CHAPTER 35

BOARD OF MEDICAL EXAMINERS

Authority

N.J.S.A. 45:1-15.1 and 45:9-2.

Source and Effective Date

R.2005 d.120, effective March 17, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Chapter Expiration Date

Chapter 35, Board of Medical Examiners, expires on March 17, 2010.

Chapter Historical Note

Chapter 35, Board of Medical Examiners, was adopted 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Chapter 35, Board of Medical Examiners, was repealed and Chapter 35, Board of Medical Examiners, was adopted as new rules by R.1983 d.314, effective August 1, 1983.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 September 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Examiners, was readopted as R.1994 d.522, effective September 19, 1994, and Subchapter 7, Chiropractic Practice, was repealed by R.1994 d.522, effective October 17, 1994.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: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Subchapter 12, Electrologists Advisory Committee; Licensure of Electrologists and Electrology Instructors; Electrology Standards of Practice, was adopted as R.2004 d.279, effective July 19, 2004. See: 35 N.J.R. 3263(a), 36 N.J.R. 3401(a).

Subchapter 13, Perfusionists, Advisory Committee, was adopted as R.2005 d.88, effective March 7, 2005. See: 36 N.J.R. 1721(a), 37 N.J.R. 782(a).

Chapter 35, Board of Medical Examiners, was readopted as R.2005 d.120, effective March 17, 2005. 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).

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).

13:35–6.23 Presence of chaperones

(a) In all office settings, a licensee shall provide notice to a patient, or any other person who is to be examined, of the right to have a chaperone present:

1. During breast and pelvic examinations of females; and

2. During genitalia and rectal examinations of both males and females.

(b) The notice required by (a) above shall either be provided in written form to the patient or by conspicuously posting a notice in a manner in which patients or any other person who is to be examined are made aware of the right to request a chaperone and to decline care if a chaperone acceptable to the patient is not available. In circumstances where the posting or the provision to the patient of the written notice would not convey the right to have a chaperone present, the licensee shall use another means to ensure that the patient or person to be examined understands his or her right to have a chaperone present.

(c) A licensee shall not be obligated to provide further care for the immediate medical problem presented if the licensee is unable to provide a requested chaperone acceptable to the patient.

(d) A licensee shall not be obligated to provide further care for the immediate medical problem presented if the patient refuses to have a chaperone present and it is the licensee's desire to have a chaperone present during the examination.

(e) If care is not to be provided to a patient under the circumstances described in (c) or (d) above, the licensee shall, consistent with the principles of informed consent, discuss with the patient the risks of not receiving further care.

New Rule, R.2004 d.135, effective April 5, 2004.
See: 35 N.J.R. 3262(a), 36 N.J.R. 1814(a).

13:35–6.24 Reporting of communicable diseases by licensees

(a) A licensee shall report a case of a communicable disease in accordance with Department of Health and Senior Services regulations at N.J.A.C. 8:57–1.

(b) A licensee shall report a case of Acquired Immunodeficiency Syndrome (AIDS) and infection with Human Immunodeficiency Virus (HIV) in accordance with Department of Health and Senior Services regulations at N.J.A.C. 8:57–2.

(c) Failure to report pursuant to the requirements of this section shall constitute professional misconduct subjecting the licensee to disciplinary action by the Board.

New Rule, R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

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:

1. Requirements, by specialty or expertise, for physicians authorized to declare death upon the basis of neurological criteria; and

2. Currently accepted medical standards, including criteria, tests and procedures, to govern declarations of death upon the basis of neurological criteria.

13:35–6A.2 Definitions

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

"Appropriate period of observation" means the minimum amount of time which must pass between the performance of the initial examination to determine whether brain death has occurred and the second corroborative examination.

"Attending physician" means the physician (or his or her designee) primarily responsible for the care and treatment of the individual upon whom a declaration of brain death is to be made.

"Brain death" means the irreversible cessation of all functions of the entire brain, including the brainstem.

"Corroborating physician" means the physician responsible for performance of the second examination to determine whether brain death has occurred.

"Duly qualified" means the satisfactory completion of a residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
In "Duly qualified", added a reference to the American Osteopathic Association.

13:35–6A.3 Requirements for physicians authorized to declare death on the basis of neurological criteria

(a) The attending physician shall be a plenary licensed physician. The attending physician may specialize or engage in any area of practice.

(b) The corroborating physician shall be a plenary licensed physician, who shall:

1. When determinations of brain death are to be made upon individuals above two months of age, be either a duly qualified neurologist or a neurosurgeon;

2. When determinations of brain death are to be made upon individuals at or below two months of age, be either a duly qualified neonatologist, a pediatric neurologist or a pediatric neurosurgeon, or a neurologist or neurosurgeon who has been trained in or is experienced in pediatric cases.

(c) In the event the attending physician meets the standards for qualification as a corroborating physician set forth in (b) above, then the corroborating physician may specialize or engage in any area of practice.

13:35–6A.4 Standards for determination of brain death

(a) A person may be pronounced dead if it is determined by that person's attending physician, and confirmed independently by a corroborating physician, that brain death has occurred. Either the attending physician or the corroborating physician shall perform the initial clinical examination. After passage of an appropriate period of time, in accordance with the standards set forth in N.J.A.C. 13:35–6A.5(a)3iii, the physician who did not perform the initial clinical examination (that is, the corroborating physician if the initial clinical examination was performed by the attending physician or the attending physician if the initial clinical examination was performed by the corroborating physician) shall perform a second independent clinical examination. Determinations of brain death shall be made in accordance with the mandatory criteria set forth in N.J.A.C. 13:35–6A.5.

(b) If the individual to be declared dead upon the basis of neurological criteria is or may be an organ donor, then neither the attending physician nor the corroborating physician shall have any responsibility for any contemplated recovery or transplant of that individual's organs, including, but not limited to, being the organ transplant surgeon, the attending physician of the organ recipient, or otherwise an individual subject to a potentially significant conflict of interest relating to procedures for organ procurement.

(c) Death shall not be declared on the basis of neurological criteria if either the attending physician or the corroborating physician has any reason to believe, on the basis of information in the individual's available medical records, or information provided by a member of the individual's family or any other person knowledgeable about the individual's personal religious beliefs that such a declaration would violate the personal religious beliefs of the individual. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardiorespiratory criteria.

13:35–6A.5 Criteria and testing for establishment of brain death

(a) Declarations of brain death shall be made in accordance with accepted medical standards. At a minimum, each examining physician must be able to make the mandatory determinations set forth below and must document the method(s) by which said determinations are made within the patient's chart.

1. Clinical determination that the individual is in a deep coma as marked by cerebral unreceptivity and unresponsivity: Each examining physician must be able to clinically determine that the individual is in a deep coma as marked by cerebral unreceptivity and unresponsivity. In making that determination, the examining physician shall test to ensure that the individual has no behavioral or reflex response to painful stimuli presumed to be mediated at a level above the spinal cord. If, in the opinion of the examining physician, medical circumstances require confirmation of the determination, the examining physician shall confirm the determination with appropriate studies, including but not necessarily limited to an electroencephalogram or blood-flow study.

2. Clinical determination that brain stem functions are absent: Each examining physician must be able to clinically determine that brain stem functions are absent. In making said determination, the examining physician shall test pupillary light, corneal, oculocephalic, oculovestibular, oropharyngeal and respiratory (apnea) reflexes. Absence of all such reflexes must be found. In testing for apnea, pupillary response to light and ocular movements, the examining physician must be able to make the determinations specified below and, in so doing, perform the tests specified below:

i. Apnea: Spontaneous respirations must be determined to be absent. Confirmation of apnea may be made using the technique of apneic oxygenation or by using other appropriate tests;

ii. Pupils: Pupillary response to light must be determined to be absent. The effect of mydriatic agents must be excluded; and

iii. Ocular responses: Ocular responses must be determined to be absent to passive head turning and to cold caloric testing.

3. Clinical determination of irreversibility: Each examining physician must be able to establish that the cessation of all functions of the entire brain is irreversible. In making said determination, the examining physician shall:

i. Make reasonable efforts to establish the cause of the coma, which cause should be determined to be sufficient to account for the loss of brain functions. The determination may be made by careful clinical examination and investigation of history. If the history is unknown, relevant knowledge of causation may be acquired by computed tomographic scan, measurement of core temperature, drug screening, electroencephalogram, angiography, or other appropriate procedures;

ii. Establish that there is no possibility of any recovery of any brain functions by excluding the possibility of reversible conditions such as hypothermia, neuromuscular blockade, shock, or drug or metabolic intoxication. Toxicology screening is required unless there is a reliable history that the individual did not use any sedative drugs, including ethanol; and

iii. Establish that the cessation of all brain functions persists for an appropriate period of observation. In order to so determine, all of the required findings specified above shall be independently made by both examining physicians, and the second examination shall be performed:

(1) At least six hours after the initial examination, in all instances where the individual upon whom the determination of brain death is to be made is above the age of one year and has not sustained anoxic brain damage, only so long as the cause of coma can be established to be irreversible and the diagnosis has been established with appropriate confirmatory tests such as an electroencephalogram or a blood flow study;

(2) At least 12 hours after the initial examination, in all instances where the individual upon whom the determination of brain death is to be made is:

(A) Above the age of one year and has not sustained anoxic brain damage, so long as the cause of coma can be well established to be irreversible without confirmatory tests; or

(B) Above the age of one year and has sustained anoxic brain damage, so long as irreversibility has been established with confirmatory tests; or

(C) At or below the age of one year and has not sustained anoxic brain damage, so long as the cause of coma can be established to be irreversible and the diagnosis has been established with confirmatory tests.

(3) At least 24 hours after initial examination, in all instances where the individual upon whom the determination of brain death is to be made:

(A) Has sustained anoxic brain damage, where irreversibility has not been established by confirmatory tests;

(B) Is at or below the age of one year, has not sustained anoxic brain damage, and where the diagnosis has not been established with confirmatory tests; or

(C) Is at or below age one year, has sustained anoxic brain damage, and where the diagnosis has been established with confirmatory tests.

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)3iii, added "At least" at the beginning of (1) and (2), and rewrote (3).

13:35–6A.6 Objective documentation

When objective documentation shall be needed to substantiate clinical findings, confirmation shall be made by appropriate tests such as an electroencephalogram, four-vessel angiography or radioisotope cerebral angiography.

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 a 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 "medicine" 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.

"Non-prescription substance" means an over-the-counter preparation, a vitamin or food supplement, or any compounded combination of any of these preparations and supplements or a transdermal patch or strip for which no prescription is required pursuant to law.

"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).
Amended by R.2000 d.400, effective October 2, 2000.
See: 31 N.J.R. 2454(a), 32 N.J.R. 3576(a).
In definition of "Drug", substituted "medicine" for "medication"; inserted definition for "Non-prescription substance".

13:35–7.1A Examination of patient's condition required prior to dispensing drugs or issuing a prescription; exceptions

(a) Except as provided in (b) below, a practitioner shall not dispense drugs or issue prescriptions to an individual, pursuant to the requirements of this subchapter, without first having conducted an examination, which shall be appro-

priately documented in the patient record. As part of the patient examination, the practitioner shall:

1. Perform an appropriate history and physical examination;

2. Make a diagnosis based upon the examination and all diagnostic and laboratory tests consistent with good medical care;

3. Formulate a therapeutic plan and discuss such plan, along with the basis for the plan and the risks and benefits of various treatment options, with the patient; and

4. Ensure the availability of the physician or coverage for the patient for appropriate follow-up care.

(b) Notwithstanding (a) above, an examination of the patient's condition shall not be required prior to the dispensing of drugs or the issuance of a prescription under the following circumstances:

1. In admission orders for a newly hospitalized patient;

2. For a patient of another physician for whom the practitioner is taking calls;

3. For continuation medications on a short term basis for a new patient prior to the patient's first appointment;

4. For an established patient who, based on sound medical practice, the physician believes does not require a new examination before issuing a new prescription;

5. For a patient examined by a healthcare professional who is in collaborative practice with the practitioner; and

6. When treatment is provided by a practitioner for an emergency medical condition.

(c) For purposes of this section, the term "emergency medical condition" as used in (b) above means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

New Rule, R.2003 d.372, effective September 15, 2003.
See: 34 N.J.R. 3059(a), 35 N.J.R. 4287(a).

13:35–7.2 Requirements for issuing written prescriptions for medicines

(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) Written prescriptions shall be issued only on New Jersey Prescription Blanks (NJPB), secured from an approved vendor and subject to the required security mandates of the prescription blank program.

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

1. The prescribing practitioner's full name, address, telephone number, license 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.

(e) 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.