attachment 5

Sample patient letter 1: From continuing practice which physician is leaving

Date (at least 30 days in advance)

Patient Name

Address

Dear Patient:

Please be advised that on _____ (date) _____ (name of physician) is retiring after a long and distinguished career in medicine, and we wish him the best.

The physicians, nurses, allied health professionals and staff at our practice will continue to provide the same quality health care you received from _____ (name of physician). If you wish to remain a patient of this practice, you do not have to do anything.

If, however, you would prefer to seek medical care elsewhere, you are free to do so. You may pick up a copy of your medical records at our office or you may ask us to transfer them directly to another office. For either of these options, we will need a signed authorization to transfer records. You may find this on our website at: _____ (website address). You may return that to our office in person, electronically, or by mail.

Please call us if you have any questions about your current or future treatment.

Sincerely,

Continuing Physician or Practice Manager Signature

Attachment 6

Sample patient letter 2: From continuing practice which physician is leaving to go to a competitor

Date (at least 30 days in advance)

Patient Name

Address

Dear Patient:

Please be advised that _____ (name of physician) has accepted a position with a practice in a nearby city and will be leaving us soon. We wish him the very best in his new venture.

Patients who wish to be treated by _____ (name of physician) at his new practice may have a copy of their records transferred. Your original records will be retained at our practice. You have the right to choose your healthcare provider, and we are committed to fully supporting your decision.

_____ (name of founding physician), founder of the practice, along with our entire nursing and allied healthcare team, will continue to provide the latest in a wide range of medical services. Care you have received from _____ (name of physician) in the past will remain available at our practice.

If you wish to have a copy of your medical records sent to _____'s (name of physician) new practice, or have any questions about current or future treatment, please contact our office.

Sincerely,

Continuing Physician or Practice Manager Signature

Attachment 7

Sample patient letter: From physician entering new practice to former patients

Date

Patient Name

Address

Dear Patient:

I am excited to announce that I am now a part of _____ (name of new medical practice).

I enjoyed caring for you at _____, (name of former medical practice) and my primary goal during my transition is to maintain the health and wellness of all my patients.

Being a part of _____ (name of new medical practice) will allow me to continue offering you primary care and wellness services. I am also excited to offer you additional benefits and resources, including the latest medical records technology and access to _____ specialists.

If you need primary care or wellness services, I would be happy to continue caring for you at my new location at _____ (name and address of new medical practice). If you wish to have your medical records transferred from my former practice location, please contact that office directly and ask them to do so.

If you would like to make an appointment with me, please call _____ (phone number). I will begin seeing patients on _____ (date).

Thank you for your patience and understanding during this transition. I hope to re-establish care with you at my new practice location.

Sincerely,
Physician's Signature

Attachment 8

Authorization to transfer records

Authorization to Release Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), federal law pertaining to Early Childhood Intervention (34 C.F.R. part 300), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (N.C.G.S. 122C).

_____	_____
Patient Name	Date of Birth
_____	_____
Persons/organizations providing the Information	Persons/organizations receiving the formation

Specify description of information (including dates):

All records of or other information regarding my treatment for all dates.

Purpose of the disclosure:

I understand that this authorization will expire on _____ (date) or one year from the date it is signed, whichever is earlier. Initials: _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received. Initials: _____

I understand that I am authorizing the release of substance abuse, AIDS, HIV, or other communicable diseases, if such information is present in my record. Initials: _____

 Signature of Patient or Patient’s Representative (Form MUST be completed before signing).

 Date

_____	_____
Printed Name of Patient’s Representative	Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Attachment 9

Notice for door of practice, advertisement in newspaper, or posting on practice's website

Re: Solo Physician who died or abandoned his practice

IF YOU ARE OR WERE A PATIENT OF _____ (name of physician):

We regret to inform you that _____ (name of physician) died/closed his practice/terminated his practice on _____ (date).

If you would like to pick up copies of your medical records, please contact _____ (name of contact) at _____ (contact information) by _____ (date) to make arrangements to do so. The records will be available free of charge. After _____ (date), the records will be destroyed to protect your confidential information.

If you have questions, please contact _____ (name of contact) at _____ (contact information).

Attachment 10

“The physician-patient relationship” (NCMB Position Statement)

A physician’s first responsibility is to his or her patients. Having assumed care of a patient, the physician’s responsibility is to provide competent, compassionate, and economically prudent care within the standards of acceptable medical practice and to make treatment decisions that are in the best interest of the patient. It is the Board’s position that it is unethical for a physician to allow financial incentives or other interests to adversely affect or influence his or her medical judgment or patient care. Patient advocacy is a fundamental element of the patient-physician relationship and should not be altered by the health care system or setting in which a physician practices. All physicians should exercise their best professional judgement when making patient care decisions. When economic or other interests are in conflict with patient welfare, the patient’s welfare must take priority. Physicians who hold administrative leadership positions should foster policies that support the physician-patient relationship and enhance the quality of patient care.

Elements of the Physician-Patient Relationship

Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Mutual trust is fundamental to the physician-patient relationship and requires that:

- There be appropriate professional communication between the physician and the patient;
- The physician timely report all significant findings to the patient or the patient’s legally designated surrogate/guardian/personal representative;
- Conflict of interest between the patient and the physician or third parties be resolved to the benefit of the patient;
- Personal details of the patient’s life shared with the physician are held in confidence;
- The physician maintain competence, professional knowledge, and skills;
- There is respect for the patient’s autonomy;
- The physician maintains a compassionate and professional demeanor;
- The physician respect the patient’s right to request restrictions on medical information disclosure;
- The physician be an advocate for appropriate medical care;
- Patient advocacy remains unaltered by the health care system or setting; and
- The physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust and fostered by professional communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, and appropriate care are foremost considerations of physicians.

This same fundamental physician-patient relationship also applies to all licensees of this Board.

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in accord with the physician's underlying obligation to support continuity of care.

Patient termination must be accompanied by appropriate written notice provided to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. A copy of such notification is to be included in the medical record. Should the physician be a member of a group or an employee of a large practice, the notice of termination must also state clearly whether the termination involves only the individual physician, other physicians in the practice, or the entire practice. In the latter case, those members of the group joining in the termination must be designated. It is advisable that the notice of termination also include instructions for transfer of or access to the patient medical records.

When a physician's employment status is terminated by an employer, the physician or his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer.

(Adopted: July 1995)

(Amended: July 1998, January 2000, March 2002, August 2003, September 2006, July 2012, September 2016)

Attachment 11

AMA Opinion 3.3.1 Management of Medical Records

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practice's medical records) should:

- (a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients' medical records by unauthorized staff.
- (b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
 - (i) immunization records, which should be kept indefinitely;
 - (ii) records of significant health events or conditions and interventions that could be expected to have a bearing on the patient's future health care needs, such as records of chemotherapy.
- (c) Make the medical record available:
 - (i) as requested or authorized by the patient (or the patient's authorized representative);
 - (ii) to the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death);
 - (iii) as otherwise required by law.
- (d) Never refuse to transfer the record on request by the patient or the patient's authorized representative, for any reason.

- (e) Charge a reasonable fee (if any) for the cost of transferring the record.
- (f) Appropriately store records not transferred to the patient's current physician.
- (g) Notify the patient about how to access the stored record and for how long the record will be available.
- (h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

*AMA Principles of Medical Ethics: IV, V
2016 American Medical Association*

Attachment 12

MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention (NCMB Position Statement)

This comprehensive position statement was formerly three separate position statements: *Access to medical records*, *Medical record documentation*, and *Retention of medical records*.

Documentation

The North Carolina Medical Board takes the position that an accurate, current, and complete medical record is an essential component of patient care. Licensees should maintain a medical record for each patient to whom they provide care. The medical record should be legible. When the caregiver does not write legibly, notes should be dictated, transcribed, reviewed, and signed within a reasonable time. It is incumbent upon the licensee to ensure that the transcription of notes is accurate (particularly in those instances where dictation software is utilized).

The medical record is a chronological document that:

- Records pertinent facts about an individual’s health and wellness;
- Enables the treating care provider to plan and evaluate treatments or interventions;
- Enhances communication between professionals, assuring the patient optimum continuity of care;
- Assists both patient and physician in communication with third party participants;
- Allows the physician to develop an ongoing quality assurance program;
- Provides a legal document to verify the delivery of care; and
- Is available as a source of clinical data for research and education.

The following required elements should be present in all medical records:

- The purpose of each patient encounter and appropriate information about the patient’s history and examination, plan for any treatment, and the care and treatment provided;
- The patient’s past medical history including serious accidents, operations, significant illnesses, and other appropriate information;
- Prominent notation of medication and other significant allergies, or a statement of their absence;
- Clearly documented informed consent obtained from the patient when appropriate; and
- Date of each entry.

The following additional elements reflect commonly accepted standards for medical record documentation:

- Each page in the medical record contains the patient’s name or ID number.
- Personal biographical information such as home address, employer, marital status, and all telephone numbers, including home, work, and mobile phone numbers.
- All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.

- All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded.
- Encounter notes should include appropriate arrangements and specified times for follow-up care.
- All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
- An appropriate immunization record is evident and kept up to date.
- Appropriate preventive screening and services are offered in accordance with the accepted practice guidelines.

Electronic Health Records

The Board recognizes and encourages the trend towards the use of electronic health records ("EHR"). The promise and potential of information technology in health care, particularly the use of EHR presents providers with distinct challenges. While the Board encourages the adoption and appropriate use of various forms of EHR, there are some unique aspects and problems associated with EHR that have been repeatedly encountered by the Board, some of which are discussed below. This subsection is meant to identify issues which the Board has repeatedly found to be problematic in malpractice and complaint cases coming to the Board's attention. It is important to recognize that this, and other Board position statements, are not comprehensive and do not describe exhaustively every standard that might apply in every circumstance. Basic, well-established principles of medical record documentation, as outlined above, apply to all forms of medical record documentation, including EHR.

The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- **EHR Deficiencies.** Providers, on occasion, attribute errors or lack of follow-up, such as missed or lost abnormal laboratory results or x-ray reports, to deficiencies in their EHR. This is not acceptable. Providers must be aware of the idiosyncrasies and weaknesses of the EHR system they are using and adjust their practice accordingly. Providers are ultimately responsible for the adequate oversight and monitoring of the EHR.
- **Responsibility of Licensees.** EHR are becoming increasingly sophisticated and may provide flags for follow-up care or other clinical decision-making support, such as health maintenance recommendations. While an EHR system may assist in the clinical decision-making process, it is not responsible for decision making. For example, it is not acceptable to blame an EHR because it failed to recommend particular testing. Increasingly elaborate documentation, clinical management, and productivity tools may also result in increased opportunities for errors or omissions. These errors are a failure of the provider to assume appropriate responsibility for the care of the patient. In the end, decision-making responsibility rests solely with the provider; regardless of the information or notices provided by the EHR.
- **Use of Templates.** The Board cautions against overuse of template content or reliance on EHR software which pre-populates, carries forward, or clones information from one

encounter to the next, or from different providers, without the provider carefully reviewing and updating all information. Documentation of clinical findings for each patient encounter must accurately and contemporaneously reflect the actual care provided.

- **Availability of, or Access to, EHR.** Physicians must be able to provide patient medical records in a timely manner for various situations, such as consultations, transfer of care to another provider, or practice closure. The Board has encountered situations where providers were unable to access their patients’ medical records due to fee or other disputes with the EHR vendor. This is particularly true when the medical records are maintained off site (cloud storage). Providers must understand provisions of their contract with the EHR vendor in this regard. These principles of medical record access apply as well to telemedicine providers.
- **Breakdown of Patient-Provider Communication.** Misunderstandings and miscommunications between patients, patient family members, practitioners, and office staff generate a substantial percentage of complaints received by the Board. Many EHR systems allow direct patient-provider communication (i.e. “patient portal”). While this form of communication can facilitate communication, such as follow-up of lab or x-ray results or medication refills, they also place a responsibility on the provider to provide timely responses to legitimate requests from patients for feedback or information.
- **Employed Licensees and Independent Contractors.** The Board recommends all employed licensees/independent contractors review their employment agreements regarding ownership of the EHR. There should be explicit provisions which set forth the rights and duties of the practice and the licensee upon termination of employment, with regards to notification of patients and access to medical records.

Access to Medical Records

A licensee’s policies and practices relating to medical records under his or her control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient’s care. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a licensee in the course of diagnosing and treating patients are primarily for the licensee’s use and to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their medical records pursuant to HIPAA privacy regulations.

Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Licensees are responsible for safeguarding and protecting the medical record and for providing adequate security measures.

Each licensee has a duty on the request of a patient or the patient’s representative to release a copy of the record in a timely manner to the patient or the patient’s representative, unless the licensee believes that such release would endanger the patient’s life or cause harm to another person. This includes medical records received from other licensees’ offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records

only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Licensees may charge a reasonable fee for the preparation and/or the photocopying of medical records, keeping in mind that state law limits fees a licensee can charge for copies of medical records in certain cases, including liability claims for personal injury, social security disability claims, and workers' compensation claims. To assist in avoiding misunderstandings, and for a reasonable fee, the licensee should be willing to review the medical records with the patient at the patient's request. Medical records should not be withheld because an account is overdue or a bill is owed (including charges for copies or summaries of medical records).

Should it be the licensee's policy to complete insurance or other forms for established patients, it is the position of the Board that the licensee should complete those forms in a timely manner. If a form is simple, the licensee should perform this task for no fee. If a form is complex, the licensee may charge a reasonable fee.

To prevent misunderstandings, the licensee's policies about providing copies or summaries of medical records and about completing forms should be made available in writing to patients when the licensee-patient relationship begins.

Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those medical records.*

When responding to subpoenas for medical records, unless there is a court or administrative order, licensees should follow the applicable federal regulations.

Retention of Medical Records

Licensees have both a legal and ethical obligation to retain patient medical records. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records. Patient interests related to present and future healthcare needs should be a licensee's primary consideration when determining how long to retain medical records.

Other Considerations and Board Expectations:

- Patients should be notified regarding how long the licensee will retain medical records.
- In order to preserve confidentiality when discarding old medical records, all medical records should be retained and destroyed in a HIPAA compliant manner, including both paper medical records and EHR. If it is feasible, patients should be given an opportunity to claim the medical records or have them sent to another care provider before old medical records are discarded.
- The licensee should respond in a timely manner to requests from patients for access to, or copies of, their medical records.
- Licensees should notify patients of the amount, and under what circumstances, the

licensee will charge for copies of a patient's medical record.

- Those licensees providing episodic care should attempt to provide a copy of the patient's medical record to the patient, the patient's primary care provider, or, if applicable, the referring licensee.

It should be noted that these expectations relate solely to Board inquiries and do not preempt other legal or ethical record retention requirements. Licensees are encouraged to seek advice from private legal counsel and/or their malpractice insurance carrier.

*NOTE: Refer also to the Board's Position Statement *on Departures from or Closings of Medical Practices*.

(Adopted July 2018) (Replaced Medical Record Documentation; Access to Medical Records; and Retention of Medical Records)

Attachment 13

N.C. Gen. Stat. § 90-411. Record copy fee.¹

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars (\$10.00), inclusive of copying costs. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. Charges for medical records and reports related to claims under Article 1 of Chapter 97 of the General Statutes shall be governed by the fees established by the North Carolina Industrial Commission pursuant to G.S. 97-26.1. This section shall not apply to Department of Health and Human Services Disability Determination Services requests for copies of medical records made on behalf of an applicant for Social Security or Supplemental Security Income disability. (1993, c. 529, s. 4.3; 1993 (Reg. Sess., 1994), c. 679, s. 5.5; 1995 (Reg. Sess., 1996), c. 742, s. 36; 1997-443, ss. 11.3, 11A.118(b). 2019-191, s. 42.)

¹ This statute was revised pursuant to [Session Law 2019-191](#). Those changes are reflected here and go into effect October 1, 2019.

Attachment 14

N.C. Gen. Stat. § 90-412. Electronic medical records.

- (a) Notwithstanding any other provision of law, any health care provider or facility licensed, certified, or registered under the laws of this State or any unit of State or local government may create and maintain medical records in an electronic format. The health care provider, facility, or governmental unit shall not be required to maintain a separate paper copy of the electronic medical record. A health care provider, facility, or governmental unit shall maintain electronic medical records in a legible and retrievable form, including adequate data backup.
- (b) Notwithstanding any other provision of law, any health care provider or facility licensed, certified, or registered under the laws of this State or any unit of State or local government may permit authorized individuals to authenticate orders and other medical record entries by written signature, or by electronic or digital signature in lieu of a signature in ink. Medical record entries shall be authenticated by the individual who made or authorized the entry. For purposes of this section, "authentication" means identification of the author of an entry by that author and confirmation that the contents of the entry are what the author intended.
- (c) The legal rights and responsibilities of patients, health care providers, facilities, and governmental units shall apply to records created or maintained in electronic form to the same extent as those rights and responsibilities apply to medical records embodied in paper or other media. This subsection applies with respect to the security, confidentiality, accuracy, integrity, access to, and disclosure of medical records. (1999-247, s. 2; 2007-248, s. 3.)

Attachment 15

N.C. Gen. Stat. § 90-5.1. Powers and duties of the Board.

- (a) The Board shall:
- (1) Administer this Article.
 - (2) Issue interpretations of this Article.
 - (3) Adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this Article.
 - (4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.
 - (5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or non-licensee. In the case of the death of a licensee, the rules may provide for the disposition of the medical records by the estate of the licensee. This subsection shall not apply to records created or maintained by persons licensed under other Articles of this Chapter or to medical records maintained in the normal course of business by licensed health care institutions.
 - (6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.
 - (7) Develop educational programs to facilitate licensee awareness of provisions contained in this Article and public awareness of the role and function of the Board.
 - (8) Develop and implement methods to identify dyscompetent licensees and licensees who fail to meet acceptable standards of care.
 - (9) Develop and implement methods to assess and improve licensee practice.
 - (10) Develop and implement methods to ensure the ongoing competence of licensees.
- (b) Nothing in subsection (a) of this section shall restrict or otherwise limit powers and duties conferred on the Board in other sections of this Article. (2007-346, s. 5. 2019-191, s. 5.)

Attachment 16

N.C. Gen. Stat. § 90-5.2. Board to collect and publish certain data.

- (a) The Board shall require all licensees to report to the Board certain information, including, but not limited to, the following:
- (1) The names of any schools of medicine or osteopathy attended and the year of graduation.
 - (2) Any graduate medical or osteopathic education.
 - (3) Any specialty board of certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.
 - (4) Specialty area of practice.
 - (5) Hospital affiliations.
 - (6) Address and telephone number of the primary practice setting.
 - (7) A current, active e-mail address, which shall not be considered a public record within the meaning of Chapter 132 of the General Statutes. This information may be used or made available by the Board for the purpose of disseminating or soliciting information affecting public health or the practice of medicine.
 - (8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.
 - (9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.
 - (10) Conviction of a felony.
 - (11) Conviction of certain misdemeanors, occurring within the last 10 years, in accordance with rules adopted by the Board.
 - (12) Any medical license, active or inactive, granted by another state or country.
 - (13) Certain malpractice information received pursuant to G.S. 90-5.3, G.S. 90-14.13, or from other sources in accordance with rules adopted by the Board.
- (a1) The Board shall make e-mail addresses reported pursuant to G.S. 90-5.2(a)(7) available to the Department of Health and Human Services for use in the North Carolina Controlled Substance Reporting System established by Article 5E of this Chapter.
- (b) Except as provided, the Board shall make information collected under G.S. 90-5.2(a) available to the public.
- (c) The Board may adopt rules to implement this section.
- (d) Failure to provide information as required by this section and in accordance with Board rules or knowingly providing false information may be considered unprofessional conduct as defined in G.S. 90-14(a)(6). (2007-346, s. 6; 2009-217, s. 2; 2013-152, s. 5; 2016-117, ss. 2(e), (f); 2019- 191, s. 6.).

Attachment 17

21 NCAC 46.3001 Procedure for disposing of drugs

- (a) All registrants under G.S. 90-85.21 shall develop and implement policies and procedures to ensure that all outdated, improperly labeled, adulterated, damaged or unwanted drugs or drug containers with worn, illegible or missing labels are destroyed or disposed of so as to render them unusable.
- (b) Any permit holder in possession of outdated, adulterated or unwanted drugs other than controlled substances may dispose or destroy such drugs by returning them to the manufacturer, by incineration at a properly permitted facility, or by any other means approved by the Board which will assure protection against unauthorized possession or use. Destructions under this Paragraph taking place at the permit holder's premises shall be witnessed by a licensed pharmacist and documented.
- (c) Any permit holder in possession of any controlled substance and desiring or required to dispose of such substance may file a written request on a form provided by the Board for authority and instructions to dispose of such substance. If destruction under this Paragraph takes place at the permit holder's premises such destruction shall be jointly witnessed by at least two licensed pharmacists approved by the Board. All destructions of controlled substances shall be documented and the document shall be retained by the permit holder for a period of at least three years. Copies of the document shall be sent to the Drug Enforcement Administration.

History Note: Authority G.S. 90-85.6; 90-85.21; Eff. October 1, 1993; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017.

Attachment 18

“The retired physician/licensee” (NCMB Position Statement)

The retirement of a licensee is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the licensee in any form or setting. According to the Board’s definition, the retired licensee is not required to maintain a currently registered license and SHALL NOT:

- Provide patient services;
- Order tests or therapies;
- Prescribe, dispense, or administer drugs;
- Perform any other medical and/or surgical acts; or
- Receive income from the provision of medical and/or surgical services performed following retirement.

The North Carolina Medical Board is aware that a number of licensees consider themselves “retired,” but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such licensees customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those licensees for their willingness to continue service following “retirement,” but it recognizes such service is not the “complete cessation of the practice of medicine” and therefore must be joined with an undiminished awareness of professional responsibility. That responsibility means that such licensees SHOULD:

- Practice within their areas of professional competence;
- Prepare and keep medical records in accord with good professional practice; and
- Meet the Board’s continuing medical education requirement.

The Board also reminds “retired” licensees with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position statements of the Board are as relevant to them as to licensees in full and regular practice, and that they continue to be subject to the risks of liability for any medical and/or surgical acts they perform.

(Adopted: January 1997)

(Amended September 2006; July 2012)

(Reviewed May 2016)

Attachment 19

Online conversion of full license to retired volunteer license form

Licensure

Retired Volunteer License Form

Complete the form below to submit a request to convert a full license to a retired limited volunteer license. You will receive an email confirming receipt of your request.

Conversion of Full License to Retired Volunteer License

By submission of this form I indicate my wish to convert my full North Carolina professional license to a Retired Limited Volunteer License. I understand that I may not receive or accept any compensation or payment, direct, monetary, in-kind, or otherwise, for the provision of medical services rendered as a volunteer. I understand I must continue to comply with applicable continuing medical education requirements.

I propose to practice in the following location(s):

Location(s):

Applicant Information

* First Name:

Middle Name: 

* Last Name:

License Type:

* NC License Number:

* Address:

* City

* State

* Zipcode

Email Address:

* Phone/Cell Number:

Attachment 20

21 NCAC 32B .1701 Scope of practice under limited volunteer license and retired limited volunteer license

The holder of a Limited Volunteer License or a Retired Volunteer Limited 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;

Amended Eff. November 1, 2013;

Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016.

Attachment 21

21 NCAC 32B .1702 Application for limited volunteer license

- (a) The Limited Volunteer License is available to physicians who hold an active license in a state or jurisdiction other than North Carolina, and who wish to volunteer at civilian indigent clinics.
- (b) In order to obtain a Limited Volunteer License, an applicant shall:
 - (1) Submit a completed application, attesting under oath or affirmation 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, two inches by two inches, affixed to the oath or affirmation attested to by a notary public;
 - (3) Submit documentation of a legal name change, if applicable;
 - (4) 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 the license;
 - (5) Submit 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) Submit a NPDB report, dated within 60 days of submission of the application;
 - (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 to the Board a non-refundable fee pursuant to G.S. 90-13.1(a) 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 materials 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;

Amended Eff. November 1, 2013;

Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016..

Attachment 22

21 NCAC 32B .1703 Scope of practice under retired 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;

Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016.

Attachment 23

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, have an inactive license, and who wish to volunteer at indigent clinics.
- (b) An applicant who has never held a North Carolina license but held an active license in another state or jurisdiction, which is currently inactive, shall:
 - (1) Submit a completed application, attesting under oath or affirmation 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, two inches by two inches, affixed to the oath or affirmation which has been attested to 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 licensure from another state or jurisdiction indicating the status of the license and whether or not any action has been taken against the license;
 - (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 to the Board a non-refundable fee pursuant to G.S. 90-13.1(a) to cover the cost of a criminal background check;
 - (9) Submit a FSMB Board Action Data Bank report;
 - (10) Submit a NPDB report, dated within 60 days of submission of the application;
 - (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 Application for Retired Volunteer License.
- (d) An applicant who held a North Carolina license which has been inactive less than six months may convert to a Retired Limited Volunteer License by completing the Application for Retired Volunteer License.
- (e) An applicant who held a North Carolina license which has been inactive for more than six months, but less than two years shall meet the requirements set forth in 21 NCAC 32B .1360.
- (f) An applicant who held a North Carolina license which has been inactive for more than two years shall meet the requirements set forth at 21 NCAC 32B .1350.
- (g) A physician who has been out of practice for more than two years will be required to complete a reentry program as set forth in 21 NCAC 32B .1370.

- (h) 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.
- (i) 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;

Amended Eff. November 1, 2013;

Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016.

Attachment 24

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 which can be found on the Board's website in the application section at <http://www.ncmedboard.org/licensing>, 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 the 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 shall provide information about the applicant's immigration and work status which the Board shall use to verify the applicant's ability to work lawfully in the United States; Those applicants who are not present in the US and who do not plan to practice physically in the US shall include a statement to that effect in the application.
 - (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, if the Board needs more information to complete the application.
- (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.
- (d) Notwithstanding the above provisions of this Rule, the licensure requirements established by rule at the time the applicant first received his or her equivalent North Carolina license shall apply. Information about these Rules is available from the Board.

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:

Amended Eff. September 1, 2014; Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016.

Attachment 25

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 which can be found on the Board's website in the application section at <http://www.ncmedboard.org/licensing>, attesting under oath or affirmation that information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application; Submit documentation of a legal name change, if applicable;
 - (2) Supply a certified copy of the 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 shall provide information about the applicant's immigration and work status which the Board shall use to verify the applicant's ability to work lawfully in the United States. Applicants who are not present in the U.S. and who do not plan to practice physically in the US shall submit a written statement to that effect.
 - (3) Furnish an original ECFMG certification status report of a currently valid certification of the ECFMG if the applicant is a graduate of a medical school other than those approved by LCME, AOA, COCA, or CACMS. 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;
 - (4) Submit the AMA Physician Profile; and, if applicant is an osteopathic physician, also submit the AOA Physician Profile;
 - (5) Submit a NPDB/HIPDB report dated within 60 days of the application’s submission;
 - (6) Submit a FSMB Board Action Data Bank report;
 - (7) Submit documentation of CME obtained in the last three years, upon request;
 - (8) Submit two completed fingerprint cards supplied by the Board;
 - (9) Submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
 - (10) 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;
 - (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; and
 - (12) 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:
 - (A) Obtained certification or recertification of CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA; or
 - (B) Met requirements for ABMS MOC (maintenance or certification) or AOA OCC (Osteopathic continuous Certification);
 - (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. If a primary source verification is not possible, then a third party verification shall be submitted.
- (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.
- (g) Notwithstanding the above provisions of this Rule, the licensure requirements established by rule at the time the applicant first received his or her equivalent North Carolina license shall apply. Information about these Rules is available from the Board.

History Note: Authority G.S. 90-8.1; 90-9.1; 90-10.1; 90-13.1;

Eff. August 1, 2010;

Amended Eff. September 1, 2014; November 1, 2013; November 1, 2011;

Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016.

Attachment 26

21 NCAC 32B .1370 Reentry to active practice

- (a) An applicant for licensure who has not actively practiced or who has not maintained continued competency for the two-year period immediately preceding the filing of an application for a license shall complete a reentry agreement as a condition of licensure.
- (b) The first component of a reentry agreement involves assessing the applicant's current strengths and weaknesses in the intended area(s) of practice. The process may include testing and evaluation by colleagues, educators or others.
- (c) The second component of the reentry agreement is education. Education shall address the applicant's area(s) of needed improvement and consist of a reentry period of retraining and education upon terms based on the factors set forth in Paragraph (d) of this Rule.
- (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, or National Commission on Certification of Physician Assistant certification or recertification.
- (e) If the Board approves an applicant's plan for reentry, the approved plan shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board, and any applicable Board agents assisting with the reentry agreement.
- (f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.
- (g) Unsatisfactory completion of the reentry agreement or practicing outside the scope of the reentry agreement 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.

Upon successful completion of the reentry agreement, the Board shall terminate the reentry agreement.

History Note: Authority G.S. 90- 8.1; 90-14(a)(11a);

Eff. March 1, 2011;

Amended Eff. January 1, 2016; Pursuant to G.S. 150B-21.3A rule is necessary without substantive public interest Eff. March 1, 2016.