CALIFORNIA

PHYSICIAN SUPERVISOR/ASSISTANT RATIOS FOR MEDICALLY UNDERSERVED AREAS

Legislative changes contained in SB 1950 (Figueroa, Chapter 1085, Statutes of 2002) allow physicians who work in medically underserved areas to supervise up to four physician assistants. (Physician assistants, or PAs, are health care professionals licensed to practice medicine with physician supervision.) During Sunset Review hearings held in 2001, the Department of Consumer Affairs and the Joint Legislative Sunset Review Committee (JLSRC) supported a recommendation from the Physician Assistant Committee to increase the number of PAs that a physician may supervise. Both the department and the JLSRC noted, "As California's population continues to grow, the need for health care providers, particularly in hard-to-recruit areas, also increases. Many primary health care providers in these areas already rely on physician assistants to expand the number of patients they can care for on a daily basis."

They also noted that implementation of this change will increase the number of Californians receiving care in these communities. The Physician Assistant Committee commented that "Given a PA's training and the fact that many PAs come from a diverse and multi-cultural background, they are particularly suited to assist physicians in medically underserved areas of California." Legislation creating this change will be reviewed by the JLSRC at the next Sunset Review hearing for the Physician Assistant Committee in 2005. For further information, please call the Physician Assistant Committee office at (916) 263-2670.

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COLORADO

SYSTEM ERRORS/CASE STUDIES

Frequently, complaints against physicians reveal systems errors or communication breakdowns rather than physician incompetence or negligence. The Colorado Board of Medical Examiners is sharing some of these stories with you. We suggest you review these stories and use this information to eliminate the potential for these problems in your practice.

CASE 1 ISSUE: FAILURE TO FOLLOW UP ON LAB TESTS THAT WERE ORDERED.

Situation:
A female patient presents to the emergency department (ED) complaining of severe abdominal cramping. She was physically evaluated in the ED and a urinalysis and urine pregnancy test was performed and were both negative. However, a serum pregnancy test was also ordered but the patient was discharged from the ED before the results of that test returned and were reviewed. This test was positive. The patient subsequently presented to a different ED 20 days later and was diagnosed with an ectopic pregnancy.

Board Comments:
If tests are ordered, it is imperative that timely follow-up of the results occur. In the situation above, it may have been reasonable to discharge the patient prior to the availability of the serum pregnancy test results, but it is incumbent upon the treating physician to assure there is a reliable system in place to obtain the test results and bring any abnormal or concerning results to the physician's attention.

CASE 2 ISSUE: FAILURE TO PERSONALLY COMMUNICATE CRITICAL INFORMATION

Situation:
The board has seen a number of cases in the past several months in which critical diagnoses were made but were not personally communicated to the treating physician. This occurs in those specialty areas, such as radiology and pathology, where the diagnosing physician does not have direct patient contact. In the cases that have come to the board's attention, instead of the radiologist or pathologist calling the treating physician directly, the report was either added to an electronic record that the treating physician could access or a hard copy report was faxed to the treating physician's office.

Board Comments:
In those instances when a physician makes a diagnosis, such as cancer, that will be of major significance to the effective and timely treatment of the patient, the board believes it is always the best practice for the diagnosing physician to personally contact the treating physician to assure the test results have been received and understood. If the treating physician is unavailable, at a minimum, the physician should leave an urgent message on voicemail or with the answering service. Finally, it should be clearly documented in the record how the diagnosis was communicated and to whom.

THE MEDICAL MARIJUANA REGISTRY

In the November 2000 general election, Coloradans passed Amendment 20 and the Colorado Department of Public Health and Environment (CDPHE) was tasked with implementing and administering the Medical Marijuana Registry program. On June 1, 2001, the Registry began accepting and processing applications for Registry Identification cards. Since this program began, there have been numerous questions about how this law impacts physicians in Colorado, especially since it appears to be in direct conflict with federal laws surrounding the prescription of Schedule I substances.

It is clear that under Colorado law, physicians are provided protection if and when they recommend the use of medical marijuana for their patients. Specifically, Amendment 20 provides an exception from the state's criminal laws for a physician who elects to advise a patient and provide them written documentation indicating they believe their patient might benefit from the medical use of marijuana, provided that such advice is based upon the physician's contemporaneous assessment of the patient's medical history and current medical condition, and a bona fide physician-patient relationship exists. The physician must also have diagnosed their patient as having a debilitating medical condition that is covered under the current law (cancer; glaucoma; HIV/AIDS; cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis).

It is also true that physicians currently have protection under federal law. In October 2003, the U.S. Supreme Court declined to hear an appeal by the Bush Administration regarding a Ninth Circuit Court of Appeals decision pertaining to physician recommendations of medical marijuana. That decision enjoined the federal government from punishing physicians for recommending marijuana to their patients, as First Amendment rights regarding freedom of speech protect this type of communication. Also, the Drug Enforcement Administration (DEA) in Colorado has indicated that as long as doctors are not prescribing marijuana (which, according to the DEA, means using an actual prescription pad), they are not in violation of federal law. The local DEA office has received and reviewed a copy of the physician certification form and has assured the Administrator of the Medical Marijuana Registry that this form does not constitute a prescription, and that it is not something the DEA considers to be in violation of federal law.

It is extremely important for physicians to be aware that all information received by the Registry is completely confidential, and physicians' names are never shared with anyone for any reason. The Administrator of the Medical Marijuana Registry, Gail Kelsey, is available to answer questions, distribute information, and give presentations about the program and discuss its impact on doctors and patients. She can be contacted at (303) 692-2184, or via e-mail at gail.kelsey@state.co.us if you would like further information about this program.

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NEW MEXICO

AMA CODE OF MEDICAL ETHICS AND BOARD RULES: INFORMING PATIENTS OF LAB RESULTS

Section 16.10.8.9 of the Rules of the New Mexico Medical Board states that the board adopts the ethical standards set forth in the Code of Medical Ethics of the American Medical Association (AMA). This means that the board will follow the guidelines articulated in the Code for issues not specifically addressed in board rules. This category includes issues like the retention of medical records, physician self-prescribing, informed consent, and many others. This column will be devoted to discussing a different issue in each newsletter.

There has been some question recently about board policy on reporting laboratory test results to patients. For

clarification, the AMA Code of Ethics guidelines are:

- Physicians should have a consistent policy about the reporting of test results, and patients should be informed of this policy before or at the time of the test.

- Policies should include when and by whom results will be given to the patient, and under what circumstances. For example, who will deliver the results if the test is negative, and who will speak to the patient if the results are positive.

- Patients should receive test results within a reasonable amount of time. Any delays that can be anticipated should be discussed with the patient at the time of the test.

- Test results should be given to the patient in language that the patient can understand, and patients must receive all the information from tests that they will need to make informed decisions about their medical treatment.

- Physicians should take precautions to ensure that patient confidentiality is maintained. For example, results should not be left on an answering machine or given to a third party without specific patient permission. They should not be sent via e-mail, or sent through the mail on a postcard.

Physicians should develop a reasonable office policy that balances the rights and concerns of patients with the needs and circumstances of their practice.

The AMA Code of Medical Ethics can be ordered and accessed online at www.ama-assn.org. If you have suggestions for future topics in this column, please call Jenny Felmley, public information officer, at (505) 827-4013 or jenny. felmley@state.nm.us.

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SOUTH CAROLINA
CONTINUED COMPETENCY REGULATION NOW LAW

The South Carolina Board of Medical Examiners introduced a regulation intended to ensure that physicians licensed in this state demonstrate continued competency either through continued medical education or other options provided in the new regulation. The General Assembly passed the legislation, and it was signed into law by Governor Mark Sanford on April 26, 2004.

81-95. Continued Competency

The continued professional competency of physicians holding a permanent license shall be assured in the following manner:

A. For renewal of a permanent license initially issued during a biennial renewal period, compliance with all educational, examination and other requirements for the issuance of a permanent license shall be deemed sufficient for the first renewal period following initial licensure.

B. For renewal of an active permanent license biennially, documented evidence of at least one of the following options during the renewal period:

1. Forty (40) hours of Category I continuing medical education sponsored by the American Medical Association (AMA), American Osteopathic Association (AOA), or other organization approved by the board as having acceptable standards for courses it sponsors, at least thirty (30) hours of which are directly related to the licensee's practice area; or

2. certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties (ABMS) or AOA or other approved specialty board certification; or

3. completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education (ACGME) or AOA; or

4. passage of the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX); or

5. successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation (IPE), the Post-Licensure Assessment System (PLAS), or the Colorado Personalized Education Program (CPEP).

C. For reinstatement of a permanent license from lapsed or inactive status of less than four years, documented evidence of at least one of the following options within the preceding two years:

1. Forty (40) hours of Category I continuing medical education sponsored by the AMA, AOA or other organization approved by the board as having acceptable standards for courses it sponsors, at least 30 hours of which are directly related to the licensee's practice area; or

2. certification of added qualifications or recertification after examination by a national specialty board recognized by the ABMS or AOA or other approved specialty board certification; or

3. completion of a residency program or fellowship in medicine in the United States or Canada approved by the ACGME or AOA; or

4. passage of the SPEX or COMVEX; or

5. successful completion of a clinical skills assessment program approved by the board, such as the IPE, the PLAS or the CPEP.

D. For reinstatement of a permanent license from lapsed or inactive status of four years or more, documented evidence of at least one of the following options:

1. Certification of added qualifications or recertification after examination by a national specialty board recognized by the ABMS or AOA or other approved specialty board certification; or

2. completion of a residency program or fellowship in medicine in the United States or Canada approved by the ACGME or AOA; or

3. passage of the SPEX or COMVEX; or

4. successful completion of a clinical skills assessment program approved by the board, such as the IPE, the PLAS or the CPEP.

PRE-SIGNED BLANK PRESCRIPTIONS ARE UNLAWFUL

The act of a physician pre-signing blank prescriptions as a "time-saver" or as a "convenience to staff" is not only unlawful, but can lead to criminal actions by others and result in sanctions against the physician's medical license.

Section 44-53-395 of the South Carolina Code of Laws, as amended, states in part:

"(A) It shall be unlawful: (1) for any practitioner to issue any prescription document signed in blank. The issuance of such document signed in blank shall be prima facie evidence of a conspiracy to violate this section."

An recent investigation conducted by the South Carolina Board of Medical Examiners revealed that a physician issued pre-signed blank prescriptions in his office and that an employee used the prescriptions to obtain drugs by fraud to further an addiction. The results of criminal activity by the employee and licensure sanction of the physician could not be justified as either time saving or convenient.

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NORTH CAROLINA
NORTH CAROLINA'S ALLIED HEALTH CARE PROFESSIONALS

North Carolina's health care environment is continuously evolving to include a blend of medical providers. This blend includes not only physicians, but also physician assistants (PAs), nurse practitioners (NPs), and, most recently, clinical pharmacist practitioners (CPPs). As allied health care professionals, PAs, NPs and CPPs work alongside licensed physicians, improving access to medical care services necessary to meet the needs of North Carolina and its residents.

The state of North Carolina has established regulations governing the practice of PAs, NPs and CPPs. To be granted a license or approval to practice, each practitioner is responsible for fulfilling certain criteria and complying with regulations specific to his or her chosen profession. All three are responsible for establishing and maintaining a relationship between themselves and a designated supervisory physician. This supervision must be continuous, and, although it is not necessary that the supervising physician be present when the practitioner is providing care, it is required the supervisor be readily accessible. This requirement, among others,

assures public safety in the delivery of medical care by all practitioners, and requires they take responsibility for their patients in a variety of settings. The scope of that responsibility must be delineated in terms that are consistent with the applicable statutes and rules and that are understandable to colleagues, the public, and regulatory agencies.

Physician Assistants

A PA is an individual licensed by, and registered with, the North Carolina Medical Board to perform medical acts, tasks, or functions under the supervision of a physician licensed by the board. A PA must have graduated from a physician assistant or surgeon assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor agencies. (21 NCAC 32S .0101)

On completion of her or his medical education, and before performing any medical tasks in North Carolina, the PA must obtain a valid North Carolina license. This requires that the PA successfully complete the examination of the National Commission on Certification of Physician Assistants, receive acknowledgement of his or her intent to practice agreement with a primary supervising physician, and have a specific practice location approved by the board. With all criteria met, and following action by the North Carolina Medical Board, the PA will be issued a license.

The PA's intent to practice agreement with his or her supervisory physician is the most important and fundamental document required before practicing in North Carolina. There is no fee for this documentation, which includes the name, practice address, and telephone number for both the PA and the primary supervising physician. (21 NCAC 32S .0112— Notification of Intent to Practice).

Additional supervision requirements include having a written practice agreement that outlines the scope of practice for the PA. This document must be clearly identified in writing and maintained at each practice setting. The scope of practice describes the tasks delegated to the PA, the relationship the PA has with a primary supervising physician, and the process for evaluating the PA's performance. The practice agreement must be signed by the supervising physician and the PA, and, along with numerous other documents, must be readily available to the Board or its representatives upon request. Although the scope of practice is defined by the PA and her or his supervising physician, it is important to note that the primary supervising physician has responsibilities beyond continuous availability and support. According to a recently enacted rule change, a PA and supervising physician must meet every six months to discuss, among other things, clinical practice issues. However, for PAs in a new practice arrangement, the PA and supervising physician must meet monthly for the first six months. These meetings must be documented and the record of such meetings must be available for inspection by Board agents upon request (21 NCAC 32S .0110).

PAs may treat patients with prescription medications as long as they comply with North Carolina standard rules. Administrative rule 21 NCAC 32S .0109 reads: "a PA is authorized to prescribe, order, procure, dispense, and administer drugs and medical devices subject to conditions." Conditions include the requirement that there must be a written statement on prescriptive authority in which the supervising physician and the PA acknowledge they are both familiar with the laws and rules regarding prescribing. The written statement on prescribing must be reviewed periodically. Each prescription written by a PA must include, in addition to other information, the PA's name, practice address, telephone number, and license number, as well as the responsible physician's name and telephone number.

Nurse Practitioners

Subchapter 32M — Approval of Nurse Practitioners of the North Carolina Medical Board's rules, defines an NP as: "a currently licensed nurse approved to perform medical acts, consultation, collaboration, and evaluation of the medical acts performed ... under an agreement with a licensed physician for ongoing supervision...."

To be approved to practice as an NP, the NP must first have completed an approved course of study. It is also necessary she or he pass a certification examination by a national credentialing body. (However, as noted below, an NP may practice temporarily for six months while waiting to take the required examination or while awaiting the test results.) Before beginning employment, it is necessary that an NP receive written confirmation of approval to practice from the North Carolina Board of Nursing and the North Carolina Medical Board.

Each NP applying for approval may be granted interim status while the boards complete the processing of his or her application. The practice of an NP with interim status is subject to several limitations: there are no prescribing priv-

ileges; all notations in patient charts must be countersigned within two working days; and there must be documentation of weekly face-to-face consultation with the primary supervising physician. An NP with interim approval may practice for a period not to exceed six months.

For an NP who has met all other requirements for approval to practice but who is awaiting notification of successful completion of the national certification examination, temporary approval may be granted. In temporary status, an NP has limited privileges, including review and countersignature of notations by the supervising physician on every NP patient contact within seven days for the first six months, face-to-face consultation with the supervising physician weekly for a month, and, afterwards, face-to-face consultation monthly for a minimum of five months. Effective Aug. 1, 2004, temporary approval is granted for a maximum of six months. Any NP being approved to practice for the first time is subject to the guidelines outlined for temporary approval status. Should an NP have a lapse in practice, change primary supervising physicians, or change written protocols, she or he is required to follow the temporary status guidelines for a minimum of six months and to notify both boards of the changes.

Initially, as with PAs, there must be a defined collaborative practice agreement that is site-specific and serves as a guideline in defining the scope of the NP's practice. It must include a drug and device agreement and a predetermined plan for emergencies. Should a clinical practice issue arise not included in the collaborative practice agreement, the NP and the supervising physician are required to consult and document the action taken. Collaborative practice agreements must be reviewed annually. On request by the North Carolina Board of Nursing and the North Carolina Medical Board, the NP must also demonstrate the ability to perform the medical acts outlined in the agreement.

In addition, the administrative rules further require a Quality Improvement Process (QIP) to be reviewed every six months. The NP and supervising physician team must develop a process that includes the description of a clinical problem, evaluation of the treatment used, and a plan to improve outcomes. All consultations between the NP and the supervising physician, including the QIP, should be signed by both and kept for review by the boards upon request.

Clinical Pharmacist Practitioners

CPPs are newly appointed health professionals in our state authorized by the legislature to provide drug therapy management to patients under the supervision of a licensed physician. To practice, a CPP must obtain approval from both the North Carolina Board of Pharmacy and the North Carolina Medical Board. Like PAs and NPs, CPPs are required to produce a signed agreement with their supervising physician, as well as maintain a copy at each practice setting. The agreement shall be specific in regard to the physician, pharmacist, patient, and disease. In the agreement, the CPP must specify the predetermined drug therapy (including diagnosis and product selection by the patient's physician), any modifications that may be permitted, dosage forms, dosage schedules, and tests that may be ordered. In addition, weekly quality control meetings must be scheduled to review and countersign all orders.

To apply for approval, the CPP candidate must hold a current, unrestricted North Carolina pharmacy license and must meet one of the following qualifications:

1. He or she may be certified by the Board of Pharmaceutical Specialties, be a certified geriatric pharmacist, or have completed an American Society of Health System Pharmacists' residency program with two years clinical experience approved by the boards;

2. he or she may hold the academic degree of doctor of pharmacy with three years clinical experience approved by the boards; or

3. he or she may hold the academic degree of bachelor of science in pharmacy with five years clinical experience approved by the boards and have completed two NCCPC or ACPE approved certification programs. Submission of an application and an endorsement by the North Carolina Board of Pharmacy is required, along with appropriate fees and, as noted earlier, a signed supervising physician agreement (21 NCAC 32T .0101). The supervising physician is responsible for ongoing supervision and evaluation of the drug therapy management performed by the CPP, and shall review and countersign each order written by the CPP within seven days.

Conclusion

PAs, NPs and CPPs make a vital contribution to the well-being and health care management of the public. In each

field, an individual's approval to practice may be restricted, denied, or terminated should the board determine she or he has violated the related laws and rules governing that field. While practicing, these professionals must wear an identification tag displaying their professional title. North Carolina Administrative Code 32S .0113 states it is "unethical and dishonorable to represent oneself as a physician." Only an individual licensed and approved by the North Carolina Medical Board may legally identify himself or herself as a physician and serve as a supervisor for physician extenders.

Physicians who are in post-graduate training or resident training programs are not eligible to supervise PAs, NPs or CPPs. Among a variety of additional responsibilities, supervising physicians are not only accountable for their own actions, but for the actions of the practitioners they supervise. In North Carolina, all practitioners are expected to practice within the standards of care in our state. Failure to function in accordance with any provisions outlined in NCGS 90-14(a) of the Medical Practice Act or administrative rules may result in the board initiating an investigation and/or disciplinary action against the offending physician.

Each year, practitioners are required to register and pay all appropriate fees. Practitioners who change their supervising physician, scope of practice, practice address, public address, or name, must inform the board within 15 days so board records may reflect a practitioner's current information. In addition, all practitioners in these three health care professions are responsible for accumulating credit hours for continuing education. Guidelines for specific requirements for individual practitioner, as well as information on licensing, rules, and statutes, can be found on board website at www.ncmedboard.org.

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TEXAS
RULE CHANGES

The board adopted the following rule changes that were published in the Texas Register:

Chapter 162
Supervision of Medical School Students: Rule review, repeal of §§162.1-162.3, and new §162.1 regarding the requirements for Texas physicians who supervise medical school students in Texas.

Chapter 163
Licensure: Amendments to §§163.1, 163.5, 163.6, 163.10, 163.13 regarding general clean up of the sections; and changes relating to relicensure and the expedited licensure process consistent with the mandates of Senate Bill 104 and Senate Bill 558 of the 78th Legislature.

Chapter 165
Medical Records: Amendments to §§165.1, 165.3, and 165.4 regarding definitions and general clean up and amendments to §§165.1 and 165.2 and new §165.5 concerning medical records. The amendments clarify the definitions for medical records and maintenance of records and add requirements of the Health Insurance Portability and Accountability Act (HIPAA) as appropriate. The new provisions of §165.5 outline the requirements concerning transfer or disposal of medical records.

Chapter 166
Physician Registration: Amendments to §§166.1-166.6 regarding biennial registration mandated by Senate Bill 104.

Chapter 168
Persons with Criminal Backgrounds: Rule review and repeal of §168.1. The text of the repeal will be incorporated into the new Chapter 190.

Chapter 171
Postgraduate Training Permits: Amendments to §171.2 regarding eligibility for postgraduate training permits and to §171.6 regarding faculty temporary permits that would allow active military physicians, holding part-time appointments at Texas medical schools, to be eligible for faculty temporary permits.

Chapter 173
Physician Profiles: Rule review and amendments to §§173.1, 173.3, and 173.4 that will make the sections consistent with the requirements of Senate Bill 104 by removing the 10-year reporting limitation in §173.1(b)(18)-(21) adding paragraph (25) regarding malpractice information, and outlining the timeline for updating the profile following the filing of formal complaints.

Chapter 175
Fees, Penalties, and Applications: Amendments to §§175.1, 175.2, and 175.4 regarding biennial registration fees for physicians; increased penalty fees for late physician registration; surcharges for physician assistant, acupuncture, and acudetox renewal; registration and

penalty fees for surgical assistants; and fees for approval of continuing acupuncture education providers.

Chapter 176

Health Care Liability Lawsuits and Settlements: New chapter consistent with Senate Bill 104 regarding reporting responsibilities for licensees against whom a health care liability complaint has been filed and a settlement has been made.

Chapter 178

Complaints: New §§178.1-178.8 concerning procedures for initiation, filing, and appeals of complaints. In addition, Chapter 188 of this title (relating to Complaint Procedure Notification) was repealed and the text regarding the process for complaint procedure notification was incorporated into this new chapter.

Chapter 179

Investigations: Repeal of §§179.1-179.5 and new §§179.1-179.7 regarding a system of procedures for the investigation of jurisdictional complaints.

Chapter 182

Use of Experts: New §§182.1-182.6 regarding the use of experts consistent with the requirements of Senate Bill 104. The new sections will establish procedures, qualifications and duties of these professionals serving as expert panel members, consultants and expert witnesses to the board.

Chapter 183

Acupuncture: Amendments to §§183.10 and 183.20 and new §183.22 concerning written instructions in medical records and continuing acupuncture education.

Chapter 184

Surgical Assistants: Amendments to §184.4 regarding examination requirements for licensure. Amendments to §§184.8 and 184.25 regarding biennial registration and annual continuing education requirements, and repeal of §§184.10 and 184.11 regarding fees related to the renewal of expired licenses and schedule of fees. The repealed sections were added to Chapter 175 relating to Fees, Penalties, and Applications as part of the adopted changes to Chapter 175.

Chapter 185

Physician Assistants: Amendments to §§185.7 and 187.15 permitting the Physician Assistant Board's designee to issue temporary licenses and concerning a physician's eligibility to supervise a physician assistant.

Chapter 187

Procedural Rules: Amendments to §§187.2, 187.9, 187.13, 187.16, 187.18, 187.24, 187.44, 187.56, 187.57, 187.60, and the repeal of §§187.5 and 187.40 concerning the timeline for scheduling informal settlement conferences; temporary suspension or restriction of licenses; required suspension or revocation of licenses for certain offenses; and ineligibility determinations for licensure applicants.

Chapter 190

Disciplinary Guidelines: Repeal of §190.1; and new Subchapter A, §§190.1-190.2; new Subchapter B, §190.8; and new Subchapter C, §§190.14-190.15 regarding disciplinary guidelines in licensure and disciplinary matters.

Chapter 192

Office-Based Anesthesia: Rule review and amendments to §§192.2-192.4 and 192.6 regarding general cleanup of the sections and the establishment of a process for biennial registration consistent with Senate Bill 104.

Chapter 193

Standing Delegation Orders: Amendments to §§193.2 and 193.6 regarding the delegation of prescriptive authority as mandated by House Bill 1095 of the 78th Legislature and applications for waiver and meetings of the Prescriptive Delegation Waiver Advisory Committee. §193.11 was added regarding delegation and supervision of the use of lasers.

Chapter 194

Non-Certified Radiologic Technicians: Rule review of Chapter 194; amendments to §§194.1-194.4 and 194.6; repeal of §§194.7-194.10 and new 194.7-194.11 regarding general cleanup and reorganization of the chapter.

Chapter 196

Voluntary Surrender of a Medical License: Amendments to §§196.1-196.3 for general clean up of the chapter.

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LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.