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

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

12. Heat-treated and chemically-treated dress eyewear

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

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

SUBCHAPTER 6. GENERAL RULES OF PRACTICE

13:35–6.1 Practice identification

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

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

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

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

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

New Rule, R.1985 d.103, effective March 4, 1985.
See: 16 N.J.R. 3178(a), 17 N.J.R. 606(a).
This adoption repealed former rule "Degree designation".
Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Case Notes

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

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

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

13:35–6.2 Pronouncement of death

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

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

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

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

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

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

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

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

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

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

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

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

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

13:35–6.3 Sexual misconduct

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The patient solicited or consented to sexual contact with the licensee; or

2. The licensee was in love with or had affection for the patient.

APPENDIX

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

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

and further expand upon the Board's reasoning in promulgating such a regulation.

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

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

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

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

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

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

(vi) **Sexual or Romantic Relationships with Former Patients.** Sexual activity with a former patient may also be inappropriate if the patient has been unduly influenced by the prior professional relationship or if the physician utilizes trust, knowledge, or emotions derived from the previous professional relationship. The clearest example of this phenomenon is known as "transference" between a patient and psychotherapist, which may last for many years following the conclusion of therapy.

B. **Recommendations and Guidelines for Conduct.**

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

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

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

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

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

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

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

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

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Deleted reference to specific statute.
Amended by R.1990 d.291, effective June 4, 1990.
See: 22 N.J.R. 905(a), 22 N.J.R. 1738(a).
Included podiatric physicians as those who can countersign orders and prescriptions written by a podiatric trainee.
Repealed by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).
Section was "Countersigning of order and prescriptions of unlicensed physicians."
New Rule, R.1996 d.242, effective May 20, 1996.
See: 28 N.J.R. 65(a), 28 N.J.R. 2560(a).

Case Notes

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

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

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

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

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

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

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

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

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

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

4. The physician shall not direct the administration by a certified medical assistant of an injection which includes any of the following: controlled dangerous substances, experimental drugs including any drug not having approval of the Food and Drug Administration (FDA), or any substance used as an anti-neoplastic chemotherapeutic agent with the exception of corticosteroids.

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

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

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
In (a)3, inserted "purchasing or" preceding "prescribing".
Repealed by R.1992 d.75, effective February 18, 1992 (operative April 15, 1992).
See: 23 N.J.R. 161(a), 23 N.J.R. 1063(a), 24 N.J.R. 626(a).
Section was "Prohibition of kickbacks, rebates or receiving a payment for services not rendered."
New Rule, R.1997 d.226, effective June 2, 1997.
See: 28 N.J.R. 2317(a), 28 N.J.R. 3512(a), 29 N.J.R. 2564(a).

13:35–6.5 Preparation of patient records, computerized records, access to or release of information; confidentiality, transfer or disposal of records

(a) The following terms shall have the following meanings unless the context in which they appear indicates otherwise:

"Authorized representative" means, but is not necessarily limited to, a person who has been designated by the patient or a court to exercise rights under this section. An authorized representative may be the patient's attorney or an agent of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian

who has custody (whether sole or joint) will be deemed to be an authorized representative.

"Examinee" means a person who is the subject of professional examination where the purpose of that examination is unrelated to treatment and where a report of the examination is to be supplied to a third party.

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

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

(b) Licensees shall prepare contemporaneous, permanent professional treatment records. Licensees shall also maintain records relating to billings made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Treatment records shall be maintained for a period of seven years from the date of the most recent entry.

1. To the extent applicable, professional treatment records shall reflect:

i. The dates of all treatments;

ii. The patient complaint;

iii. The history;

iv. Findings on appropriate examination;

v. Progress notes;

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

vii. Diagnosis or medical impression;

viii. Treatment ordered, including specific dosages, quantities and strengths of medications including refills if prescribed, administered or dispensed, and recommended follow-up;

ix. The identity of the treatment provider if the service is rendered in a setting in which more than one provider practices;

x. Documentation when, in the reasonable exercise of the physician's judgment, the communication of test results is necessary and action thereon needs to be taken, but reasonable efforts made by the physician responsible for communication have been unsuccessful; and

xi. Documentation of the existence of any advance directive for health care for an adult or emancipated minor, and associated pertinent information. Documented inquiry shall be made on the routine intake history form for a new patient who is a competent adult or emancipated minor. The treating doctor shall also make and document specific inquiry of or regarding a patient in appropriate circumstances, such as when providing treatment for a significant illness, or where an emergency has occurred presenting imminent threat to life, or where surgery is anticipated with use of general anesthesia.

2. Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialled by the licensee.

3. A patient record may be prepared and maintained on a personal or other computer only when it meets the following criteria:

i. The patient record shall contain at least two forms of identification, for example, name and record number or any other specific identifying information;

ii. An entry in the patient record shall be made by the physician contemporaneously with the medical service and shall contain the date of service, date of entry, and full printed name of the treatment provider. The physician shall finalize or "sign" the entry by means of a confidential personal code ("CPC") and include date of the "signing";

iii. Alternatively, the physician may dictate a dated entry for later transcription. The transcription shall be dated and identified as "preliminary" until reviewed, finalized and dated by the responsible physician as provided in (b)3ii above;

iv. The system shall contain an internal permanently activated date and time recordation for all entries, and shall automatically prepare a back-up copy of the file;

v. The system shall be designed in such manner that, after "signing" by means of the CPC, the existing entry cannot be changed in any manner. Notwithstanding the permanent status of a prior entry, a new entry may be made at any time and may indicate correction to a prior entry;

vi. Where more than one licensee is authorized to make entries into the computer file of any professional treatment record, the physician responsible for the medical practice shall assure that each such person obtains a CPC and uses the file program in the same manner;

vii. A copy of each day's entry, identified as preliminary or final as applicable, shall be made available promptly:

(1) To a physician responsible for the patient's care;

SUBCHAPTER 7. PRESCRIPTION, ADMINISTRATION AND DISPENSING OF DRUGS

Authority

N.J.S.A. 45:9–2 and 45:9–22.11.

Source and Effective Date

R.1997 d.475, effective November 3, 1997.
See: 29 N.J.R. 842(a), 29 N.J.R. 4706(a).

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.

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.

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 dispersed, 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.