

**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Chapter 35, Board of Medical Examiners, was repealed and Chapter 35, Board of Medical Examiners, was adopted as new rules by R.1983 d.314, effective August 1, 1983.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Examiners, was readopted as R.1994 d.522, effective September 19, 1994, and Subchapter 7, Chiropractic Practice, was repealed by R.1994 d.522, effective October 17, 1994.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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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.

1. In an inpatient setting, the supervising physician or physician-designee is continuously or intermittently present on-site with constant availability through electronic communications for consultation or recall;

2. In an outpatient setting, the supervising physician or physician-designee is constantly available through electronic communications for consultation or recall;

3. The supervising physician regularly reviews the practice of the physician assistant;

4. The supervising physician personally reviews all charts and patient records and countersigns all medical orders as follows:

i. In an inpatient setting, within 24 hours of the physician assistant's entry of the order in the patient record; and

ii. In an outpatient setting, within a maximum of seven days of the physician assistant's entry of the order in the patient record, except that in the case of any medical order prescribing or administering medication, a physician shall review and countersign the order within 48 hours of its entry by the physician assistant; and

5. The following supervisory ratios are met:

i. In a private practice which is not hospital based or institutionally affiliated, no more than two physician assistants to one physician at any one time;

ii. In all other settings, no more than four physician assistants to one physician at any one time.

(c) Upon application to the Board, the Board may alter the supervisory ratios set forth in (b) above.

(d) A supervising physician who is a department head may assign physician assistants under his or her supervision to attending and staff physicians, who shall be responsible for the practice of the physician assistant during the assignment. In all other settings in which a physician assistant is employed, the supervising physician of record shall be considered to be the person responsible for the practice of the physician assistant.

Amended by R.2000 d.349, effective August 21, 2000.  
See: 31 N.J.R. 2132(a), 32 N.J.R. 3174(a).

In (b)4ii, inserted an exception.

### 13:35-2B.11 Recordkeeping

(a) Licensees shall make contemporaneous, permanent entries into professional treatment records which shall accurately reflect the treatment or services rendered. To the extent applicable, professional treatment records shall reflect:

1. The dates and times of all treatments;
2. The patient complaint;

3. The history;

4. Findings on appropriate examination;

5. Progress notes;

6. Any orders for tests or consultations and the results thereof;

7. Diagnosis or medical impression; and

8. Treatment ordered. If medications are ordered, the patient record shall include:

i. Specific dosages, quantities and strengths of medications;

ii. A statement indicating whether the medication order is written pursuant to protocol or specific physician direction. Acceptable abbreviations are "prt" for protocol and "spd" for specific physician direction;

iii. The physician assistant's full name, printed or stamped, and the license number; and

iv. The supervising physician's full name, printed or stamped.

(b) If the information required pursuant to (a)8iii and iv appears at least once in the patient record, it need not be repeated each time a medication order is entered in the patient record.

(c) The physician assistant shall sign each entry in the patient record and record the designation "PA-C" following his or her signature.

(d) To the extent a physician assistant is charged with independent responsibility for the provision of information used to prepare bills and claims forms, such information shall accurately reflect the treatment or services rendered.

### 13:35-2B.12 Requirements for issuing prescriptions for medications

(a) A physician assistant may issue prescriptions only in accordance with the following conditions:

1. A physician assistant shall not issue prescriptions for controlled dangerous substances.

2. A physician assistant shall provide the following on all prescription blanks:

i. The physician assistant's full name, professional identification ("PA-C"), license number, address and telephone number. This information shall be printed or stamped on all prescription blanks;

ii. The supervising physician's full name, printed or stamped;

iii. A statement indicating whether the prescription is written pursuant to protocol or specific physician direction. Acceptable abbreviations are "prt" for protocol and "spd" for specific physician direction;

- iv. The full name, age and address of the patient;
- v. The date of issuance of prescription;
- vi. The name, strength and quantity of drug or drugs to be dispensed and route of administration;
- vii. Adequate instruction for the patient. A direction of "p.r.n." or "as directed" alone shall be deemed an insufficient direction;
- viii. The number of refills permitted or time limit for refills, or both;
- ix. The signature of the prescriber, hand-written; and
- x. Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the physician assistant's initials next to the chosen option, in addition to the space required for the signature in (a)3ix above.

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

In (a), deleted a former 1, and recodified former 2 and 3 as 1 and 2.

### 13:35-2B.13 Eligibility for temporary licensure

(a) An individual who has filed an application for licensure and is waiting to take the next scheduled examination administered by the National Commission on Certification of Physician Assistants (NCCPA) or awaiting the results of the examination may apply to the Board for a temporary license to be employed under the direct supervision of a physician, as defined in N.J.A.C. 13:35-2B.2 and 2B.15.

(b) An applicant for temporary licensure shall submit to the Board, with the completed application form, the documents required pursuant to N.J.A.C. 13:35-2B.5, the required fee, and evidence that the applicant has filed an application for the NCCPA examination.

New Rule, R.1995 d.423, effective August 7, 1995.  
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).

### 13:35-2B.14 Temporary licensure; scope of practice

(a) A temporary license holder who has complied with the practice requirements set forth in N.J.A.C. 13:35-2B.3 may perform all of the procedures within the scope of practice of a physician assistant, as set forth in N.J.A.C. 13:35-2B.4(a) and (b) and subject to the limitations therein, except that a temporary license holder shall not issue prescriptions.

(b) A temporary license holder shall engage in practice only under the direct supervision of a physician pursuant to the provisions of N.J.A.C. 13:35-2B.15.

New Rule, R.1995 d.423, effective August 7, 1995.  
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).

### 13:35-2B.15 Supervision of temporary license holder

(a) A temporary license holder shall not render care unless the following conditions are met:

1. In any setting, the supervising physician or physician designee or a licensed physician assistant with privileges in the same discipline:
  - i. Is continuously present on-site; and
  - ii. Countersigns, immediately after its entry in the chart, any order for medication written by the temporary license holder.
2. The supervising physician or physician designee:
  - i. Personally reviews all charts and patient records within 24 hours of the temporary license holder's entry in the chart and record; and
  - ii. Countersigns any order for medication written by the temporary licensee and countersigned by a licensed physician assistant.

New Rule, R.1995 d.423, effective August 7, 1995.  
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).

### 13:35-2B.16 Expiration of temporary license; renewal

(a) A temporary license shall expire 30 days after the temporary license holder has received notification of successful completion of the examination or immediately upon the applicant's receipt of notification of failure to pass the examination.

(b) An applicant who fails an examination shall cease and desist from the performance of his or her duties.

(c) Except in extenuating circumstances such as the applicant's critical illness or incapacitation, a temporary license may not be renewed. An applicant seeking to renew based upon extenuating circumstances shall be required to present to the Board satisfactory documentation of the basis for the renewal request.

New Rule, R.1995 d.423, effective August 7, 1995.  
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).

## SUBCHAPTER 3. LICENSING EXAMINATIONS AND ENDORSEMENTS, LIMITED EXEMPTIONS FROM LICENSURE REQUIREMENTS

### 13:35-3.1 Licensing examination; physicians

(a) Effective December 1994, the standard medical and surgical licensing examination in the State of New Jersey shall be the United States Medical Licensing Examination (USMLE), Step 3. The licensing examination administered by the National Osteopathic Board of Examiners shall also be recognized as an alternative standard licensing examination for graduation of American Osteopathic Association-approved Osteopathic Medical Schools.

(b) Prior to January 1995, the Federation Licensing Examination (FLEX) shall serve as one of the two standard medical and surgical licensing examinations in the State of New Jersey.

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.1994 d.522, effective October 17, 1994.

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

### 13:35-3.8 Administrative processing of license application

(a) In the case of candidates who are graduates of professional schools or colleges approved by the Board and whose required documents (for example, complete application form, diploma, transcript and license in foreign countries, with attested translations thereof (if not in English) by an official translator approved by the Board) are in the possession of the Board and apparently authentic, the Executive Director of the Board shall be authorized to admit such candidate to the licensing examination.

(b) Any applicant who fails to satisfy the documentary requirements set forth in (a) above may be reviewed individually by the Board.

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

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

Changed reference from secretary to Executive Director.

### 13:35-3.9 Postponement of or absence from examination; transfer or refund of fee

(a) An application for examination for any category of license may be postponed and transferred, along with the fee already paid, upon written request of the applicant, from the examination for which the applicant was scheduled, but only to the next subsequent examination. Any request for a transfer of fee must be supported by a reason accepted as valid by the Board. Request for transfer of fee and postponement of examination must be made prior to the first day of the examination.

(b) When an applicant has withdrawn from, or has failed to appear at, a scheduled examination, the Board may, at its discretion, authorize the refund of the paid examination fee. A request for refund must be made no later than 30 days after the scheduled date of the examination and must present good cause of an unusual personal nature. The Board shall review the particular circumstances of each case in determining the appropriateness of refund.

(c) No later than 90 days prior to the scheduled date of the next examination subsequent to the examination whose fee was transferred, an applicant whose request for postponement and transfer was granted pursuant to (a) above, shall submit to the Board notice of intention to take the said examination and to apply the transferred fee, along with any additional fee required by the then current fee schedule.

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

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

Entire text deleted and replaced.

### 13:35-3.10 Subversion or attempt to subvert the licensing examination process

(a) The purpose of this rule is to enhance the security of licensing examination materials and to discourage certain

types of conduct in the licensing examination process, whether by applicants or by current license holders subject to regulation by the Board.

(b) Any individual found by the Board to have engaged in conduct which subverts or attempts to subvert the licensing examination process may, at the discretion of the Board, have his or her scores on the licensing examination withheld and/or declared invalid, be found ineligible for licensure, be disqualified from the practice of the pertinent profession, and/or be subject to the imposition of other appropriate sanctions pursuant to N.J.S.A. 45:1-22.

(c) Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to:

1. Conduct which violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the licensing examination; aiding by any means in the reproduction or reconstruction of any portion of the licensing examination; selling, distributing, buying, receiving or having unauthorized possession of any portion of a future, current or previously administered licensing examination.

2. Conduct which violates the standard of test administration, such as communicating with any other examinee during the administration of the licensing examination; copying answers from another examinee or permitting one's answers to be copied by another examinee during the administration of the licensing examination; having in one's possession during the administration of the licensing examination any books, notes, written or printed materials or data of any kind, other than the examination materials distributed.

3. Conduct which violates the credentialing process, such as falsifying or misrepresenting educational credentials or other information required for admission to the licensing examination; impersonating an examinee or having an impersonator take the licensing examination on one's behalf.

### 13:35-3.11 Standards for licensure of physicians graduated from medical schools not approved by American national accrediting agencies

(a) An applicant for a license to practice medicine and surgery in this State, who is a graduate of a medical school not eligible for and not accredited by the Liaison Committee on Medical Education or the American Osteopathic Association, shall satisfy the conditions in this section to be deemed eligible for New Jersey licensure by examination or to be licensed by endorsement of a sister-state license.

(b) During the course of the applicant's medical training, and at the time of graduation, the medical school(s) was listed (or notified of eligibility for listing) in the World Directory of Medical Schools published by the World Health Organization, or the medical school(s) was approved and authorized by the country of domicile to confer the degree or certificate evidencing completion of a medical curriculum for the plenary practice of medicine and surgery.

(c) The applicant shall demonstrate successful completion of the full medical curriculum, didactic elements and clinical training prescribed by the medical school and by the country in which the medical school is located and within which the training took place, and successful completion of all of the educational requirements to practice medicine in that country.

(d) If the applicant is a national of the country in which the medical training was received, the applicant shall have obtained an unrestricted license or certificate of registration to practice medicine and surgery in that country.

(e) An applicant who has successfully completed the full basic science studies (or the equivalent of the first two years of an American medical school) in the foreign medical school located in the country of domicile authorized to confer the degree or certificate and has been given academic credit for successful completion of clinical training programs in United States hospitals, with residency programs approved by the American Council on Graduate Medical Education and the American Osteopathic Association in that field, shall demonstrate that the medical school was approved by the New Jersey State Board of Medical Examiners to conduct such a program in this State, or that the program was performed in a sister-state and recognized as acceptable by the Board.

(f) A graduate of a foreign medical school shall demonstrate to the satisfaction of the Board that he or she holds certification issued by the Educational Commission for Foreign Medical Graduates (ECFMG) which was granted following the attainment of a passing score on an acceptable examination and verification of his or her credentials by ECFMG. The Board shall accept certification of successful completion of an approved Fifth Pathway program in lieu of issuance of the ECFMG Certificate.

(g) The applicant shall demonstrate satisfaction of all other requirements of law.

(h) The applicant shall demonstrate attainment of a passing grade on an examination approved by the New Jersey Medical Board for purposes of medical licensure in this State.

(i) An applicant who has successfully completed the full basic science studies, or the equivalent of the first two years of an American medical school, in the foreign medical school located in the country of domicile authorized to confer the degree or certificate, but who has completed clinical training in the United States in a program not specifically approved by the Board, shall demonstrate prior licensure in another state and compliance with all other provisions of this section and of law, and may then be eligible to be considered for licensure in this State by endorsement. An applicant from a program specifically disapproved by the Board or conducted outside of an available approved-program procedure shall not be eligible under this subsection.

(j) Any applicant having received a medical degree from a medical school not eligible for and not accredited by the Liaison Committee on Medical Education or the American Osteopathic Association on or after July 1, 1985 shall also demonstrate successful completion of a three-year post-graduate training program accredited by the American Council on Graduate Medical Education, the American Osteopathic Association, or any other equivalent group or agency recognized by the Board of Medical Examiners.

R.1984 d.281, effective July 2, 1984 (except subsection (f) which will be operative July 1, 1985).

See: 16 N.J.R. 503(b), 16 N.J.R. 1806(a).

Amended by R.1986 d.67, effective March 17, 1986.

See: 18 N.J.R. 50(a), 18 N.J.R. 568(a).

Text added to (f) "a document indicating ... applicable) followed by".

Amended by R.1988 d.7, effective January 4, 1988.

See: 19 N.J.R. 1534(a), 20 N.J.R. 102(a).

Deleted text in (f) "followed by successful ..."; added (k).

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

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

Deleted references to specific statutes.

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.356, effective October 18, 1999.

See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Rewrote (c), (e) and (j); and in (i), rewrote the first sentence.

### 13:35-3.12 Standards for licensure of physicians with post-secondary educational deficiencies

(a) An applicant for licensure to practice medicine and surgery in this State shall submit proof to the Board that, prior to having commenced medical school studies, he or she has successfully completed a satisfactory course of at least two years, at a college or university accredited by an agency recognized by the Board, during which period he or she shall have earned at least 60 credits, and passed at least one three-credit course in each of the following subjects: chemistry, physics and biology.

(b) The Board in its discretion may waive any or all of the pre-medical requirements set forth in (a) above if the credentials presented include proof of the following:

1. Certification by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association;
2. Award of a Ph.D. degree in a health-related field from a college or university accredited by an agency recognized by the Board;
3. Award of an M.P.H. degree from a college or university accredited by an agency recognized by the Board; or
4. Award of a National Institute of Health Research Award.

(c) The Board in its discretion may waive up to one half of the required credits and/or the required subjects if the credentials presented include proof of successful completion of the full term of a fellowship program accredited by the American College of Graduate Medical Education or American Osteopathic Association acceptable to the Board.

(d) The Board in its discretion may waive any or all of the required subjects if the credentials presented include proof of a score of 80 on each part of the Federation Licensing Examination or the Uniform State Medical Licensing Examination.

(e) If the Board identifies substantive deficiencies, and none of the credentials identified at (b), (c) or (d) above have been presented, the applicant may be provided leave to secure such credentials and the Board, upon request, may provide guidance to applicants seeking to remediate deficiencies.

New Rule, R.1994 d.539, effective November 7, 1994.  
Sec: 26 N.J.R. 2742(b), 26 N.J.R. 4418(a).

### 13:35-3.13 Criminal history record information

The Board shall require a criminal history record check by the Division of State Police of all applicants for initial licensure to practice medicine and surgery in this State. Such criminal history record checks shall be obtained, processed and maintained in accordance with the procedures established by the Division of State Police pursuant to P.L. 1994, c.60 (N.J.S.A. 53:1-20.5 et seq.) and N.J.A.C. 13:59. Such criminal history records shall be disseminated in strict accordance with the limitations established by the Division of State Police pursuant to N.J.A.C. 13:59-1.6 and are not public records within the meaning of the Right to Know Law, P.L. 1963, c.73 (N.J.S.A. 47:1A-1 et seq.). Fees for criminal history record checks shall be paid by applicants for licensure in conformity with P.L. 1994, c.60 (N.J.S.A. 53:1-7) and N.J.A.C. 13:59-1.3 and 1.4. In addition to its use in evaluating an application for initial licensure, the Board may obtain criminal history record information from the Division of State Police for any other purpose authorized by statute or regulation.

New Rule, R.1995 d.554, effective October 16, 1995.  
Sec: 27 N.J.R. 1743(a), 27 N.J.R. 3964(a).

## SUBCHAPTER 4. SURGERY

### Subchapter Historical Note

Petition for Rulemaking. See: 31 N.J.R. 2276(a), 32 N.J.R. 609(a), 32 N.J.R. 1260(a).

### 13:35-4.1 Major surgery; qualified first assistant

(a) A major surgical procedure is one with a substantial hazard to the life, health or welfare of the patient. By way of example, but not limitation, a major surgical procedure includes:

1. A procedure in which an opening is made into any of the three major body cavities (abdomen, chest or head), exclusive of endoscopic approaches which explore existing channels and involve no transverse of a body wall (for example, bronchoscopy, colonoscopy) or are exclu-

sively diagnostic (for example, laparoscopy, colposcopy). With respect to non-diagnostic endoscopic procedures requiring the transverse of a body wall, a duly qualified first assistant shall be immediately available on the premises of the health care facility;

2. A procedure performing a major amputation;

3. A procedure performed where the locality, the condition, the difficulty or the length of time required to operate would constitute a direct hazard to the life of the patient.

(b) A major surgical procedure shall be performed by a duly qualified surgeon with a duly qualified assisting physician who may be a duly qualified resident in or rotating through a training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association.

(c) In addition to those individuals listed in (b) above who may act as qualified first assistants, in a health care facility licensed by the Department of Health and Senior Services, a duly qualified registered nurse first assistant (RNFA) or a duly qualified physician assistant may so act. A duly qualified certified nurse midwife (CNM) may also act as a qualified first assistant in the performance of cesarean sections. For purposes of this subsection, a licensed CNM shall be deemed to be "duly qualified" provided that the CNM has taken and passed a 30-hour didactic training course that includes anatomy, physiology, surgical technique (including wound closure), and direct observation of cesarean sections. Following the completion of the course, a CNM shall serve and be supervised as a second assistant on 10 cesarean sections and complete a supervised preceptorship as a first assistant in 20 cesarean sections.

(d) A duly qualified surgeon, duly qualified assistant physician, duly qualified resident, duly qualified registered nurse first assistant, duly qualified physician assistant, or duly qualified certified nurse midwife (CNM) shall be determined by the hospital credentials committee in conjunction with the chairman or chief of the appropriate committee in conjunction with the chairman or chief of the appropriate department or division consistent with the requirements of law or applicable rule.

(e) Licensees shall comply with the rules as promulgated by the medical staff at the health care facility and shall cooperate to assure compliance with the rules of the Board as well as any rules of the Department of Health and Senior Services which licenses the facility.

(f) In all instances in which a registered nurse first assistant, a physician assistant, or duly qualified certified nurse midwife (CNM) may act as first assistant pursuant to (c) above, the operating surgeon shall have discretion to determine whether to utilize such an individual as a first assistant, despite the fact that they are permitted to so act pursuant to this rule.

(g) In the event of incapacity or unavailability of the operating surgeon during a major surgical procedure, the functions of a first assistant who is not a physician shall be limited to maintaining the status of the patient while a substitute operating surgeon is summoned, except in matters of dire emergency. "Dire emergency" shall include only those circumstances posing a significant risk of imminent death or serious bodily injury to the patient, such as uncontrolled bleeding.

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.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.503, effective September 5, 1995.  
See: 27 N.J.R. 1744(a), 27 N.J.R. 3365(a).

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

In (a)1, substituted "on the premises of the health care facility" for "in the operating suite" at the end; and rewrote (e).

Amended by R.2000 d.66, effective February 22, 2000.  
See: 31 N.J.R. 252(a), 32 N.J.R. 710(a).

In (c), added the second through fourth sentences; and in (d) and (f), inserted references to duly qualified certified nurse midwives.

#### Cross References

Physician assistant, assisting surgery, see N.J.A.C. 13:35-2B.1 et seq.

#### Case Notes

Validity of rule (dissenting opinion). *Eatough v. Albano*, 673 F.2d 671 (1982) certiorari denied 102 S.Ct. 2931, 457 U.S. 1119, 73 L.Ed.2d 1331.

License revocation for violation of Medical Practice Act upheld; no denial of due process; Board could only impose monetary penalty for each statutory provision violated; additional penalties for multiple violations of each provision improper where physicians had no prior convictions for such offenses. In re Suspension of License of Wolfe, 160 N.J.Super. 114, 388 A.2d 1316 (App.Div.1978) certification denied 78 N.J. 406, 396 A.2d 592 (1978).

Former N.J.A.C. 13:35-7.1 governing the conduct of major surgery upheld as not inconsistent with the Medical Practice Act and as neither arbitrary, capricious, unreasonable nor vague. *Garden State Community Hospital v. State Bd. of Medical Examiners*, 147 N.J.Super. 592, 371 A.2d 794 (App.Div.1977) certification denied 74 N.J. 283, 377 A.2d 688 (1977).

#### 13:35-4.2 Termination of pregnancy

(a) This rule is intended to regulate the quality of medical care offered by licensed physicians for the protection of the public, and is not intended to affect rules of the Department of Health establishing institutional requirements. To the extent that rules of the two agencies may overlap, the Medical Board recognizes and relies upon the regulatory procedures of the Department of Health in establishing minimum acceptable standards for non-physician personnel, equipment and resources, the adequacy of the physical plant of the facility in which surgical procedures shall be performed, and the facility's interrelationship with an adequate network of health care-related resources such as ambulance service, etc.

(b) The termination of a pregnancy at any stage of gestation is a procedure which may be performed only by a physician licensed to practice medicine and surgery in the State of New Jersey.

(c) Provisions of this rule referring to stage of pregnancy shall be in terms of weeks from start of last menstrual period or "weeks LMP." For example, the stage of pregnancy at 12 weeks' gestational size, as determined by a physician, is the equivalent of 14 weeks from the first day of the last menstrual period (LMP).

(d) After 14 weeks LMP, any termination procedure other than dilatation and evacuation (D & E) shall be performed only in a licensed hospital.

(e) Fifteen weeks through 18 weeks LMP: After 14 weeks LMP and through 18 weeks LMP, a D & E procedure may be performed either in a licensed hospital or in a licensed ambulatory care facility (referred to herein as LACF) authorized to perform surgical procedures by the Department of Health. The physician may perform the procedure in an LACF which shall have a Medical Director who shall chair a Credentials Committee. The Committee shall grant to operating physicians practice privileges relating to the complexity of the procedure and commensurate with an assessment of the training, experience and skills of each physician for the health, safety and welfare of the public. A list of the privileges of each physician shall contain the effective date of each privilege conferred, shall be reviewed at least biennially, and shall be preserved in the files of the LACF.

(f) Nineteen weeks through 20 weeks LMP: A physician planning to perform a D & E procedure after 18 weeks LMP and through 20 weeks LMP in an LACF shall first file with the Board a certification signed by the Medical Director that the physician meets the eligibility standards set forth in (f)1 through 7 below and shall comply with its requirements.

1. The physician is certified or eligible for certification by the American Board of Obstetrics-Gynecology or the American Osteopathic Board of Obstetrics-Gynecology, and the physician satisfactorily completes at least 15 hours of Continuing Medical Education each year in obstetrics-gynecology.

2. The physician has admitting and surgical privileges at a nearby licensed hospital which has an operating room, blood bank, and an intensive care unit. The hospital shall be accessible within 20 minutes driving time during the usual hours of operation of the clinic.

3. The procedure shall be done in a location which is designated by the Department of Health as a licensed ambulatory care facility (LACF) authorized to perform surgical procedures as in subsection (e) above. The LACF shall be licensed by the Department of Health as an ambulatory care facility authorized to perform surgical procedures. The facility shall be in current and good standing at all times when surgical procedures are performed there. The LACF shall have a written agreement with an ambulance service assuring immediate transportation of a patient at all times when a patient has been admitted for surgery and until the patient has been discharged from the recovery room.

3. Administer contrast material through the use of a power injector;

4. Administer contrast materials into pre-existing urinary catheters, whether indwelling or otherwise;

5. Administer contrast materials into pre-existing nasogastric tubes or other gastric or intestinal feeding tubes;

6. Administer intravenous flush solutions such as saline or heparin; and

7. Administer glucagon and such other pharmaceuticals as shall be approved by the Board.

(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; and

6. Intravenous flush solutions such as saline or heparin.

(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).

### 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).

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## 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:

**13:35-6A.7 Certification of death**

The attending physician and the corroborating physician shall both document within the patient record the results of all tests performed during their examinations, and shall both sign the chart. After the two clinical examinations and appropriate confirmatory tests have been completed and documented on the patient's chart, and if both examiners have been able to make all requisite determinations, then brain death may be declared. The two physicians who performed the clinical examinations shall both certify death in the patient's chart and the attending physician shall certify death on the death certificate.

## SUBCHAPTER 7. PRESCRIPTION, ADMINISTRATION AND DISPENSING OF DRUGS

**13:35-7.1 Definitions**

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

“Actual acquisition cost” means the cost actually incurred by the practitioner in acquiring a drug from a supplier and shall not include any amounts charged by any entity in which the practitioner has a direct or indirect financial or other beneficial interest.

“Administer” means the physical, in-person provision of a drug by way of injection, vaccine, allergenic extract or nebulized preparation or the provision of multiple dose vials of injectable medications.

“Amphetamine or sympathomimetic amine” means a drug which, chemically and pharmacologically, acts as a central nervous system stimulant.

“Anabolic steroid” means any drug or hormonal substance, chemically and pharmacologically related to testosterone (other than estrogen, progestin and corticosteroids), which promotes muscle growth, as well as any salt, ester, or isomer of such substance which acts in a similar manner in the human body.

“Controlled substance” means a drug classified in any of the schedules (I through V) of the Controlled Dangerous Substances Act, N.J.S.A. 24:21-5 to 24:21-8.1, recognized to have a potential for abuse or to lead to physical or psychological dependence.

“Dispensing” means the distribution of drugs intended by the physician for the personal use of the patient. “Dispensing” as used in this subchapter does not include the in-office administration of injections, vaccines, allergenic extracts or nebulized preparations or the provision of multiple dose vials of injectable medication.

“Drug” means any article recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to those sources, including, but not limited to, a controlled substance, a prescription legend drug, an over-the-counter preparation, a vitamin or food supplement, or any compounded combination of any of the above or transdermal patch or strip, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or medical condition in humans or intended to affect the structure or function of the human body. The term, as used in this subchapter, is synonymous with “medication” as used in N.J.S.A. 45:9-22.11. “Drug,” as used in this subchapter, does not mean a device or durable medical equipment.

“Intractable pain” means pain which has been shown to be refractory or resistant to management with standard methods of treatment or for which insufficient relief has been found after reasonable efforts.

“Narcotic” means an analgesic drug which chemically and pharmacologically acts as an opioid.

“Practitioner” means any licensee subject to the regulatory authority of the Board authorized to prescribe or dispense drugs, including physicians, podiatrists and, to the extent permitted by law and rule, registered residents, resident permit holders, physician assistants and certified nurse midwives.

“Prescribing” means the act of directing that a patient take a drug included in prescription legend through either a written or verbal order.

“Terminal illness” means a diagnosed medical condition with a prognosis of less than one year.

Petition for Rulemaking.  
See: 30 N.J.R. 1643(a), 31 N.J.R. 2658(b).

**13:35-7.2 Requirements for issuing written prescriptions for drugs**

(a) A practitioner, acting within the scope of lawful practice and after an examination or evaluation of the patient's condition, may issue a written prescription for a drug to a patient, guardian or authorized representative in the form authorized by this section. The practitioner shall assure that appropriate follow-up is provided and that the effects of the drug are properly evaluated and integrated into the treatment plan for the patient.

(b) (Reserved)

(c) A practitioner shall include the following information on each written prescription:

1. The prescribing practitioner's full name, address, telephone number and proper academic degree or identification of professional practice for which licensed;
2. The full name, age and address of the patient;
3. The date of issuance;

4. The name, strength and quantity of the drug prescribed;

5. Words, in addition to numbers, to indicate the drug quantity authorized if the prescription is for a Schedule II controlled substance, for example: ten (10) Percodan; or five (5) Ritalin 5 mg;

6. The number of refills permitted or time limit for refills, or both;

7. The handwritten original signature of the prescribing practitioner;

8. An explicit indication, by initials placed next to "do not substitute" (see (e) below), if it is the prescribing practitioner's intention that a specified brand name drug be dispensed;

9. The prescribing practitioner's D.E.A. number, if the drug is a controlled substance; and

10. Adequate instruction for the patient as to frequency; a direction of "p.r.n." or "if needed" alone may be used if appropriate.

(d) A prescribing practitioner shall advise each patient by adequate notice, for example, by a sign or pamphlet in the waiting room of the office, that the patient may request the practitioner to substitute a generic drug for any brand name drug prescribed.

(e) Each practitioner shall use only written prescription blanks which shall be imprinted with the words "substitution permissible" and "do not substitute," with a space for the prescribing practitioner's initials next to the chosen option, and which shall not include preprinted information designed to discourage or prohibit substitution.

(f) When preprinted prescription blanks are not available, the full name of the prescribing practitioner must be legibly printed or stamped under the original signature.

#### Case Notes

Charges of misconduct against physician who prescribed medication to his girlfriend were dismissed due to his familiarity with her medical history and her sophisticated knowledge of such medication. In the Matter of the Suspension or Revocation of the License of Kunish, 96 N.J.A.R.2d (BDS) 9.

#### 13:35-7.3 Verbal prescriptions (Reserved)

#### 13:35-7.4 Electronically transmitted prescriptions (Reserved)

#### 13:35-7.5 Requirements for the dispensing of drugs and special limitations applicable to the dispensing of drugs for a fee

(a) A practitioner, acting within the scope of lawful practice and after an examination or evaluation of the patient's condition, may dispense a drug directly to a patient, guardian or authorized representative under the circumstances and limitations set forth in this section. The practitioner shall assure that appropriate follow-up is provided and that the effects of the drug are properly evaluated and integrated into the treatment plan for the patient.

(b) A practitioner who dispenses drugs in the office shall maintain those drugs in an area kept in an orderly and sanitary manner, and in accordance with standard pharmaceutical practice and manufacturer recommendations concerning storage conditions, including refrigeration, where necessary. A practitioner shall not maintain in inventory any drugs which are outdated, misbranded, deteriorated, adulterated, recalled, unlabeled, damaged, discontinued or which were previously dispensed to a patient. A practitioner shall be responsible for the disposal of such drugs in a manner which will not pose a health hazard and in accordance with all local, State and Federal requirements.

(c) All drugs dispensed shall be recorded in the applicable patient record.

(d) All drugs dispensed, with the exception of samples of drugs which are not controlled substances and which are packaged and labeled by the manufacturer, shall be recorded in a permanent, contemporaneous dispensing log which shall contain, at a minimum, the following:

1. The full name of the patient;
2. The complete name of each drug dispensed;
3. The strength and quantity of the drug dispensed;
4. Instructions as to the frequency of use;
5. The date of dispensing; and
6. The identity of the dispensing practitioner, if more than one practitioner dispenses in the office.

(e) Each different drug dispensed, in whatever dosage form, shall be placed in a separate container with a safety closure cap, unless the patient requests otherwise or the drug is a pharmaceutical sample which has been packaged and labeled by the manufacturer.

(f) Each drug dispensed, including pharmaceutical samples, shall bear a legible label which includes the following:

1. The complete name of the drug dispensed;
2. The strength and quantity of the drug dispensed;
3. Instructions as to the frequency of use;
4. Special precautions, as appropriate; and
5. The expiration date of the drug.

(g) With respect to any drug which is not packaged by the manufacturer as a sample, the label shall also include the following:

1. The full name of the patient;
2. A list of the ingredients if the drug was compounded, not manufactured;
3. The date of dispensing; and
4. The identity of the dispensing practitioner.

(h) A practitioner shall not charge any patient a fee for a drug packaged and labeled by a manufacturer as a sample. For any drug dispensed which is not packaged by the manufacturer as a sample, a practitioner may charge a fee to allow for a recoupment of a portion of overhead and administrative costs, which fee shall not exceed the actual acquisition cost plus an additional sum not to exceed 10 percent of the actual acquisition cost.

(i) Subject to the exception in (j) below, if a practitioner charges a fee for the drug dispensed, either directly or through a global office visit charge which is more than that practitioner's usual and customary office visit charge, the practitioner:

1. Shall not dispense that drug or a substantially equivalent drug in a quantity or in dosages greater than that which would allow the patient a seven-day supply;
2. (Reserved)
3. Shall assure that information is given to the patient regarding the alternative availability of the drug outside of the practitioner's office; and
4. Shall disclose to the patient in advance of purchase and again on the bill the actual acquisition cost of the drug.

(j) In accordance with N.J.S.A. 45:9-22.11, the requirements set forth at (i) above shall not apply to a practitioner:

1. If the office at which the dispensing occurs is situated 10 or more miles from the nearest licensed pharmacy;
2. If the drug is dispensed pursuant to an oncological or AIDS protocol;
3. If the drug dispensed is a salve, ointment or drops; or
4. If the drug is dispensed in, and directly related to, the services rendered to the patient at:
  - i. A hospital emergency room;
  - ii. A student health center at an institution of higher education; or
  - iii. A publicly subsidized community health center, family planning clinic or prenatal clinic.

**13:35-7.6 Limitations on prescribing, administering or dispensing of controlled substances; special exceptions for management of pain**

(a) When prescribing, dispensing or administering controlled substances, a practitioner shall ensure that a patient's medical history has been taken and physical examination accomplished, including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of any pain. The medical record shall reflect:

1. A recognized medical indication for the use of the controlled substance;
2. The complete name of the controlled substance;
3. The dosage, strength and quantity of the controlled substance; and
4. The instructions as to frequency of use.

(b) With respect to Schedule II controlled substances, unless the requirements of (c) below are met, a practitioner shall not authorize a quantity calculated to exceed 120 dosage units or a 30-day supply, whichever is less.

(c) A practitioner may exceed the 120 dosage unit limitation for Schedule II controlled substances in (b) above, if the practitioner follows a treatment plan designed to achieve effective pain management which has been tailored to the needs of a patient who is suffering pain from cancer, intractable pain or terminal illness. The treatment plan shall state objectives by which treatment success is to be evaluated, such as pain relief and improved physical and psychological function, and shall indicate if any further diagnostic evaluations or other treatments are planned. The practitioner shall discuss the risks and benefits of the use of controlled substances with the patient, guardian or authorized representative.

(d) When controlled substances are continuously prescribed for management of pain for three months or more, the practitioner:

1. Shall review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain and the patient's progress toward treatment objectives;
2. Shall remain alert to problems associated with physical and psychological dependence; and
3. Shall periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs such as nonsteroidal anti-inflammatories, or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence.

(e) If treatment objectives are not being met, the practitioner:

1. Shall assess the appropriateness of continued treatment with controlled substances or undertake a trial of other drugs or treatment modalities; and
2. Shall consider referring the patient for independent evaluation or treatment in order to achieve treatment objectives.

(f) A practitioner shall remain alert to the possibility that controlled substances may be misused or diverted. A practitioner managing pain in a patient with a history of sub-

stance abuse shall exercise extra care by way of monitoring, documentation and possible consultation with addiction medicine specialists, and should consider the use of an agreement between the practitioner and the patient concerning controlled substance use and consequences for misuse.

(g) The practitioner shall keep accurate and complete records including that information required by (a) above as well as:

1. The medical history and physical examination of the patient;
2. Other evaluations and consultations;
3. Treatment plan objectives;
4. Evidence of informed consent;
5. Treatments and drugs prescribed or provided, as in (a) above;
6. Any agreements with the patient; and
7. Periodic reviews conducted.

**13:35-7.7 Prohibitions on prescribing, administering or dispensing of controlled substances for detoxification; limited exceptions**

(a) A practitioner shall not issue a prescription for a narcotic drug listed in any schedule which drug is intended for the purpose of "detoxification" or "maintenance treatment."

(b) Unless registered with the New Jersey Department of Health and Senior Services to conduct a narcotic treatment program pursuant to N.J.S.A. 24:21-10 and N.J.A.C. 8:65-11.2, a practitioner shall not dispense or administer a narcotic drug listed in any schedule which drug is intended for the purpose of "detoxification" or "maintenance treatment," except:

1. To relieve acute withdrawal symptoms, provided that:
  - i. Such treatment shall not exceed 72 hours;
  - ii. No more than one day's supply of the drug is provided to the patient at a time; and
  - iii. Arrangements are made for referring the patient to an addiction specialist or a drug treatment program for treatment; or
2. As an adjunct to other medical or surgical treatment for conditions other than addiction in a licensed health care facility.

**13:35-7.8 Prohibitions and limitations in the prescribing, administering or dispensing of amphetamines and sympathomimetic amines**

(a) A practitioner shall not prescribe, order, dispense, administer, sell or transfer any amphetamine or sympathomimetic amine designated as a Schedule II controlled substance for use in weight management, dieting or any other anorectic purpose, or for the treatment of fatigue.

(b) A practitioner may prescribe, dispense or administer amphetamine or sympathomimetic amine drugs or compounds designated as Schedule II controlled substances, only as follows:

1. For the treatment of the following conditions:
  - i. Narcolepsy established by recognized diagnostic criteria;
  - ii. Idiopathic Central Nervous System Hypersomnia established by recognized diagnostic criteria;
  - iii. Attention Deficit Disorder established by recognized diagnostic criteria;
  - iv. Drug-induced brain dysfunction;
  - v. Epilepsy;
  - vi. Depression shown to be refractory to other therapeutic modalities; and
  - vii. Senile apathetic behavior;
2. For immediate use in a hospital for acute conditions such as depression associated with illness or surgery;
3. For the differential diagnostic psychiatric evaluation of depression; or
4. For the clinical investigation of the effects of such drugs or compounds in which case, in addition to other requirements of applicable law, prior application therefor shall have been made to the Board and approval granted before any such investigation is begun.

(c) A practitioner who prescribes, dispenses or administers amphetamines or sympathomimetic amines shall prepare and maintain patient medical records which accurately reflect the utilization of any drug subject to this section, the specific diagnosis, the information upon which the diagnosis is based, including testing and consultations, and the treatment objectives for which the drug is being prescribed.

(d) The following list, although not exhaustive or exclusive, includes many of the generic and brand-name Schedule II drugs which are subject to this section:

Adderall  
Amphetamine  
Desoxyn  
Dexedrine  
Dextroamphetamine  
Methamphetamine