

CHAPTER 35

BOARD OF MEDICAL EXAMINERS

Authority

N.J.S.A. 45:9-2.

Source and Effective Date

R.1999 d.356, effective September 20, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Executive Order No. 66(1978) Expiration Date

Chapter 35, Board of Medical Examiners, expires on September 20, 2004.

Chapter Historical Note

Chapter 35, Board of Medical Examiners, was filed and became effective prior to September 1, 1969.

Chapter 35, Board of Medical Examiners, was repealed and Chapter 35, Board of Medical Examiners, was adopted as new rules by R.1983 d.314, effective August 1, 1983. See: 15 N.J.R. 503(a), 15 N.J.R. 1255(a).

Subchapter 7, Chiropractic Practice, was adopted as R.1984 d.533, effective November 19, 1984. See: 16 N.J.R. 686(a), 16 N.J.R. 3208(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1989 d.532, effective September 21, 1989. See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Subchapter 6A, Declarations of Death upon the Basis of Neurological Criteria, was adopted as R.1992 d.309, effective August 3, 1992. See: 23 N.J.R. 3635(a), 24 N.J.R. 2731(c).

Subchapter 2A, Limited Licenses: Certified Nurse Midwifery, was adopted as R.1992 d.332, effective Subchapter 8, 1992. See: 23 N.J.R. 3632(a), 24 N.J.R. 3094(a).

Subchapter 9, Acupuncture, was adopted as R.1993 d.299, effective June 21, 1993. See: 24 N.J.R. 4013(a), 25 N.J.R. 2689(c).

Subchapter 10, Athletic Trainers, was adopted as R.1993 d.546, effective November 1, 1993. See: 25 N.J.R. 265(a), 25 N.J.R. 4935(a), 26 N.J.R. 483(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1994 d.522, effective September 19, 1994, and Subchapter 7, Chiropractic Practice, was repealed by R.1994 d.522, effective October 17, 1994. See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Subchapter 2B, Limited Licenses: Physician Assistants, was adopted as R.1994 d.538, effective November 7, 1994. See: 25 N.J.R. 5099(b), 26 N.J.R. 4411(b).

Subchapter 11, Alternate Resolution Program, was adopted as R.1995 d.339, effective June 19, 1995. See: 27 N.J.R. 1363(a), 27 N.J.R. 2412(a).

Subchapter 7, Prescription, Administration and Dispensing of Drugs, was adopted as R.1997 d.475, effective November 3, 1997. See: 29 N.J.R. 842(a), 29 N.J.R. 4706(a).

Subchapter 4A, Surgery, Special Procedures, and Anesthesia Services Performed in an Office Setting, was adopted as R.1998 d.294, effective June 15, 1998. See: 29 N.J.R. 2238(a), 30 N.J.R. 2236(b).

Petition for Rulemaking. See: 30 N.J.R. 740(c), 1642(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1999 d.356, effective September 20, 1999. See: Source and Effective Date. See, also, section annotations.

Law Review and Journal Commentaries

How New Jersey Regulates Doctors. Theodosia Tamborlane, 132 N.J.L.J. No. 15, S24 (1992).

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SUBCHAPTER 1. MEDICAL SCHOOLS, COLLEGES, EXTERNSHIPS, CLERKSHIPS AND POST-GRADUATE WORK

13:35-1.1 Observership program

(a) "Observer" shall mean an undergraduate medical student of an allopathic or osteopathic school accredited either by the Liaison Committee on Medical Education or the American Osteopathic Association or a foreign medical school listed in the World Health Organization Directory and whose graduates are accepted by the New Jersey Board of Medical Examiners as eligible to sit for the licensure examination. Observerships are limited to the student's vacation period in an extra-curricular professional experience as delineated in this section.

(b) An observership program shall be limited to:

1. Observation of operative procedures;
2. The taking of histories;
3. The performance of physical examinations;
4. The performance of non-invasive procedures under the direct supervision of and in the immediate presence of the supervising licensed physician; and
5. The participation in patient rounds and other organized patient care activities of the supervising physician.

(c) At no time shall the observer be delegated any responsibility for the care of the patient, the patient's diagnosis or any aspect of the patient's treatment, including the prescription of medication for the patient. An observer shall make no entries on the patient's permanent record.

(d) The observer shall at all times of patient contact wear an identifying badge inscribed "Medical Student."

(e) Prior to commencing participation in an observership program, the student shall have obtained written permission from the Chief of Staff and the Administration of the participating hospital and shall retain such letter.

(f) Under no circumstances shall the performance of any of the duties listed in (b) above by an observer, while engaged in such a program, be construed as the practice of medicine.

(g) The time spent in an observership program shall not be considered as part of or credited toward fulfillment of any statutory academic or clinical requirements for licensure.

Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Substituted references to observers for references to externs and substituted references to observerships for references to externships throughout; in (a), substituted "delineated in this section" for "hereafter delineated" at the end; and in (f), substituted "duties listed in (b) above" for "above duties" following "any of the".

13:35-1.2 Fifth Pathway

(a) The Board shall accept application for licensure from an applicant who does not meet the usual statutory prerequisites for educational background, in the following circumstances to be known as the Fifth Pathway:

1. The applicant has completed the entirety of the academic curriculum in residence at a medical school in a foreign country located outside of the United States, Puerto Rico or Canada or in a school-authorized clinical training program;

2. The medical school was approved throughout the applicant's period of education by the government of the country of domicile to confer the degree of Doctor of Medicine and Surgery or its equivalent, and was listed in the World Health Organization Directory;

3. The applicant has satisfactorily completed all the requirements for a matriculated student of that foreign medical school to receive a diploma, except for internship and/or social service;

4. The applicant has achieved a passing score on a screening examination acceptable to the Educational Commission on Foreign Medical Graduates (ECFMG) even though not eligible for ECFMG certification; and

5. The applicant has had his or her academic record reviewed and approved by a medical school approved by the Liaison Committee on Medical Education, which school has accepted the applicant in a one-academic-year program of supervised clinical training under its direction, and the applicant has satisfactorily completed that program as evidenced by receipt of a certificate issued by the sponsoring medical school.

(b) The applicant meeting the requirements in (a) shall thereafter be deemed by the Board to be eligible to enter a graduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). Upon satisfactory completion of the three years of post-graduate training required by N.J.A.C. 13:35-3.11, the applicant may apply for licensure in this State.

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Rule deleted and replaced with new text.

13:35-1.3 Postgraduate training

Postgraduate training shall be taken under the auspices of a hospital or hospitals accredited for such training by the Accreditation Council for Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA) or by the American Podiatric Medical Association (APMA), as applicable to the profession. The program shall further be acceptable to the Board, which shall take into account the standards adopted by the Advisory Graduate Medical Education Council (AGMEC).

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Rule deleted and replaced with new text.

Case Notes

Reasonable regulation of advertising. Att'y Gen. Form Op. No. 20 (1977).

13:35-1.4 Military service in lieu of M.D. or D.O. internship or postgraduate training

The Board may grant a license to practice medicine and surgery to any person who shall furnish proof, satisfactory to the Board, that such person has fulfilled all of the formal requirements established by law, and who has served at least two years in active military service in the United States Army, Air Force, Navy, Marine Corps, Coast Guard or the U.S. Public Health Service as a commissioned officer and physician and surgeon in a medical facility which the Board determines constitutes the substantial equivalent of the approved internship or residency training program required by law; provided, however, that such military service actively occurred subsequent to graduation from an approved medical school.

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Reference to N.J.S.A. deleted and replaced with word "law".

13:35-1.5 Registration and permit requirements for graduate medical education programs in medicine or podiatry

(a) The following words and terms shall have the following meanings unless the context in this section indicates otherwise:

“Applicant” means a graduate of a medical or podiatric school, unlicensed in this State, seeking authorization to engage in the practice of medicine or podiatry as a resident in a graduate medical education program. A registration applicant is seeking authorization to participate in the first

year of a graduate medical education program. A permit applicant is seeking authorization to participate in his or her second year (or beyond) of a graduate medical education program.

13:35-5.2 Minimum standards and tolerances of optical lenses

(a) Every pair of lenses, spectacles, eyeglasses or appurtenances thereto, prepared for or dispensed to the intended wearers from written prescriptions of physicians duly licensed to practice their profession, or duplication, replacements, reproductions or repetitions, must conform to the following minimum standards and tolerances:

PHYSICAL QUALITY AND APPEARANCE

1. Surface imperfections

TOLERANCE: No pits, scratches (other than hairline), grayness or watermarks shall be acceptable.

2. Glass defects

TOLERANCE: No bubbles, striae and inclusions shall be acceptable.

3. Localized power errors

TOLERANCE: Waves found by visual inspection shall be passable if no deterioration in image quality is found when the localized area is examined with a standard lens measuring instrument.

4. Refractive powers

TOLERANCE: 0.0. to 6.00, + or -0.12.

6.25 to 12.00, 2 per cent of power.

Above 12.00, + or -0.25.

Maximum cylinder power variation + or -0.12.

5. Refractive power addition

TOLERANCE: + or -0.12.0.

6. Cylinder Axis

TOLERANCE: 0.12 to 0.37 + or -3 degrees.

0.50 to 1.00, + or -2 degrees.

1.12 on up, + or -1 degree.

7. Prism power and location of specified optical center

TOLERANCE: Vertical + or -0.25 prism for each lens or a total of 0.50 prism imbalance. Horizontal + or -0.25 prism for each lens or a total of 0.50 prism imbalance.

8. Segment size

TOLERANCE: + or -0.5 mm. Pair must be symmetrical upon visual inspection.

9. Segment location

TOLERANCE: As specified within + or -0.5 mm.

10. Lens size:

i. Rimless

TOLERANCE: + or -0.5 mm;

ii. Bevel, for plastic frames

TOLERANCE: + or -0.5 mm;

iii. Bevel, for metal frames

TOLERANCE: To fit standard specified frame. Lens shape must match. Edges must be smooth and straight and sharp edge must be removed.

11. Heat-treated and chemically-treated industrial safety eyewear

TOLERANCE: Tolerance for power, size and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1-1972 and subsequent revisions.

12. Heat-treated and chemically-treated dress eyewear

TOLERANCE: Tolerance for power, size and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1-1972 and subsequent revisions.

(b) Provided, however, that nothing herein shall be construed to prohibit deviations beyond those established by this rule, provided that good medical cause exists therefor.

SUBCHAPTER 6. GENERAL RULES OF PRACTICE**13:35-6.1 Practice identification**

(a) A physician with a plenary license to practice medicine and surgery in the State of New Jersey shall make representation for professional purposes (office identification, stationery, professional cards, signature on insurance claim forms, education, etc.) in a manner clearly indicating such plenary licensure and/or practice specialty; for example: Dr. John Doe, physician and surgeon; or Dr. Jane Smith, physician; or Dr. John Doe, surgeon; or Dr. Jane Smith, licensed to practice medicine and surgery; or Dr. Jane Doe, physician, practice limited to (name of specialty); or similar accurate descriptive terms. In addition to or as an alternative to these titles, a licensee may use the standard and accepted abbreviation of professional degree conferred by the medical school; that is, John Smith, M.D.; Jane Smith, D.O., as the case may be.

(b) An applicant or current licensee who is a graduate of both an A.M.A.-accredited allopathic professional school and an A.O.A.-accredited osteopathic professional school may elect to use either M.D. or D.O. as the primary abbreviation following the name and shall notify the Board of such election.

(c) A licensee with a limited license issued by the Board shall identify himself or herself for professional purposes in a manner clearly indicating the licensed profession by name or by using the recognized and accepted abbreviation of the degree actually conferred by the professional college; for example: Jane Smith, Podiatrist or Jane Smith, D.P.M.; John Doe, Bioanalytical Laboratory Director or John Doe, B.L.D. or John Doe, Specialty Bioanalytical Laboratory Director in Chemistry, etc.; Jane Smith, Certified Nurse Midwife or C.N.M.

(d) The use of any letters in immediate conjunction with the name of a licensee shall be deemed a representation of earned academic professional degree. Any such degree shall have been conferred by an educational institution authorized by the appropriate higher education authorities in its state of domicile to do so. The licensee may also list abbreviations of membership in non-profit incorporated professional societies.

(e) All representations by licensees of degree abbreviations or of professional society affiliations shall comply with this rule, and any use of an academic degree or professional or membership abbreviation not in accordance with these standards shall be deemed a misrepresentation and professional misconduct.

(f) All professional representations, including, but not limited to, letterhead stationery, business cards and claim forms, shall identify the street address(es) of the licensee's professional practice location(s). A post office box, whether for general mailing or for billing purposes, may be listed on the professional representation as a preferred mailing address but the professional representation shall also include the licensee's professional practice location(s).

New Rule, R.1985 d.103, effective March 4, 1985.

See: 16 N.J.R. 3178(a), 17 N.J.R. 606(a).

This adoption repealed former rule "Degree designation".

Amended by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Amended by R.1999 d.154, effective May 17, 1999.

See: 30 N.J.R. 4317(a), 31 N.J.R. 1360(b).

Added (f).

13:35-6.2 Pronouncement of death

(a) The following words and terms, when used in this section, shall have the following meanings unless the context clearly indicates otherwise.

“Attending physician” means any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who, prior to the person’s death, had attended, supervised or directed ongoing medical treatment of the patient as a primary care physician or as a specialist undertaking to treat a significant chronic medical illness which could lead to death. A physician providing such ongoing treatment, who has issued or renewed a prescription issued to the person within the six month period preceding the death, will be deemed to be an attending physician, regardless of whether the physician has personally examined the person within that six month period.

“Certificate of death” means the official document prepared for filing pursuant to N.J.S.A. 26:6-6 et seq. which is signed by a physician and sets forth the information pertaining to a person’s last sickness, immediate and contributing causes of death and burial and the identity of the medical personnel who made the pronouncement of death.

“Covering physician” means any physician who has assumed the responsibility for providing care and treatment to an attending physician’s patients during his or her unavailability. A covering physician shall also bear a responsibility to exercise his or her best medical judgment when making a pronouncement of death or drawing the conclusions called for in completing the certificate of death.

“Pronouncement of death” means the act of conducting an inquiry concerning the circumstances of a death, checking for vital signs, ascertaining pertinent history and, where appropriate, performing a complete external examination of the unclothed body and providing a medical opinion as to conclusion and cause(s) of the death.

(b) Every physician licensed by the Board and engaged in the active practice of medicine in this State shall ensure that he or she meets the obligations set forth in this section. If the physician is unavailable, he or she shall arrange for another physician to assume these responsibilities.

(c) Upon notification of an apparent death, the attending physician or designated covering physician shall proceed without inordinate delay to the location of the presumed decedent and shall make the proper determination and pronouncement of the death.

(d) Where the apparent death has occurred outside a licensed hospital and the attending or covering physician has been notified but is unable to go to the location to make the determination and pronouncement, said physician may specify another physician or may arrange with a professional nurse (R.N.) or a paramedic in accordance with N.J.A.C. 8:41-7.5, which requires the relay of findings, including telemetered electrocardiograms, if feasible to attend the presumed decedent and make the determination and pronouncement. In every such instance a written record, which may be contained within a police record, shall be prepared describing the circumstance and identifying the physician and any other person designated as above to perform the death pronouncement responsibility. Such report shall be promptly communicated orally to the attending physician for use in preparation of the death certificate. A copy of the report shall be provided to the physician as soon as practicable.

(e) Where the probable death has occurred outside a licensed hospital and the attending or recovering physician is known but cannot be reached after exercise of reasonable diligence, or no attending physician is known, then any physician, professional nurse or paramedic in accordance with N.J.A.C. 8:41-7.5 may proceed to the scene and make the determination and pronouncement of death. A written record shall be prepared as set forth in (d) above. Following pronouncement of death, the information shall be promptly communicated to the physician for preparation of the death certificate and a copy of the report provided as soon as practicable. If no attending physician is known or if an attending physician is not available to sign in a reasonable period of time, the death shall be immediately reported to the County Medical Examiner.

(f) In cases of death within the jurisdiction of the County Medical Examiner, the examiner shall without inordinate delay require the proper and established means for the determination and pronouncement of death, and shall arrange for the removal of the body and completion of the death certificate.

(g) A certificate of death shall be prepared and completed by a physician within a reasonable period of time, not to exceed 24 hours after the pronouncement of death. The factual data set forth in the certificate shall be based, to the greatest extent possible, upon the personal knowledge of the physician preparing the certificate. The physician shall provide an immediate cause of death as well as such contributing causes as the physician can best determine from the medical history obtained from other health care professionals, family or friends of the decedent, from observation of the condition of the body when pronounced and the circumstances known concerning the death. If the physician lacks sufficient information to provide an immediate cause of death, he or she may indicate an underlying potentially fatal medical condition which in the professional judgment of the physician may, or is likely to, have caused death.

(h) Nothing contained in this section shall be deemed to impose an obligation upon any person not licensed by the Board of Medical Examiners to pronounce death.

Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).
Amended by R.1995 d.412, effective August 7, 1995.
See: 27 N.J.R. 1745(a), 27 N.J.R. 2960(a).

13:35-6.3 Sexual misconduct

(a) By this section, the Board of Medical Examiners is identifying for its licensees conduct which it shall deem to be violative of law. Specialized concerns with respect to those licensees who provide psychiatric or psychotherapeutic services are also identified.

(b) As used in this section, the following terms have the following meanings unless the context indicates otherwise:

1. "Licensee" means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

2. "Patient" means any person who is the recipient of a professional service rendered by a licensee for purposes of diagnosis, treatment or a consultation relating to treatment. "Patient" for purposes of this section also means a person who is the subject of professional examination even if the purpose of that examination is unrelated to treatment.

3. "Patient-physician relationship" means an association between a physician and patient wherein the physician owes a continuing duty to the patient to be available to render professional services consistent with his or her training and experience. The performance of any professional medical service including, but not limited to, the issuance of a prescription or authorization of a refill of a prescription is deemed to be a professional service and evidence of a patient-physician relationship.

4. "Sexual contact" means the knowing touching of a person's body directly or through clothing, where the circumstances surrounding the touching would be construed by a reasonable person to be motivated by the licensee's own prurient interest or for sexual arousal or gratification. "Sexual contact" includes, but is not limited to, the imposition of a part of the licensee's body upon a part of the patient's body, sexual penetration, or the insertion or imposition of any object or any part of a licensee or patient's body into or near the genital, anal or other opening of the other person's body.

5. "Sexual harassment" means solicitation of any sexual act, physical advances, or verbal or non-verbal conduct that is sexual in nature, and which occurs in connection with a licensee's activities or role as a provider of medical services, and that either: is unwelcome, offensive to a reasonable person, or creates a hostile workplace environment, and the licensee knows, should know or is told this; or is sufficiently severe or intense to be abusive to a reasonable person in that context. "Sexual harassment" may consist of a single extreme or severe act or of multiple acts and may include, but is not limited to, conduct of a licensee with a patient, co-worker, employee, student or supervisee whether or not such individual is in a subordinate position to the licensee.

6. "Spouse" means either the husband or wife of the licensee or an individual in a long-term committed relationship with the licensee.

(c) A licensee shall not engage in sexual contact with a patient with whom he or she has a patient-physician relationship. The patient-physician relationship is considered ongoing for purposes of this section in all contexts other than the provision of psychiatric or psychotherapeutic services, unless: actively terminated, by way of written notice to the patient and documentation in the patient record; or the last professional service was rendered more than one year ago.

1. In the context of the provision of psychiatric or psychotherapeutic services, the patient-physician relationship shall be considered ongoing for purposes of this section unless the last professional service was rendered more than two years ago; provided, however, the patient-physician relationship shall be considered ongoing for an indefinite period of time if the patient, by reason of emotional or cognitive disorder, is vulnerable to the exploitative influence of the licensee.

(d) A licensee shall not seek or solicit sexual contact with a patient with whom he or she has a patient-physician relationship and shall not seek or solicit sexual contact with any person in exchange for professional services.

(e) A licensee shall not engage in any discussion of an intimate sexual nature with a patient, unless that discussion is related to legitimate patient needs. Such discussion shall not include disclosure by the licensee of his or her own intimate sexual relationships.

(f) A licensee shall provide privacy and examination conditions which prevent the exposure of the unclothed body of the patient unless necessary to the professional services rendered.

(g) A licensee shall not promote, permit or condone sexual contact between group members in therapy groups.

(h) A licensee shall not engage in sexual harassment, whether in a professional setting (including, but not limited to, an office, hospital or health care facility) or elsewhere.

(i) A licensee shall not engage in any other activity (such as, but not limited to, voyeurism or exposure of the genitalia of the licensee) which would lead a reasonable person to believe that the activity serves the licensee's personal prurient interests or is for the sexual arousal, the sexual gratification or the sexual abuse of the licensee or patient.

(j) Violation of any of the prohibitions or directives set forth at (c) through (i) above shall be deemed to constitute gross or repeated malpractice pursuant to N.J.S.A. 45:1-21(c) or (d) or professional misconduct pursuant to N.J.S.A. 45:1-21(e).

(k) Nothing in this section shall be construed to prevent a licensee from rendering medical examination or treatment to a spouse, providing that the rendering of such service is consistent with accepted standards of medical care and that the performance of medical services is not utilized to exploit the patient for the sexual arousal or sexual gratification of the licensee.

(l) It shall not be a defense to any action under this section that:

1. The patient solicited or consented to sexual contact with the licensee; or
2. The licensee was in love with or had affection for the patient.

APPENDIX

POLICY STATEMENT REGARDING SEXUAL ACTIVITY BETWEEN PHYSICIANS AND PATIENTS AND IN THE PRACTICE OF MEDICINE

It is beyond dispute that sexual contact with patients is in conflict with the very essence of the practice of medicine. Despite that fact, the Board of Medical Examiners continues to receive complaints of sexual activity involving physicians and other licensees with patients. While the Board is promulgating a regulation to specifically notify licensees of conduct which it deems to be violative of law and will subject them to disciplinary action, this statement is meant as an advisory to licensees to guide professional behavior and further expand upon the Board's reasoning in promulgating such a regulation.

A. Background. It is well established that sexual activity between physicians and patients is almost always harmful to the patient and is prohibited. Whether harkening back to the proscription of the Hippocratic oath,¹ or referring to more recent pronouncements such as the Code of Medical Ethics of the Council of Ethical and Judicial Affairs of the American Medical Association which term sexual activities between physicians and patients harmful,² commentators have uniformly condemned such activities by physicians.

(i) **Rationale for the Policy.** A patient must have absolute confidence and trust in his or her physician. Insertion of sexual activity into the professional relationship destroys such trust because the personal interest of the physician is in conflict with the interest of the patient.

(ii) **Inequality of Power Between Physician and Patient.** Physicians are in a unique position as to the physical and emotional vulnerability of patients. Physicians are expected to examine patients undressed who expose not only their bodies but the most intimate details of their personal lives.

(iii) **Physician in Position of Authority.** Patients seek assistance and guidance from physicians. The doctor/patient relationship is not one of equality, the patient being vulnerable to abuses of power.

(iv) **Negative Psychological Consequences for Patient.** Commentators and researchers have concluded that sexual activity between physicians and patients is almost always damaging to the patient.

(v) **Public Trust in the Profession.** In order to maintain the community perception of the integrity of the medical profession, personal boundaries must be maintained.

(vi) **Sexual or Romantic Relationships with Former Patients.** Sexual activity with a former patient may also be inappropriate if the patient has been unduly influenced by the prior professional relationship or if the physician utilizes trust, knowledge, or emotions derived from the

previous professional relationship. The clearest example of this phenomenon is known as "transference" between a patient and psychotherapist, which may last for many years following the conclusion of therapy.

B. Recommendations and Guidelines for Conduct.

(i) **Licensee Responsibility**—The physician or other licensee is always responsible to ensure that the boundaries of the professional relationship are maintained. Licensees should therefore avoid verbal or physical behavior which might be interpreted as inviting a romantic or sexual relationship. Even if the patient encourages such behavior, it is the licensee's responsibility to maintain a professional manner.

(ii) **Maintaining Boundaries in Psychotherapeutic Relationships**—A licensee bears an even greater responsibility to establish and maintain boundaries between physician and patient in psychotherapeutic relationships. In furtherance of that obligation, a licensee should ensure that to the greatest extent possible, treatment should take place during the licensee's usual working hours in a professional setting, unless the specific therapy mandates otherwise (i.e. home visits for the housebound, in vivo desensitization as part of behavioral therapy). A licensee should not engage in economic dealings with psychotherapy patients.

(iii) **Explanation of Procedures, Tests and Need for Examinations**—This will ensure that patients do not misunderstand the appropriateness of the exposure of their bodies or the touching that occurs.

(iv) **Patient Privacy**—Examination conditions should ensure that patients are not embarrassed. To that end, licensees should provide privacy while a patient is removing or replacing undergarments and should provide examination gowns or draping cloths which limit exposure of the patient to the field of clinical interest.

(v) **Chaperon**—Consistent with promoting patient privacy, licensees should inform patients of the option of having a chaperon present during examination and should provide a chaperon when requested by a patient.

(vi) **Avoidance of Discussion of Personal Matters**—While it is appropriate for a licensee to discuss for example his or her training and qualifications with patients, in furtherance of the maintenance of appropriate boundaries, licensees should avoid any discussion of their own intimate personal problems or disclosure of details of their sexual lives.

¹ "... I will come for the benefit of the sick, remaining free ... of all mischief and in particular of sexual relations with both female and male persons ...".

² "sexual or romantic interactions between physicians and patients detract from the goals of the physician patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being ... at a minimum, a physician's ethical duties include terminating the physician patient relationship before initiating a dating, romantic or sexual relationship with a patient ... sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship."

Amended by R.1989 d.532, effective October 16, 1989.

See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Deleted reference to specific statute.

Amended by R.1990 d.291, effective June 4, 1990.

See: 22 N.J.R. 905(a), 22 N.J.R. 1738(a).

Included podiatric physicians as those who can countersign orders and prescriptions written by a podiatric trainee.

Repealed by R.1994 d.522, effective October 17, 1994.

See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Section was "Countersigning of order and prescriptions of unlicensed physicians."

New Rule, R.1996 d.242, effective May 20, 1996.

See: 28 N.J.R. 65(a), 28 N.J.R. 2560(a).

Case Notes

Psychiatrist's engaging in sexual relations with patient warrants suspension of medical license. In the Matter of the Suspension or Revocation of the License of Tricarico, 96 N.J.A.R.2d (BDS) 18.

Florida's revocation of physician's license for sexual misconduct supports New Jersey's license revocation. In the Matter of Vatakencherry, 96 N.J.A.R.2d (BDS) 1.

Sexually abusing patients while conducting gynecological examinations warranted revocation of license and imposition of fine. In Matter of Suspension or Revocation of License of Chunmuang, 93 N.J.A.R.2d (BDS) 27.

No proof of alleged sexual molestation by doctor. In Matter of Suspension and Revocation of License of Prada, 93 N.J.A.R.2d (BDS) 1.

Podiatrist's improper touching of female patients and relative of one patient constituted professional misconduct; license revoked and civil penalties imposed. In Matter of Suspension or Revocation of License of Schulman, 92 N.J.A.R.2d (BDS) 16.

13:35-6.4 Delegation of administration of subcutaneous and intramuscular injections to certified medical assistants

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

1. "Physician" means a doctor of medicine (M.D.), a doctor of osteopathic medicine (D.O.), or a doctor of podiatric medicine.

2. "Certified medical assistant" means a graduate of a post-secondary medical assisting education program accredited by CAHEA (The Committee on Allied Health Education and Accreditation of the American Medical Association), or its successor; ABHES (Accrediting Bureau of Health Education Schools), or its successor; or any accrediting agency recognized by the U.S. Department of Education. The educational program shall include, at a minimum, 600 clock hours of instruction and shall encompass training in the administration of intramuscular and subcutaneous injections and instruction and demonstration in: pertinent anatomy and physiology appropriate to injection procedures; choice of equipment; proper technique including sterile technique; hazards and complications; and emergency procedures. The medical assistant must also maintain current certification from the Certifying Board of the American Association of Medical Assistants (AAMA), the National Center for Competency Testing (NCCT), or registration from the American Medical Technologists (AMT), or any other recognized certifying body approved by the Board.

(b) A physician may direct a certified medical assistant employed in the medical practice in which the physician practices medicine, to administer to the physician's patients an intramuscular or subcutaneous injection in the limited circumstances set forth in this section, without being in violation of the pertinent professional practice act implemented by the Board, to the extent such conduct is permissible under any other pertinent law or rule administered by the Board or any other State agency.

(c) A physician may direct the administration of an injection by a certified medical assistant only where the following conditions are satisfied:

1. The physician has determined and documented that the certified medical assistant has the qualifications set forth in (a)2 above and has attained a satisfactory level of comprehension and experience in the administration of intramuscular and subcutaneous injection techniques.

2. The physician shall examine the patient to ascertain the nature of the trauma, disease or condition of the patient; to determine the appropriate treatment of the patient including administration of an injection; to assess the risks of such injection for a given patient and the diagnosed injury, disease or condition; and to determine that the anticipated benefits are likely to outweigh those risks.

3. The physician shall determine all components of the precise treatment to be given, including the type of injection to be utilized, dosage, method and area of administration, and any other factors peculiar to the risks, such as avoidance of administration sites on certain parts of the body. The physician shall assure that this information shall be written on the patient's record and made available at all times to the medical assistant carrying out the treatment instructions, who shall also be identified by name and credentials in the patient record on each occasion that an injection is administered.

4. The physician shall remain on the premises at all times that treatment orders for injections are being carried out by the assistant and shall be within reasonable proximity to the treatment room and available to observe, assess and take any necessary action regarding effectiveness, adverse reaction or any emergency.

5. The certified medical assistant shall wear a clearly visible identification badge indicating his or her name and credentials.

(d) The physician shall not direct the administration by a certified medical assistant of an injection which includes any of the following: any substance related to allergenic testing or treatment, local anesthetics, controlled dangerous substances, experimental drugs including any drug not having approval of the Food and Drug Administration (FDA), or any substance used as an antineoplastic chemotherapeutic agent with the exception of corticosteroids.

(d) Under (c) above, for pediatric patients, the physician shall have experience in the performance of the pertinent procedures with such patients.

(e) A physician shall not direct a diagnostic radiologic technologist holding the LRT(R) license to perform the following tasks:

1. Administer contrast material into the subarachnoid space;
2. Administer to a patient pharmaceutical materials other than those approved in accordance with (c) above; or
3. Administer radioactive materials in any form for any purpose.

(f) A physician who allows a medical resident to supervise a diagnostic radiologic student technologist shall assure that the supervision is performed concurrently with a licensed radiologic technologist or with the physician.

(g) A physician may direct an individual holding a general diagnostic or limited technologist license to perform such radiologic procedures as are authorized by the laws and rules of the State Department of Environmental Protection applicable to that licensure. A physician or a podiatric physician (DPM) may direct either a technologist holding the LRT(R) license or a technologist holding the limited license for podiatric x-ray LRT(P) to perform such radiologic procedures as are authorized and applicable to the holder of a LRT(P) license.

(h) A physician may direct a technologist holding the LRT(U) license to administer a contrast medium injection into a pre-existing peripheral intravenous line or into a pre-existing urinary catheter, whether indwelling or otherwise, so long as a physician or a medical resident is on the premises and is readily available to physically attend to the patient. The physician shall be responsible for the choice and ordering of all contrast materials and for the determination of dosage and route of administration. For pediatric patients, the physician shall have experience in the performance of the pertinent procedures with such patients or shall assure consultation with a physician having such experience.

(i) Prior to delegating the tasks set forth in (g) and (h) above, the physician (or another physician in the office or, in a licensed health care facility, the head of the pertinent Department) shall personally certify and document the radiologic technologist's training and competency to perform the task. The documents shall be preserved in the personnel record and retained for at least the duration of such technologist's employment by or for that physician/facility.

(j) Except as set forth in (h) above, a physician shall not direct a technologist holding the LRT(C), LRT(D), LRT(P),

LRT(O), or LRT(U) license to perform any of the tasks set forth in (c) or (e) above.

(k) A supervising physician may direct the LNMT to establish a peripheral intravenous line.

(l) A physician who is an authorized medical user, as specified on a Byproduct Materials License issued by the Nuclear Regulatory Commission or on the Radioactive Materials License issued by the New Jersey Department of Environmental Protection, may direct an LNMT to inject radioactive materials used for diagnostic purposes when specifically designated by the supervising physician, and only as follows:

1. Into pre-existing urinary catheters, whether indwelling or otherwise;
2. Into pre-existing nasogastric tubes or other gastric or intestinal feeding tubes;
3. Into a peripheral intravenous line, into a pre-existing central intravenous line, or by direct intravenous injection; and
4. Into a spinal needle placed into the subarachnoid space by a physician who is continuously present with the patient throughout the procedure.

(m) A physician may direct the LNMT to administer, under direct physician supervision, nonradioactive pharmaceuticals as follows:

1. Adenosine and dipyridamole for use in nuclear medicine stress tests;
2. Aminophylline in conjunction with nuclear medicine stress tests;
3. Diuretics;
4. Angiotensin converting enzyme-inhibitor agents;
5. Vitamin B-12;
6. Intravenous flush solutions such as saline or heparin; and
7. Sincalide, a synthetic cholecystokinin.

(n) The Board may, from time to time, add or delete pharmaceuticals by amendment to (m) above, on its own initiative or through a petition for rulemaking.

(o) A physician shall not direct the LNMT to administer Controlled Dangerous Substances or other pharmaceuticals, including, but not limited to, atropine, neostigmine, other cardioactive medications or any other pharmaceuticals except as set forth in (m) above.

(p) The physician shall be responsible for the choice and ordering of all nonradioactive pharmaceuticals and for the determination of dosage and route of administration. The physician who is also an authorized user shall be responsible for the choice and ordering of all radioactive pharmaceuticals and for the determination of dosage and route of administration. For pediatric patients, the physician shall have experience in the performance of the pertinent procedures with such patients.

New Rule, R.1999 d.155, effective June 7, 1999.
See: 30 N.J.R. 1752(a), 31 N.J.R. 1496(a).
Petition for Rulemaking.
See: 32 N.J.R. 2166(a).
Amended by R.2003 d.286, effective July 21, 2003.
See: 34 N.J.R. 3058(a), 35 N.J.R. 3368(a).
In (m), added 7.

13:35-6.21 Hair replacement techniques

(a) As used within this section, the following terms have the following meanings unless the content indicates otherwise:

1. "Cosmetic suturing retaining process" means a method of attaching a unit of hair to the scalp via a suturing (retaining) process.

2. "Implanted prolene loop procedure" means a surgical insertion of continuous prolene sutures in and out of the scalp in concentric circles to which a hair weave is attached.

3. "Licensee" means a physician subject to regulation by the New Jersey Board of Medical Examiners.

(b) No licensee shall perform or assist in the performance of a hair replacement technique using the implanted prolene loop procedure or any other cosmetic suturing retaining process involving the use of suture material in the scalp.

(c) Nothing in this section shall preclude licensees from performing medically recognized hair transplantation techniques.

(d) Licensees shall complete and maintain patient medical records pursuant to N.J.A.C. 13:35-6.5 which accurately reflect the transplantation technique utilized in any hair replacement procedure, a brief history pertinent to the procedure, any complications which ensued, any medications prescribed and follow-up directed.

(e) Licensees shall assure that prior to the initiation of a permitted hair transplantation technique, the risks and benefits have been discussed with the patient and informed consent has been obtained.

(f) Licensees shall, by means of a telephone number by which they shall be available, provide appropriate medical coverage on a 24-hour basis to all patients undergoing a hair transplantation technique and shall maintain a log for the sole purpose of recording all complications. This log shall be available for inspection by the Board upon request.

(g) Violation of any of (b) through (f) above may be deemed to constitute one or more of the following:

1. Gross malpractice, gross neglect, or gross incompetence in the practice of the licensed profession pursuant to N.J.S.A. 45:1-21(c);

2. Professional misconduct in the practice of the licensed profession, pursuant to N.J.S.A. 45:1-21(e);

3. A failure to comply with the provisions of an act or regulation administered by the Board, pursuant to N.J.S.A. 45:1-21(h); or

4. Unprofessional conduct which would present an imminent danger to the individual patient or to the public health, safety or welfare, within the meaning of N.J.S.A. 45:9-19.5.

(h) Licensees who are in possession of information which reasonably indicates that another licensee has engaged in a prohibited hair replacement technique shall be obligated to report such information to the Board pursuant to N.J.S.A. 45:9-19.5.

New Rule, R.1994 d.86, effective February 22, 1994.
See: 25 N.J.R. 5444(a), 26 N.J.R. 1104(a).
Stay of Operative Date until February 23, 1994; further stay until April 13, 1994.
See: 26 N.J.R. 1354(a).
Withdrawal of stay of Operative Date.
See: 26 N.J.R. 4083(a).

13:35-6.22 Termination of licensee-patient relationship

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

"Emergency care or service" means the provision of medical care or services to an individual in circumstances where the individual's life or health may be threatened or compromised unless timely medical care is provided.

"Licensee" means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

"Licensee-patient relationship" means an association between a licensee and patient wherein the licensee owes a continuing duty to the patient to be available to render professional services consistent with his or her training, experience and current scope of practice.

"Patient" means any person who is the recipient of a professional service rendered by a licensee for purposes of diagnosis, treatment or a consultation relating to treatment.

(b) The licensee-patient relationship shall be deemed to exist where the licensee has provided services to the patient within one year preceding the date on which care is to be terminated or in such other circumstances where a patient has indicated to the licensee that the patient anticipates that the licensee will provide continued professional services to the patient.

(c) In order to terminate a licensee-patient relationship, a licensee shall:

1. Notify the patient, in writing, that the licensee shall no longer provide care to the patient as of a date certain. The notification required by this paragraph shall be made no less than 30 days prior to the date on which care is to be terminated, and shall be made by certified mail, return receipt requested, sent to the patient's last known address;
2. Provide all necessary emergency care or services, including the provision of necessary prescriptions, until the date on which services are terminated. The provision of any such emergency care or services shall not be deemed to manifest any intention to reestablish a licensee-patient relationship; and
3. Comply with all requirements set forth in N.J.A.C. 13:35-6.5 for access to and transfer of patient records.

(d) Notwithstanding (c) above, a licensee shall not terminate a licensee-patient relationship in the following circumstances:

1. Where to do so would be for any discriminatory purpose and/or would violate any laws or rules prohibiting discrimination; or
2. Where the licensee knows, or reasonably should know, that no other licensee is currently able to provide the type of care or services that the licensee is providing to the patient.

(e) A licensee need not comply with the requirements set forth in (c)1 above if:

1. The licensee-patient relationship has been terminated by the patient as evidenced by conduct manifesting a deliberate intention to terminate the relationship; or
2. The reason for the termination of an ongoing licensee-patient relationship is because the licensee has discontinued providing services to a particular managed care provider or health maintenance organization, in which the patient is enrolled and such managed care provider or HMO has discharged its notice obligation pursuant to N.J.S.A. 26:2S-5a(1).

(f) When requested by the patient, the licensee shall make reasonable efforts to assist the patient in obtaining medical services from another licensee qualified to meet the patient's medical needs. These efforts may include, but are not limited to, providing referrals to the patient.

New Rule, R.2000 d.399, effective October 2, 2000.
See: 31 N.J.R. 2452(a), 32 N.J.R. 3574(b).

**SUBCHAPTER 6A. DECLARATIONS OF DEATH
UPON THE BASIS OF NEUROLOGICAL
CRITERIA**

13:35-6A.1 Purpose

(a) The rules in this subchapter are established pursuant to N.J.S.A. 26:6A-1 et seq. (P.L. 1991, c.90), the New Jersey Declaration of Death Act, and set forth: